

**TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
March 31, 2022 – 3:30 o'clock p.m.**

In accordance with California Government Code Section 54953 teleconferencing will be used by the Board members and appropriate staff members during this meeting. Members of the public will also 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: 830 1470 6510; Passcode: 044627**

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 2022 Financial Statement Results	10 min.	CFO
6	New Business – None	---	----
7	Old Business – (a) Presentation by National Demographics Corporation on the Redistricting process and minimum change map and Zone Boundaries (b) Public Hearing to receive input from the public on the proposed minimum change map and Zone Boundaries (c) Board discussion on the proposed minimum change map and Zone Boundaries and Consideration of Resolution No. 811 in compliance with the Decennial Redistricting Requirements	30 min.	Chair/Board Counsel

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

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

	Agenda Item	Time Allotted	Requestor
8	<p>Chief of Staff</p> <p>a) March 2022 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on March 28, 2022.</p>	5 min.	COS
9	<p>Consideration of Consent Calendar <i>Requested items to be pulled require a second</i></p> <p>(1) Approval of an agreement to provide transitional on call coverage for OB-GYN services to include Tannaz Ebrahimi Adib, M.D., Leticia Campbell, M.D., Deena Elwan, M.D., Rahele Mazarei, D.O., Eimane Mostofian, M.D., Marlene Pountney, M.D., and Berk Suntay, M.D., for a month-to-month term up to 12 months, beginning March 1, 2022 at a daily rate of \$1,200 (weekday) and \$1,500 (weekend/holiday), for a maximum anticipated total term cost not to exceed \$156,600.</p> <p>(2) Consideration to approve a purchased services agreement with New Ultimate Billing, LLC for billing services for Orthopedic and Rehabilitation services for the 1206(b) clinic for a term of 36 months beginning March 1, 2022 and ending on February 28, 2025, for an anticipated total cost of the term of \$1,500,000.</p> <p>(3) Consideration to approve a purchased services agreement with R1, RCM, Inc. for billing services for Urology, Pulmonary and Primary Care services for the 1206(b) clinics for a term of 36 months beginning March 1, 2022 and ending on February 28, 2025, for an anticipated total cost of the term of \$1,170,000.</p> <p>(4) Consideration to approve an addendum to the existing Professional Services Agreement between Tri-City Healthcare District and Tri-City Primary Care Medical Group for Ole Snyder, M.D., family practice physician to join the group for a total amount not to exceed \$596,000 for two years.</p> <p>(5) Consideration to approve the agreement for Medical Directorship for Surgical and Perioperative Services with David Seif, M.D. for a term of 12 months, beginning April 1, 2022 and ending March 31, 2023, with an annual and term cost not to exceed \$28,800.</p> <p>(6) Approval of Resolution 810, a Resolution of the Board of Directors of the Tri-City Healthcare District Re-Ratifying the State of Emergency and Re-Authorizing Remote Teleconference Meetings</p> <p>(7) Approval of an agreement with Medline Industries, Inc. for medical supply distribution services for a term of 36 months, beginning October 1, 2022 and ending September 30, 2025, for an estimated annual cost of \$3,709,824 and a total cost for the term of \$11,129,472.</p> <p>(8) Administrative & Board Committees A. Policies 1. Patient Care Services Policies & Procedures a. Blood Glucose Point of Care Testing Procedure b. Eclampsia Management Standardized Procedure c. Latex Sensitivity-Allergy Management Policy 2. Administrative 200s District Operations</p>		

	Agenda Item	Time Allotted	Requestor
	<ul style="list-style-type: none"> a. Charity Care, Uncompensated Care, Community Service 285 3. Allied Health Professional <ul style="list-style-type: none"> a. Standards for Allied Health Professional RNFA 4. Cardiac Rehab <ul style="list-style-type: none"> a. Disaster Plan 5. Emergency Operations Plan <ul style="list-style-type: none"> a. 4004 Evacuation Plan b. 4014 Acute Care Orthopedics, and Rehabilitation Unit Specific c. 4074 Identification of Incident Command Staff-Hospital Wide d. 4086 Administrative Coordinators e. Code Yellow - Radiation Disaster, Treatment of the Contaminated Patient f. Emergency Operations Plan g. Medical Staff Assignments h. Radiology Emergency Management (Disaster) Plan i. Scalable Event (DELETE) 6. Engineering <ul style="list-style-type: none"> a. Emergency Generator Test and Failures b. Failure of Fire Alarm System 8015 c. Guidelines for Procedure for Failure of Essential Equipment 8017 (DELETE) d. System Record Drawings 8019 (DELETE) e. Utility Management Plan 4003 7. Environment of Care Manual <ul style="list-style-type: none"> a. Safety Plan 8. Infection Control <ul style="list-style-type: none"> a. Management of Patients with Multi-Drug Resistant Organisms (MDRO) and/or C. Difficile Infection b. Philosophy Policy 9. Pharmacy <ul style="list-style-type: none"> 1. Medication Error Reduction Plan (MERP) 10. Security <ul style="list-style-type: none"> 1. 601 – Universal Exposure Precautions (DELETE) 2. 602 – Use of Personal Protective Equipment (DELETE) 3. 603 – Infection Control Plan for Security – Attachment (DELETE) 4. 603 – Infection Control Plan for Security Department (DELETE) 11. Women & Newborn Services <ul style="list-style-type: none"> 1. Sponge and Sharps Counts for Vaginal Deliveries 		
	(9) Minutes – Approval of: <ul style="list-style-type: none"> a) February 24, 2022, Regular Meeting b) February 24, 2022, Special Meeting c) February 25, 2022 Special Meeting d) March 11, 2022, Special Meeting 		Standard

	Agenda Item	Time Allotted	Requestor
	e) March 23, 2022, Special Meeting (10) Meetings and Conferences – None (11) Dues and Memberships - None (12) Reports (a) Dashboard – Included (b) Construction Report – None (c) Lease Report – (February, 2022) (d) Reimbursement Disclosure Report – (February, 2022) (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 min	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		



Tri-City Healthcare District

Redistricting 2022

Recommended Map Selection



March 31, 2022
Kay Vinson, Consultant
National Demographics Corporation

Why Is Redistricting Necessary?

- The District adopted Resolution No. 791 on April 26, 2018 establishing zone-based elections, adopting map and election sequence based on 2010 Census, as required.
- By-district means the voters in each individual zone vote for a representative residing in that zone.
- The first by-zone elections:

2018 – Zones 2, 4 and 6	2022
2020 – Zones 1, 3, 5 and 7	2024
- Every 10 years the federal government conducts the Census, requiring review of zones to insure balanced population.

Role of the Board

- **Ensure compliance with procedural requirements**
 - Hold public hearings
 - Adopt new zone map before statutory deadline.

- **Provide direction to staff and consultants**
 - NDC has prepared a draft map for Board consideration that meets compliance with federal requirement for equal population.
 - Board may provide additional guidance to demographer on zone boundaries prior to finalizing the map.

Redistricting Timeline

Date	Event(s)
February 24, 2022	- NDC presented demographic analysis and draft map for public/Board input
March 31, 2022	- NDC presents map - Receive input on map - Possible adoption
April 17, 2022	Deadline Goal to Adopt Map
November 8, 2022	Election with New Map for Zones 2, 4, & 6 (Zone 5, 2-year term)



Redistricting Rules and Goals

Federal Laws

- Equal Population
- Federal Voting Rights Act
- No Racial Gerrymandering

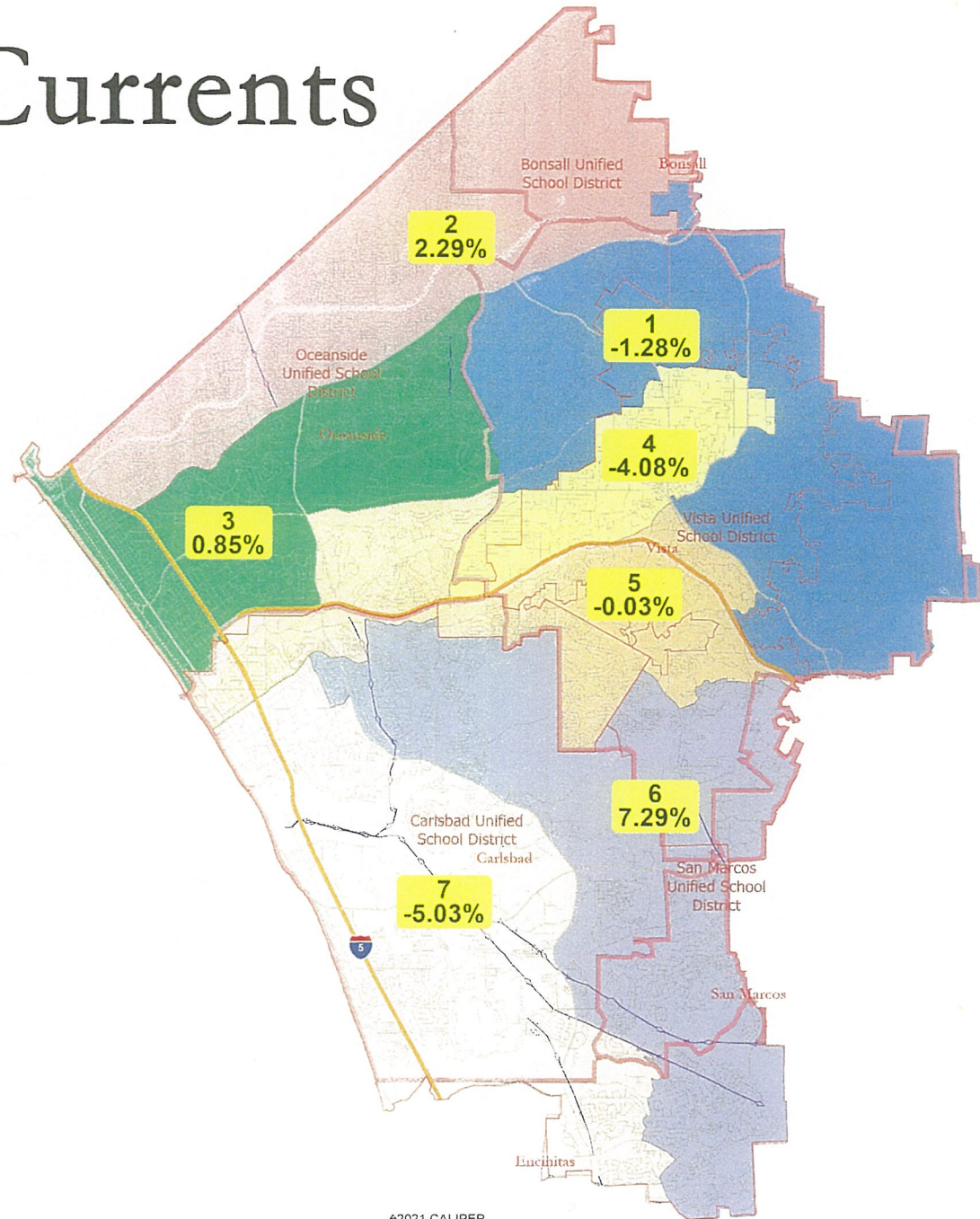


Traditional Redistricting Principles

- Topography/Geography
- Visible/Identifiable Boundaries (Natural & man-made)
- Contiguous
- Compact
- Communities of Interest
- Respect voters' choices / continuity in office
- Planned future growth
- Minimizing number of voters with election-year delays

Currents

Not Population
Balanced – 12.33%



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National Demographics Corporation

Demographics Summary

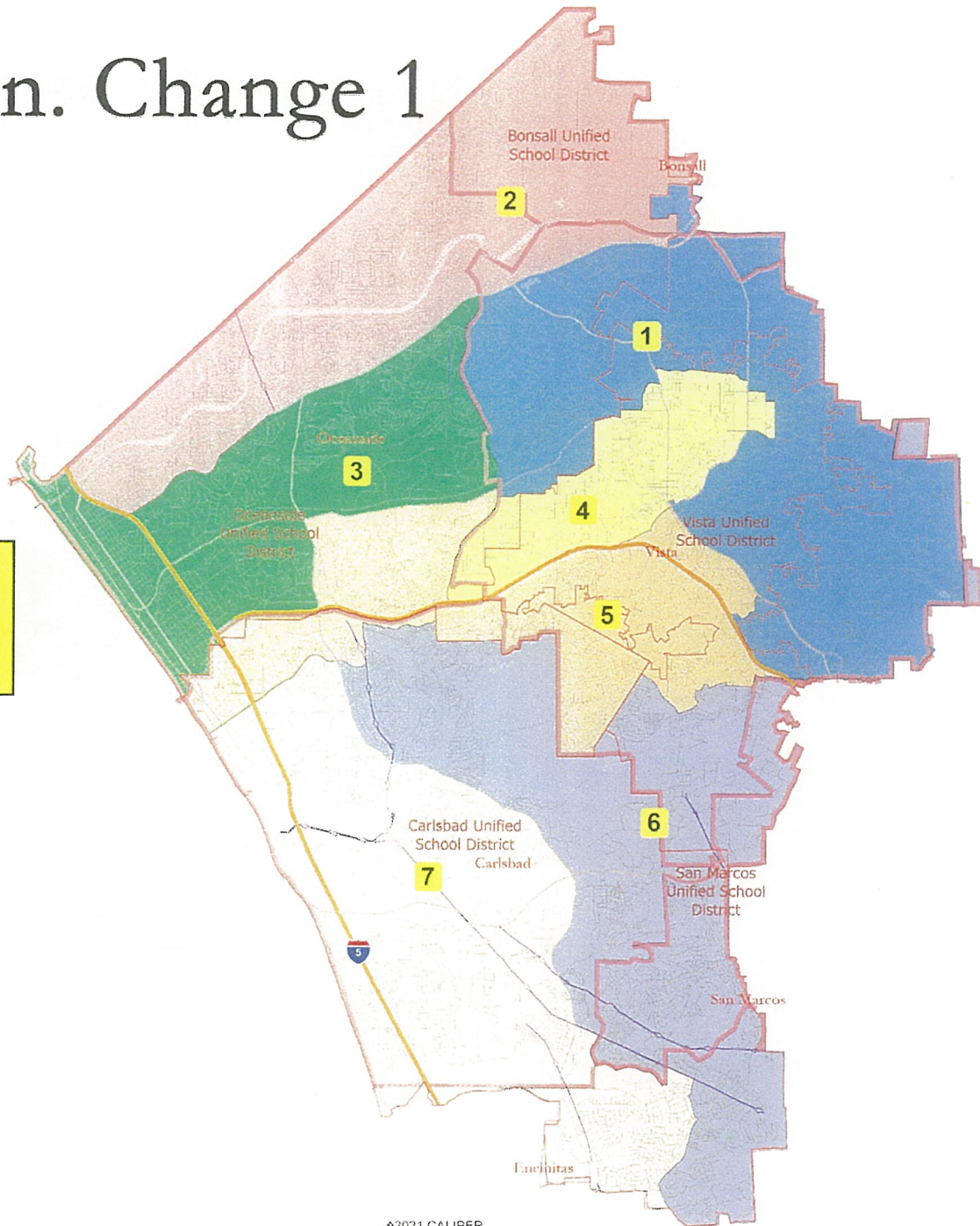
Existing Zones

Existing Zones									
District		1	2	3	4	5	6	7	Total
	Total Pop	56,858	58,914	58,084	55,244	57,579	61,797	54,697	403,173
	Deviation from ideal	-738	1,318	488	-2,352	-17	4,201	-2,899	7,100
	% Deviation	-1.28%	2.29%	0.85%	-4.08%	-0.03%	7.29%	-5.03%	12.33%
Total Pop	% Hisp	31.9%	44%	35%	67%	29%	16%	15%	34%
	% NH White	51%	34%	49%	22%	56%	66%	71%	50%
	% NH Black	3%	6%	4%	3%	3%	2%	2%	3%
	% Asian-American	9%	11%	7%	5%	7%	12%	9%	9%
Citizen Voting Age Pop	Total	41,586	38,665	41,239	33,116	42,450	43,184	40,489	280,729
	% Hisp	25%	33%	27%	56%	19%	12%	13%	25%
	% NH White	63%	46%	59%	34%	70%	76%	78%	62%
	% NH Black	4%	8%	5%	4%	2%	2%	1%	4%
	% Asian/Pac Isl.	6%	12%	6%	5%	7%	9%	7%	8%

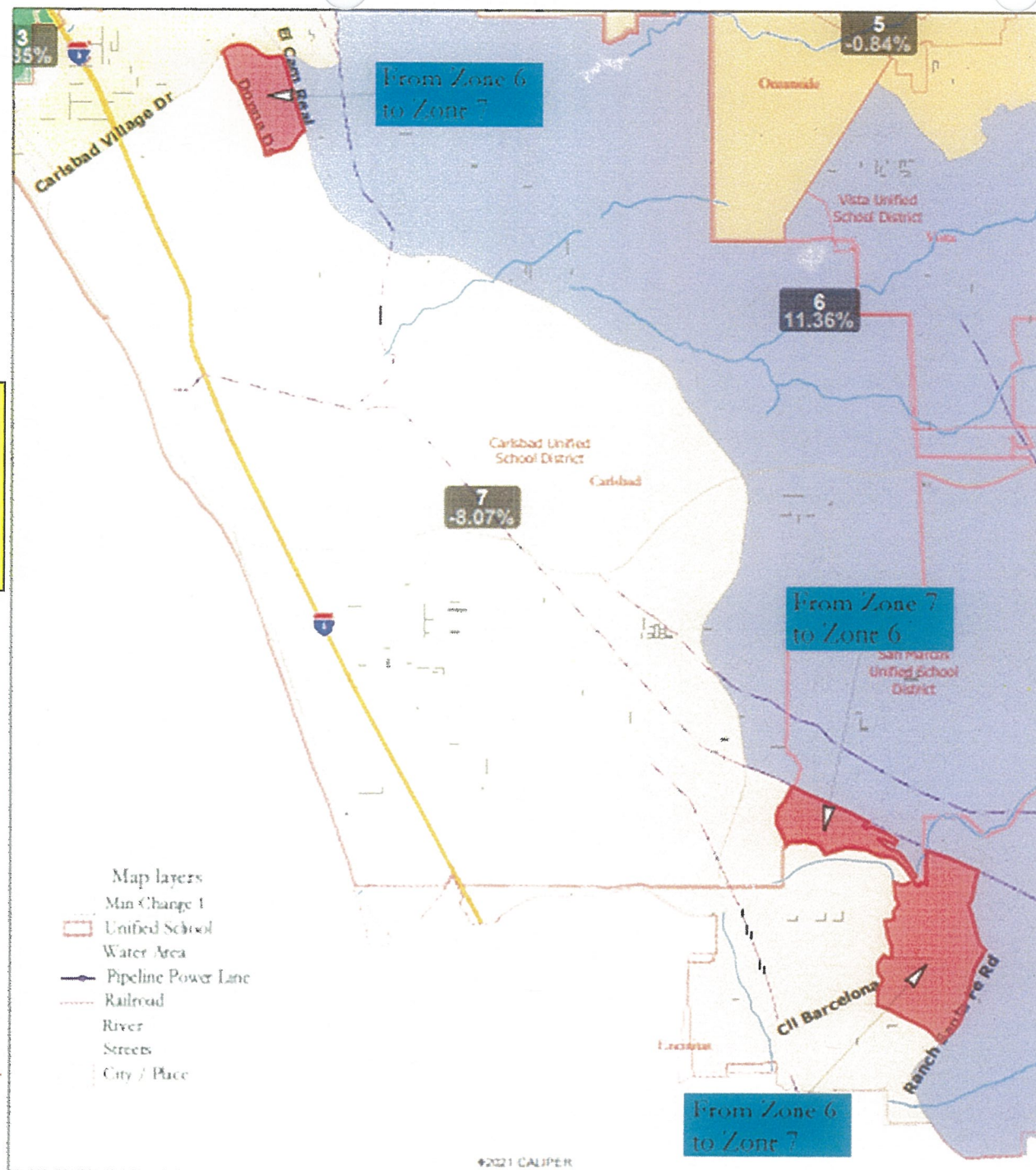
Ideal Zone Size:
Each of the 7 zones
must contain about
57,596 people

Min. Change 1

Population balanced
6.89% Deviation



- No Change to Zones 1-5
- Changes 6 and 7



Minimal Change 1

Demographic Summary

Min Change 1									
District		1	2	3	4	5	6	7	Total
	Total Pop	56,731	58,914	58,084	55,244	57,114	59,211	57,875	403,173
	Deviation from ideal	-865	1,318	488	-2,352	-482	1,615	279	3,967
	% Deviation	-1.50%	2.29%	0.85%	-4.08%	-0.84%	2.80%	0.48%	6.89%
Total Pop	% Hisp	31.8%	44%	35%	67%	29%	17%	15%	34%
	% NH White	52%	34%	49%	22%	56%	65%	71%	50%
	% NH Black	3%	6%	4%	3%	3%	2%	2%	3%
	% Asian-American	9%	11%	7%	5%	7%	12%	9%	9%
Citizen Voting Age Pop	Total	41,517	38,665	41,239	33,116	42,027	41,738	42,427	280,729
	% Hisp	25%	33%	27%	56%	19%	13%	12%	25%
	% NH White	63%	46%	59%	34%	69%	75%	78%	62%
	% NH Black	4%	8%	5%	4%	2%	2%	1%	4%
	% Asian/Pac.Isl.	6%	12%	6%	5%	7%	10%	7%	8%

Ideal Zone Size:
Each of the 7 zones
must contain about
57,596 people



March 31, 2022
Kay Vinson, Consultant
National Demographics Corporation

Public Hearing & Discussion

- Public Hearing
- Board Discussion
- Board Action: Adopt Zone Map
- Elections:
 - 2022 - Zones 2, 4 and 6
(plus Zone 5 short term)
 - 2024 - Zones 1, 3, 5 & 7

RESOLUTION NO. 811

A RESOLUTION OF THE BOARD OF DIRECTORS OF THE TRI-CITY HEALTHCARE DISTRICT COMPLYING WITH THE DECENNIAL REDISTRICTING REQUIREMENTS

WHEREAS, TRI-CITY HEALTHCARE DISTRICT (“District”) is a California healthcare district duly organized and existing under the laws of the State of California, particularly the Local Health Care District Law, constituting Division 23 of the Health and Safety Code of the State of California and, more particularly, Health and Safety Code sections 32000 et seq.; and

WHEREAS, California has enacted the Fair Maps Act (Elect. Code, § 21000 et seq.) which prescribes the local agency process for decennial redistricting. Pursuant to the Fair Maps Act, Regular districts must review their census data and conduct a public hearing on redistricting; and

WHEREAS, at a Special meeting on February 24, 2022, the Board of Directors held a duly noticed public hearing notice of which was published in a local newspaper and on the District website. The purpose of the public hearing was to explain the zone mapping process, compliance with the Fair Maps Act, and decennial redistricting. At the public hearing, the District Board provided an opportunity for input from the community and discussed the changes in population and demographics in the District from 2010 to 2020 and also reviewed a minimal change map; and

WHEREAS, at a Regular meeting on March 31, 2022, the Board held a second duly noticed public hearing, notice of which was published in a local newspaper and on the District website. The purpose of the public hearing was to hear input from the public and Board of Directors related to the adoption of a District boundary map. At said hearing, the District Board specifically discussed a minimal change map and proposed zone boundaries; and

WHEREAS, the purpose of this resolution is to comply with the Fair Maps Act and the decennial redistricting requirements by maintaining the boundaries of the proposed map that divides the District into five (5) zones as reflected in the Exhibit “A” Map; and

WHEREAS, in adopting the Exhibit “A” Map, the Board of Directors intends to and does provide for representation in accordance with demographics, including population, and geographic factors of the entire area of the healthcare district in accordance with Health and Safety Code section 32100.1 and Election Code section 21000 et seq.

NOW, THEREFORE, this Board of Directors of the Tri-City Healthcare District does hereby resolve:

Section 1. The foregoing recitals are true and correct.

Section 2. Tri-City Healthcare District is hereby divided into seven (7) consecutively numbered zones and the boundaries of the zones are more particularly described in the attached Exhibit "A" Map. Exhibit "A" also shows the zone numbers assigned to each zone, from one (1) through five (5).

Section 3. At the November 2022 General Election, three members of the District Board of Directors shall be elected on a by-zone basis from the three (3) even-numbered, single-member zones (specifically, Zones 2, 4, and 6 as such zones may be amended), and every four (4) years thereafter. In addition, a short-term election will be held in Zone 5 as a result of a vacancy. At the General Election in November 2024, four (4) members of the District Board of Directors shall be elected from the four (4) odd-numbered, single-member zones (specifically, Zones 1, 3, 5, and 7 as such zones may be amended), and every four (4) years thereafter.

Section 4. Any member of the Board of Directors elected to represent a District zone must be a resident of the zone from which he or she is elected for thirty (30) days preceding the date of the election and must be a registered voter in that zone, and any candidate for the Tri-City Healthcare District Board of Directors must reside in and be a registered voter in the zone in which he or she seeks election at the time nomination papers are issued pursuant to Health and Safety Code section 32100.1.

Section 5. Termination of residency in a zone by a member of the Board of Directors shall create an immediate vacancy for that zone unless a substitute residence within the zone is established within thirty (30) days after the termination of residency.

Section 6. Any vacancy upon the Board shall be filled by appointment by a majority of the remaining members of the Board of Directors consistent with Health and Safety Code section 32100.1. The person appointed to fill the vacancy must reside within the zone left unrepresented on the Board of Directors. Any person appointed to fill the vacancy shall hold office in accordance with Government Code section 1780.

Section 7. The Tri-City Healthcare District Board of Directors' Board Secretary or designee shall maintain a map of the District showing the current boundaries and zone numbers of each District zone as may be established and amended from time to time by resolution of the Board of Directors.

Section 8. If necessary to facilitate the implementation of this resolution, the Chief Executive Officer is authorized to make technical adjustments to the District boundaries that do not substantively affect the populations in the zones, the demographics in the zones, eligibility of candidates, the residence of elected officials within any zone, and that do not contradict the intent or terms of the California Voting Rights Act of 2001. The Chief Executive Officer shall consult with the Board Chair and the District's Board Counsel concerning any technical adjustments deemed necessary and shall advise the Board of Directors of any such adjustments required in the implementation of the zones.

Section 9. To the extent the terms and provisions of this resolution may be inconsistent or in conflict with the terms or conditions of any prior District resolution, motion, rule, regulation, or bylaw governing the same subject, the terms of this resolution shall prevail with respect to the subject matter thereof.

Section 10. In interpreting this resolution or resolving any ambiguity, this resolution shall be interpreted in a manner that effectively accomplishes its stated purpose.

Section 11. This resolution shall take effect immediately upon its adoption.

ADOPTED, PASSED, AND APPROVED this 31st day of March, 2022, at a Regular meeting of the Board of Directors of Tri-City Healthcare District, at which a quorum was present and acting throughout, by the following roll call vote:

AYES: _____
NOES: _____
ABSENT: _____
ABSTAIN: _____

Rocky J. Chavez, President
Board of Directors

ATTEST:

Gigi Gleason, Secretary
Board of Directors



TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
March 9, 2022

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 4/01/2022 – 3/31/2024)

Any items of concern will be “red” flagged in this report. Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 4/01/2022 through 3/31/2024:

- AVILA, Alfonso DO/Emergency Medicine (TeamHealth)
- BASERI, Babak MD/Oncology (The Oncology Institute)
- BUTLER, Ian MD/Critical Care (Pulmonary Specialists of North County)
- DANG-VU, Milan MD/Anesthesiology (ASMG)
- GARRISON, David MD/Critical Care (Pulmonary Specialists of North County)
- LE, Charles MD/Nephrology (iKidney Care)
- MACHALA, Sasa MD/Pulmonary (Pulmonary Specialists of North County)
- MARJON, Phillip MD/Oncology (The Oncology Institute)
- SNYDER, Ole MD/Family Medicine (Tri-City Primary Care)



TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 1 of 3
March 9, 2022

Attachment B

RESIGNATIONS: (Effective date 03/31/2022 unless otherwise noted)

Automatic:

- LOPEZ, Sandra, MD/Obstetrics & Gynecology
- OLONAN, Christopher, MD/Internal Medicine

Voluntary:

- ABBOUD, Jean, MD/Ophthalmology
- BETTI, Francesca, MD/Anesthesiology
- CHOW, Chien-Hsiang, MD/Anesthesiology
- DE LA CRUZ, Carla, MD/Anesthesiology
- DESAL, Chirag, MD/Anesthesiology
- FEDUSKA, Collin, MD/Anesthesiology
- GLASGOW, Andrew, MD/Anesthesiology
- KWAN, Evan, MD/Anesthesiology
- NELSON, Jesse, DO/Anesthesiology
- NGUYEN, Thu, MD/Anesthesiology

TCHD Board of Directors
DATE OF MEETING: March 31, 2022

PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Transitional OB/GYN Coverage

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

Physician's Names: Tannaz Ebrahimi Adib, M.D., Leticia Campbell, M.D., Deena Elwan, M.D., Rahele Mazarei, D.O., Eimaneh Mostofian, M.D., Marlene Pountney, M.D., Berk Suntay, M.D.

Area of Service: Emergency Department On-Call: OB/Gyn-Transitional Coverage

Term of Agreement: Month-Month up to 12 months, Beginning March 1, 2022

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

OB-GYN - Rate/Day	Maximum Anticipated Days	Maximum Anticipated Term Cost
Weekday \$1200	88 days	\$105,600
Weekend/holiday \$1500	34 days	\$51,000
Max Anticipated Total Term Cost:		\$156,600

Position Responsibilities:

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

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

Person responsible for oversight of agreement: Gene Ma, M.D., Chief Medical Officer

Motion: I move that the TCHD Board of Directors authorize the agreement to provide transitional ED call coverage for OB/GYN services to include Tannaz Ebrahimi Adib, M.D., Leticia Campbell, M.D., Deena Elwan, M.D., Rahele Mazarei, D.O., Eimaneh Mostofian, M.D., Marlene Pountney, M.D., and Berk Suntay, M.D., for a month to month term up to 12 months, beginning March 1, 2022 at a daily rate of \$1,200 (weekday) and \$1,500 (weekend/holiday), for a maximum anticipated total term cost of \$156,600.



**TCHD BOARD OF DIRECTORS
DATE OF BOARD MEETING: March 31, 2022
BILLING SERVICES AGREEMENT**

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

Company Name: New Ultimate Billing, LLC

Area of Service: Outpatient Professional Services Billing

Term of Agreement: 3 years beginning March 1, 2022 through February 28, 2025

Maximum Totals:

Rate	Hours per Month	Hours per Year	Monthly Cost	36 month (Term) Cost
3% of Collections	N/A	N/A	\$41,667	\$1,500,000

Responsibilities:

- Company to bill professional medical claims for orthopedic and rehabilitation services for the 1206(b) orthopedic practice
- Provide billing and coding services
- Provide monthly reporting on collections activity
- Total cost for the term is dependent on collections activity

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: Jeremy Raimo, Sr. Director-Business Development /Ray Rivas, Chief Financial Officer.

Motion:

I move that the TCHD Board of Directors authorize the agreement between TCHD and New Ultimate Billing, LLC for a term of 36 months beginning March 1, 2022 and ending February 28, 2025, for an anticipated total cost for the term of \$1,500,000.



**TCHD BOARD OF DIRECTORS
DATE OF BOARD MEETING: March 31, 2022
BILLING SERVICES AGREEMENT**

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

Company Name: R1, RCM, Inc.

Area of Service: Outpatient Professional Services Billing

Term of Agreement: 3 years beginning March 1, 2022 through February 28, 2025

Maximum Totals:

Rate	Hours per Month	Hours per Year	Monthly Cost	36 month (Term) Cost
6.25% of Collections	N/A	N/A	\$32,500	\$1,170,000

Responsibilities:

- Company to bill professional medical claims for orthopedic and rehabilitation services for the following 1206(b) clinics: Urology, Pulmonology, Primary Care
- Provide billing and coding services
- Provide monthly reporting on collections activity
- Total cost for the term is dependent on collections activity

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: Jeremy Raimo, Sr. Director-Business Development / Ray Rivas, Chief Financial Officer

Motion:

I move that the TCHD Board of Directors approve an agreement between R1, RCM, Inc. for a term of 36 months beginning March 1, 2022 and ending February 28, 2025, for an anticipated total cost for the term of \$1,170,000.

TCHD BOARD OF DIRECTORS

DATE OF MEETING: March 31, 2021

Physician Joinder Agreement Proposal – Family Medicine

Type of Agreement		Medical Directors		Panel	X	Other: Addendum to PSA
Status of Agreement	X	New Agreement		Renewal: New Rates		Renewal: Same Rates

Physician Name:

Ole Snyder M.D.

Areas of Service:

Family Medicine

Key Terms of Agreement:

Effective Date:

April 1, 2022

Community Need:

TCHD Physician Needs Assessment shows significant community need for Family Practice Physicians

Service Area:

Area defined by the lowest number of contiguous zip codes from which the hospital draws at least 75% of its inpatients

Within Annualized Fair Market Value:

YES

Terms of the Engagement:	Proposal Costs:
Monthly Professional Stipend	\$21,667 per month for 2 years (\$260,000 annually - \$520,000 total)
Sign-on Advance	\$38,000
Base Pay starting year 2	\$38,000 paid in equal monthly installments
Total Amount of Request:	\$596,000

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: Jeremy Raimo, Sr. Director Business Development / Dr.Gene Ma, Chief Medical Officer

Motion:

I move that the TCHD Board of Directors find it in the best interest of the communities served by the District to approve the expenditure, not to exceed \$596,000 in order to facilitate this Family Practice physician practicing medicine in the communities served by the District. This will be accomplished through an addendum to the existing Professional Services Agreement between Tri-City Healthcare District and Tri-City Primary Care Medical Group.

TCHD Board of Directors
DATE OF MEETING: March 31, 2022

PHYSICIAN AGREEMENT for Medical Director-Surgical and Perioperative Services

Type of Agreement	<input checked="" type="checkbox"/>	Medical Directors	<input type="checkbox"/>	Panel	<input type="checkbox"/>	Other:
Status of Agreement	<input checked="" type="checkbox"/>	New Agreement	<input type="checkbox"/>	Renewal – New Rates	<input type="checkbox"/>	Renewal – Same Rates

Vendor's Name: David Seif, M.D.

Area of Service: Medical Director- Surgical and Perioperative Services

Term of Agreement: 12 months, beginning April 1, 2022 until March 31, 2023

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

Hourly Rate	Maximum Hrs/Month	Maximum Cost/Month	Annual Cost
\$150/hr	16 hours	\$2,400	\$28,800(NTE)
Total Term Cost NTE			\$28,800(NTE)

Description of Services/Supplies:

- Medical Directorship agreement with responsibilities for the medical direction of the Department including perioperative services
- Serve as member of the OR Committee to effect changes that improve the safety and efficiency of OR operations
- Provide oversight and make recommendations for the quality review program, performance improvement projects, compliance with Hospital and Medical Staff Bylaws and regulatory standards
- Serve as liaison between the Hospital and members of the medical staff to ensure alignment behind initiatives directed at quality of care, operational excellence, and patient experience

Document Submitted to Legal for Review:	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
Approved by Chief Compliance Officer:	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
Is Agreement a Regulatory Requirement:	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No
Budgeted Item:	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>	No

Person responsible for oversight of agreement: Donna Ferguson, Interim Director of Perioperative Services/ Gene Ma, Chief Medical Officer.

Motion:

I move that the TCHD Board of Directors authorize the agreement for Medical Directorship for Surgical and Perioperative Services with David Seif, M.D. for a term of 12 months, beginning April 1, 2022 and ending, March 31, 2023, with an annual and total term cost not to exceed \$28,800.

RESOLUTION NO. 810

RESOLUTION OF THE BOARD OF DIRECTORS OF TRI-CITY HEALTHCARE DISTRICT RE-RATIFYING THE STATE OF EMERGENCY AND RE-AUTHORIZING REMOTE TELECONFERENCE MEETINGS

WHEREAS, Tri-City Healthcare District (“District”) is committed to preserving and fostering access and participation in meetings of its Board of Directors; and

WHEREAS, Government Code section 54953(e) makes provisions for remote teleconferencing participation in meetings by members of a legislative body without compliance with the requirements of Government Code section 54953(b)(3), subject to the existence of certain emergency conditions; and

WHEREAS, a required condition is that a state of emergency is declared by the Governor pursuant to Government Code section 8625, proclaiming the existence of conditions of disaster or of extreme peril to the safety of persons and property within the state caused by conditions as described in Government Code section 8558; and

WHEREAS, a proclamation is made when there is an actual incident, threat of disaster, or extreme peril to the safety of persons and property within the jurisdictions that are within the District’s boundaries, caused by natural, technological, or human-caused disasters; and

WHEREAS, it is further required that state or local officials have imposed or recommended measures to promote vaccines, masking, and social distancing, and that meeting in person at the hospital would present imminent risks to the health and safety of attendees; and

WHEREAS, the Board of Directors previously adopted Resolution No. 803 on September 30, 2021, finding that the requisite conditions exist for the Board of Directors of the District to conduct remote teleconference meetings without compliance with paragraph (3) of subdivision (b) of Government Code section 54953; and

WHEREAS, as a condition of extending the use of the provisions found in Government Code section 54953(e), the Board of Directors must reconsider the circumstances of the state of emergency that exists in the District, and the Board of Directors has done so; and

WHEREAS, emergency conditions persist in the District and vaccine compliance, masking, and social distancing measures are required to be followed on the premises of the hospital for the continued health and safety of the patients, workers, and public; and

WHEREAS, as a consequence of the local emergency persisting, the Board of Directors does hereby find that the District shall conduct its meetings without compliance

with paragraph (3) of subdivision (b) of Government Code section 54953, as authorized by Government Code section 54953(e), and that such meetings shall comply with the requirements to provide the public with access to the meetings as prescribed in Government Code section 54953(e);

THEREFORE, BE IT RESOLVED by the Tri-City Healthcare District Board of Directors as follows:

Section 1: Recitals. The Recitals set forth above are true and correct and are incorporated into this Resolution by this reference.

Section 2: Affirmation that a Local Emergency Persists. The Board of Directors hereby considers the conditions of the state of emergency in the District and proclaims that a local emergency persists throughout the District.

Section 3: Re-Ratification of the Governor's Proclamation of a State of Emergency. The Board of Directors hereby ratifies the Governor's Proclamation of a State of Emergency.

Section 4: Remote Teleconference Meetings. The District's Chief Executive Officer is hereby authorized and directed to take all actions necessary to carry out the intent and purpose of this resolution, including conducting open and public meetings in accordance with Government Code section 54953(e) and other applicable provisions of the Ralph M. Brown Act.

PASSED AND ADOPTED at a regular meeting of the Board of Directors of Tri-City Healthcare District held on March 31, 2022, by the following roll call vote:

AYES: Directors:

NOES: Directors:

ABSTAIN: Directors:

ABSENT: Directors:

Rocky J. Chavez, President
Board of Directors

ATTEST:

Gigi Gleason, Secretary
Board of Directors

TCHD BOARD OF DIRECTORS
DATE OF MEETING: March 31, 2022
MEDLINE INDUSTRIES SUPPLY DISTRIBUTION PROPOSAL

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

Vendor's Name: Medline Industries, Inc

Area of Service: Supply Chain Management

Term of Agreement: 36 months, Beginning, October 1, 2022 – Ending, September 30, 2025

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
\$309,152*	\$3,709,824	\$11,129,472

*Costs calculated from historical purchase volume and may vary

Description of Services/Supplies:

- This proposal is to convert our current primary distribution contract to Medline for lower rates.
- Anticipated savings for the 3-year term is estimated to be \$1.0M versus current rates and spend.
- TCMC has had a relationship with Medline since 2012 as the primary builder and distributor of 100% of our custom OR, and procedural areas' kits and trays. The service has been excellent for the decade.
- Medline's distribution center warehouse is located in Temecula, which will allow us to obtain products much faster in emergent situations.
- The above costs are estimates based upon historical sales volume, and are subject to change depending on our patient census.

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: Tom Moore, Director-Supply Chain Management / Ray Rivas, Chief Financial Officer

Motion:

I move that the TCHD Board of Directors authorize the agreement with Medline Industries Inc. for medical supply distribution services for a term of 36 months, beginning October 1, 2022 and ending September 30, 2025 for an estimated annual cost of \$3,709,824 and a total cost for the term of \$11,129,472.

ADMINISTRATION CONSENT AGENDA

February 15th, 2022

CONTACT: Candice Parras, CPCS


Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Blood Glucose Point of Care Testing Procedure	- Practice change	Forward To BOD For Approval
2. Eclampsia Management Standardized Procedure	- 2 year review, practice change	Forward To BOD For Approval
3. Latex Sensitivity-Allergy Management Policy	- 3 year review	Forward To BOD For Approval
Administrative 200s District Operations		
1. Charity Care, Uncompensated Care, Community Service 285	- Practice change	Forward To BOD For Approval
Allied Health Professional		
1. Standards for Allied Health Professional RNFA	- 2 year review	Forward To BOD For Approval
Cardiac Rehab		
1. Disaster Plan	- 3 year review	Forward To BOD For Approval
Emergency Operations Plan		
1. 4004 Evacuation Plan	- 1 year review, practice change	Forward To BOD For Approval
2. 4014 Acute Care, Orthopedics, and Rehabilitation Unit Specific	- 3 year review, practice change	Forward To BOD For Approval
3. 4074 Identification of Incident Command Staff-Hospital Wide	- 3 year review, practice change	Forward To BOD For Approval
4. 4086 Administrative Coordinators	- 3 year review, practice change	Forward To BOD For Approval
5. Code Yellow - Radiation Disaster, Treatment of the Contaminated Patient	- NEW	Forward To BOD For Approval
6. Emergency Operations Plan	- 1 year review, practice change	Forward To BOD For Approval
7. Medical Staff Assignments	- 3 year review, practice change	Forward To BOD For Approval
8. Radiology Emergency Management (Disaster) Plan	- NEW	Forward To BOD For Approval
9. Scalable Event	- DELETE	Forward To BOD For Approval
Engineering		
1. Emergency Generator Test and Failures	- 3 year review, practice change	Forward To BOD For Approval
2. Failure of Fire Alarm System 8015	- 3 year review, practice change	Forward To BOD For Approval
3. Guidelines for Procedure for Failure of Essential Equipment 8017	- DELETE	Forward To BOD For Approval
4. System Record Drawings 8019	- DELETE	Forward To BOD For Approval
5. Utility Management Plan 4003	- 1 year review, practice change	Forward To BOD For Approval
Environment of Care Manual		
1. Safety Plan	- 1 year review, practice change	Forward To BOD For Approval

ADMINISTRATION CONSENT AGENDA

February 15th, 2022

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
Infection Control		
1. Management of Patients with Multi-Drug Resistant Organisms (MDRO) and/or C. Difficile Infection	- 3 year review, practice change	Forward To BOD For Approval
2. Philosophy Policy	- 3 year review, practice change	Forward To BOD For Approval
Pharmacy		
1. Medication Error Reduction Plan (MERP)	- 1 year review, practice change	Forward To BOD For Approval
Security		
1. #601 - Universal Exposure Precautions	- DELETE	Forward To BOD For Approval
2. #602 Use of Personal Protective Equipment	- DELETE	Forward To BOD For Approval
3. #603 - Infection Control Plan for Security - Attachment	- DELETE	Forward To BOD For Approval
4. #603 - Infection Control Plan for Security Department	- DELETE	Forward To BOD For Approval
Women & Newborn Services		
1. Sponge and Sharps Counts for Vaginal Deliveries	- 3 year review, practice change	Forward To BOD For Approval

 Tri-City Medical Center	Patient Care Service
PROCEDURE: BLOOD GLUCOSE POINT OF CARE TESTING	
Purpose:	To accurately determine blood glucose levels at the patient's bedside.
Supportive Data:	The blood glucose meter is used to monitor the blood glucose in patients who have been diagnosed by conventional means. The meter is not to be used for screening or diagnosis of diabetes. Personnel trained and assessed through the Point of Care program may perform this procedure. Testing is under the supervision of the Laboratory Point of Care Coordinator and under the jurisdiction of the Laboratory Medical Director.
Equipment:	Alcohol Swab Docking Station Gauze Gloves Luer lock needleless blood sampling access device Needleless cannula Blood Glucose Meter Single-use Lancet StatStrip cleaning strips StatStrip control solutions level 1 low (green bottle) & level 3 high (red bottle) StatStrip test strips

A. DEFINITION(S):

1. Critically ill adult: any patient receiving intensive medical intervention/therapy with decreased peripheral blood flow, as evidenced by one or more of the following:
 - a. Severe hypotension requiring the administration of two or more intravenous vasopressors;
 - b. Any patient with a core body temperature equal or less than (\leq) 35°C;
 - c. Any patient with Emergency Severity Index (ESI) of one.
2. Critically ill neonate: all neonates in the Neonatal Intensive Care Unit (NICU) are defined as critically ill.

B. PREPARE THE METER:

1. Touch the screen to activate the meter.
 - a. Note: the meter is designed such that the operator uses their finger when dealing with the touch screen. Any sharp or abrasive material may damage the meter.
 - b. Blue bar with screen title at the top of the meter will prompt next step.
2. From the Welcome screen, Press OK/Login to begin.
 - a. For troubleshooting hints see the blood glucose meter Troubleshooting Guide on the Tri-City Healthcare District (TCHD) Intranet under Departments>Clinical>Clinical Products.
3. Perform Quality Control (QC) if indicated by meter. Meter is configured to require a QC both high and low every 24 hours. Meter will lock out at 24 hours and screen will display QC Lockout L1/L3 QC required if QC not performed. See QC and Calibration section for instructions on completing the QC.
4. At the Enter Operator ID Screen, scan or manually enter your Operator Identification (ID). ID must be 5 digits long; use zeroes to precede a 3- or 4-digit Employee ID Number (EID). Press Ok/Accept.
5. At Patient Test screen press accept or select QC.
6. At the Enter Strip Lot screen, scan the strip lot from the bottle matches the number displayed on the screen.

Patient Care Service Content Expert	Clinical Policies & Procedures	Nurse Executive Council	Department of Pathology	Pharmacy and Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/13, 08/16, 08/19, 03/20	06/13, 08/16, 11/16, 09/19, 03/20, 08/21	06/13, 01/17, 09/19, 03/20, 10/21	04/18, 10/19, 04/20	09/13, n/a	10/13, 04/18, 11/19, 05/20, 02/22	11/19, 06/20, 03/22	11/13, 05/18, n/a	12/13, 05/18, 12/19, 06/20

7. At the Enter Patient ID screen, scan the ~~AZTEC symbol~~ **FIN barcode** from the Patient's armband or manually enter Patient 10 7 digit Financial Identification Number (FIN#), Press Accept.
 - a. Non-Registered Patients in emergent situations.
 - i. Emergent patients should be issued a John/Jane Doe packet. Scan the ~~AZTEC~~ **FIN barcode** symbol from the packet.
 - ii. If packet not available, enter an invalid Patient ID to get to the downtime override key (use the following ~~10 7~~ digit FIN# 1 2 3 4 5 6 7-8-9-0)
 - iii. Fill out the Point of Care Testing Correction Form
 - iv. Available on TCMC Intranet, click on Forms Icon>Electronic Forms>Patient Care Services Forms
8. At the Confirm Patient ID screen
 - a. Valid Patient ID: Verify the FIN# (Account Number) and Patient Name are correct. Press Ok/Accept.
 - b. Invalid Patient ID: The Admission/Discharge/Transfer (ADT) feature was unable to pull Patient Name. This will occur if the meter has not been recently downloaded and does not have current ADT information, if the scanned encounter has been discharged, or if the patient is not yet registered and a John/Jane Doe ID was scanned.
 - i. Verify the Patient ID. If the correct number was scanned, and the encounter is current press Ok/Accept to Override. The Patient ID will be recognized by the data manager, the error resolved, and the result will chart.
 - ii. If the encounter is not current, obtain an armband for the current encounter and continue testing. If staff press OK/Accept and Override a discharged encounter, the result will not chart. Staff must fill out the Point of Care Testing Correction Form and send it to the lab for error resolution.
 - iii. If the patient a John/Jane Doe and is not yet registered, press OK/Accept to Override. When the patient is registered, complete the Point of Care Testing Correction Form.
9. At Select Sample Type screen, select the appropriate sample type as Capillary, Venous, Arterial or Neonatal Heel Stick, then press Accept.
10. At the Insert Strip screen, insert a test strip into the strip port at the top of the meter. The print should face up and the gold contacts enter the meter.

C. **PATIENT PREPARATION:**

1. Critically ill adult:
 - a. Only arterial or venous whole blood may be used. Do not use serum, plasma, or capillary blood.
 - i. To obtain whole blood from an arterial catheter, follow procedure for blood sample collection in Online Clinical Skills Arterial Catheter: Blood Sampling.
 - ii. To obtain whole blood from a central venous access device, follow procedure for blood sample collection in Patient Care Services (PCS) Procedure: Central Venous Access Devices, Adults.
 - iii. To obtain whole blood by venipuncture, follow procedure for blood sample collection in PCS Venipuncture for Specimen Collection.
 - 1) Only fresh whole blood or whole blood collected in lithium heparin collection device should be used for arterial and venous specimens. Test within 30 minutes when not sampling directly from a lancing device
 - 2) Fluoride, EDTA, Sodium and Ammonium blood collection devices should not be used.
 - iv. To obtain whole blood from a midline catheter, follow procedure for blood sample collection in PCS Midline Catheter, Adults.
2. Critically ill neonates:
 - a. Collect neonatal arterial or neonatal heel stick samples. The system has not been evaluated for use with neonate venous blood,

- b. The system is not intended for use with neonate Cord blood samples.
 3. Non-critically ill adult
 - a. Capillary, Arterial, or Venous whole blood may be used. Do not use serum or plasma.
 - b. Only fresh whole blood or whole blood collected in lithium heparin collection devices should be used for arterial and venous specimens. Test within 30 minutes when not sampling directly from a lancing device.
 - c. Sample size is 1.2 uL.
 4. Obtain single-use lancet
 5. Select puncture site – see Patient Care Service (PCS) Collection of Blood Specimen by Skin Puncture.
 - a. Adult/child - finger puncture
 - b. Newborn – heel stick
 6. Use the lancet to puncture the appropriate site - see PCS Collection of Blood Specimen by Skin Puncture.

D. SPECIMEN COLLECTION AND PATIENT TEST :

1. At the Apply Sample screen, obtain blood sample and touch the test strip to the a drop of blood. Hold the test strip to the blood until the meter begins the 6 second countdown.
 - a. If the strip is not filled completely in the first attempt, you must repeat the test with a new puncture and a new test strip.
 - i. Repeated squeezing of the puncture site may dilute the specimen with tissue fluid
 - b. Criteria for rejection: If you receive a strip error for insufficient sample application or any other error code, you must repeat the test with a new finger puncture and a new test strip.
 - i. Repeated squeezing of the puncture site may dilute the specimen with tissue fluid
 - c. When collecting the sample: keep the meter level, or pointed slightly down while wet test strip is in the meter. Do not tilt the meter up while there is any chance that blood can drip down into the meter. If liquid gets into meter, use the cleaning strips to wick the extra fluid as soon as possible.
 - d. Results will display in 6 seconds.
2. At the Patient Test screen
 - a. Review results:
 - i. Results may be read directly from the meter.
 - ii. Results in the normal range display in Blue.
 - iii. Results outside the normal range display in Red.
 - iv. ↑ One arrow up indicates the result is high, but not critical.
 - v. ↑↑ Double up arrows indicate the result is critical high.
 - 1) Follow PCS Critical Results and Critical Tests/Diagnostic procedure.
 - vi. ↓ One arrow down indicates the result is low, but not critical.
 - vii. ↓↓ Double down arrows indicate the result is critical low.
 - 1) Follow PCS Standardized Procedure Hypoglycemia Management in the Adult Patient
 - 2) Follow PCS Standardized Procedure Newborn Hypoglycemia During Transition to Extrauterine Life
 - 3) Follow PCS Critical Results and Critical Tests/Diagnostic procedure.
 - viii. LO indicates the result is below the readable range of the meter, or <10.
 - 1) <10 meter reads LO. Repeat test. Continue with treatment and retest according to standardized procedure for hypoglycemia
 - ix. HI indicates the result is above the readable range of the meter, or >600.
 - 1) Results >600 mg/dL. Repeat test. Obtain an order for a STAT lab glucose for a valid result for treatment (Confirmatory Testing).

- 2) Results that do not correlate with prior treatment. Repeat test. Obtain an order for a STAT lab glucose to verify result.
- b. Accept or Reject:
 - i. You must ACCEPT the result at the meter for it to be automatically charted.
 - ii. If you select neither and the meter turns off, the result will sit in a queue in the lab awaiting resolution.
 - iii. Fill out and submit the Point of Care Testing Correction Form to the LAB.
3. Remove strip by pressing down on ejector button on rear of device or remove strip manually. Ensure safe disposal into biohazard container.
4. Clean and disinfect the meter after each patient. See cleaning under Maintenance section.
5. Log off meter by selecting logout on Patient Test Screen or dock the meter when you are finished testing. Store the meter in the docking cradle and not in the tote. Battery must charge and data must transmit.
 - a. The Left light is Green when the meter is connected to the network.
 - b. The Center light is Green when data is transmitting
 - c. The Right light is Green when the battery is fully charged and Amber when the battery is charging.
 - d. Auto log off will occur after 6 ½ minutes of inactivity.

E. **DOCUMENTING RESULTS:**

1. Patients must be identified with the Financial/ Account Number (FIN). Only results identified with the FIN will be charted in CERNER. The FIN number should be scanned from the AZTEC (2D) barcode on the ARMBAND. ~~Linear~~ Barcodes with MRN information or AZTEC must not be scanned or the results will not transmit to Cerner.
2. Dock the meter in the cradle. Results and comments will automatically post to the chart.
3. If the result does not immediately chart,
 - a. Verify the meter is properly docked and connected, with green arrow indicating data transfer complete.
 - b. The INTERFACE may be temporarily down; the results will transmit and post when the interface is again functional.
4. Result was not ACCEPTED in the meter. Complete the Point of Care Testing Correction Form and send to the lab. The lab will resolve the error and process the result to the chart.
 - a. Patient ID was not recognized. (John/Jane Doe). Use downtime procedure. Select Override button on the meter, continue testing, accept the result and dock the meter. Manually enter the result on the patient's chart for immediate documentation. Complete the Point of Care Testing Correction Form and send the lab. The lab will resolve the error and process the result to the chart at a later time whenever possible.

F. **MAINTENANCE:**

1. Charging the Meter:
 - a. When the battery Low symbol displays on the screen, place the meter into the docking station. If you have a spare battery that is fully charged, you can change the battery.
 - b. The meter should always be left in the docking station when not in use.
2. Cleaning and Disinfecting the Meter Procedure:
 - a. Cleaning is not the same as disinfecting. Disinfecting means to kill or prevent the growth of disease carrying microorganisms.
 - b. Prepare the meter for cleaning and disinfecting:
 - i. Remove the test strip
 - ii. Lay the meter on a flat surface prior to cleaning and disinfecting.
3. Clean and disinfect after each patient use per manufacturer's guidelines:
 - a. See Nova Biomedical Glucose Meter instructions for use
 - b. See Chlorox Germicidal Wipes instructions for use
 - c.
 - d. If unable to clean the strip port, send the meter to the lab for a replacement. .

- e.
4. Changing the Battery:
 - a. If the meter needs a reset or is left out of the docking station for more than 8 hours or 40 tests, the battery will need to be recharged. If the meter is needed for immediate use, change the battery.
 - b. Touch the screen or the Sleep Mode Button to wake the meter up. This will allow the operator approximately 2 minutes to change the battery and not lose date/time settings.
 - c. If it takes longer than 2 minutes to change the battery. Dock the meter to reset the date and time.
 - d. Push in on the cover latch to release the cover. Take the battery cover off the back of the meter.
 - e. Remove the battery. Remove the photo below it is unnecessary.
 - f. Replace with a fully charged battery. (The battery is keyed to allow only insertion from bottom first then push in the top.)
 - g. Replace the battery cover.
 - h. Place the drained battery into the docking station to recharge. Be sure the light to the left comes on signifying the correct positioning of the battery.
5. Supplies and Storage :
 - a. Blood Glucose Meter (Operates 15 to 40C; 59 to 104F)
 - b. Glucose Test Strips (Store in original bottle 15 to 30C)
 - i. When opened, mark each bottle with the expiration date 180 days or manufacture expiration date, whichever comes first.
 - ii. Once opened, both Stat Strip bottles in the single package must be labeled because there is no safety seal on the individual bottle.
 - iii. Stable when stored as indicated for 180 days or until the printed expiration date (whichever comes first).
 - c. Glucose Control Solutions, level 1 low and level 3 high (Store 15 to 30C)
 - i. When opened, mark the bottle with the expiration date 90 days or manufacture expiration date, whichever comes first.
 - ii. Once opened, stable for 90 days or until the printed expiration date (whichever comes first).
 - d. Do not use strips or controls past their expiration date.
 - e. Remove the test strip from the vial only when ready to test and recap vial.

G. **QUALITY CONTROL AND CALIBRATION:**

1. Quality Controls (QC) are used to confirm that the meter and test strips are working correctly.
2. Control Frequency:
 - a. Meter is configured to require a QC with both Level 1 low and Level 3 High every 24 hours. Meter will lock out at 24 hours and screen will display QC Lockout.
 - b. Perform a QC if a patient test has been repeated and the blood glucose results are still lower or higher than expected
 - c. Perform a QC any time you have a concern about the function of the meter, i.e it is dropped or problems are identified (storage, operator, instrument)
 - d. Performing a QC with both Level 1 low and Level 3 high solution is required for Alere / Freedom to recognize new operators in the system. This shall be done upon initial and annual competency.
3. Perform QC with both Level 1 low and Level 3 high QC solutions to unlock meter: If one QC level fails, repeat the test only for the level that failed.
4. Procedure:
 - a. From the Welcome Screen press Login.
 - b. Manually Enter or Scan your Operator ID and press OK/Accept.
 - c. From the Patient Test Screen, press QC.
 - d. At the Enter Strip Lot screen, scan the strip lot from the bottles. Verify the strip lot number matches the number displayed on the screen.

- e. At the Enter QC Lot screen, scan the QC lot
- f. At the Insert Strip screen, insert the test strip into the meter.
- g. Mix the control well by rolling the vial, do not shake.
- h. At the Apply Sample screen, touch the tip of the test strip to the drop of control and the strip will fill by capillary action. Keep contact with the drop of control until the meter beeps, indicating sufficient sample was obtained.
 - i. The test strip must fill completely on the first attempt. If insufficient sample is obtained, repeat with a new test strip.
 - ii. HOLD THE METER LEVEL or downward WHILE TESTING. This prevents any excess liquid from seeping down the strip and into the meter, causing damage.
 - iii. If liquid gets into meter, dry strip port.
 - 1) If unable to remove liquid or the liquid dries and cannot be removed send the meter to the Lab.
- i. The QC Result screen will show with a PASS or FAIL Press Ok/Accept.
- j. If QC fails select comment and, perform corrective action:
 - i. Verify the correct level of control was scanned and tested.
 - ii. Verify the test strips and control solutions are not expired. If expired, open new strips or controls.
 - iii. Mix the control thoroughly. Repeat the test with a new strip. If the second test fails, contact the lab.
- k. Log off meter when you are finished testing. Auto log off will occur after inactivity.
- l. The meter does not require calibration.

H. **PRINCIPLE/CLINICAL SIGNIFICANCE:**

1. This test is Clinical Laboratory Improvement Amendment (CLIA) WAIVED for capillary, venous, and arterial whole blood and neonatal heel stick whole blood.
2. Glucose is measured amperometrically, using an enzyme based test strip.
3. The meter is plasma calibrated to allow easy comparison of results with laboratory methods.
4. The measurement of glucose is used in the monitoring of carbohydrate metabolism disturbances including diabetes mellitus, and idiopathic hypoglycemia, and of pancreatic islet cell carcinoma.
5. Testing by this method is not for diagnosis of or screening for diabetes.
6. Limitations
 - a. Capillary blood glucose testing is not appropriate for persons with decreased peripheral blood flow, as it may not reflect the true physiological state. Venous and arterial whole blood is the only sample that shall be used for any patient receiving intensive medical/interventional therapy with decreased peripheral blood flow, as evidenced by one or more of the following:
 - i. Severe hypotension requiring the administration of two or more intravenous vasopressors
 - ii. Any patient with a core body temperature equal or less than (\leq) 35°C
 - iii. Any patient with ESI of one
 - b. When performing frequent testing in a patient, try to use the same blood source as consistently as possible.
 - i. Rationale: Venous and capillary blood may differ in glucose concentration by as much as 70 mg/dL, depending on the time of blood collection after food intake. Draw lab serum glucose for the most accurate glucose value.
7. A test within 20% of laboratory results is considered accurate.
8. Interfering Substances
 - a. The Blood glucose meter Glucose meter exhibits no interference from the following substances at known therapeutic levels: Acetaminophen, Ascorbic acid, Dopamine, Ephedra, D+ Galactose, Ibuprofen, L-Dopa, Methyl-Dopa, Salicylate, Tetracycline, Tolazamide, and Tobutamide.

- b. The Blood glucose meter Glucose meter exhibits no interference from the following substances at or above the upper clinical normal range concentrations: Bilirubin, Cholesterol, Creatinine, Triglycerides, and Uric Acid.
- c. The Blood glucose meter Blood glucose meter Glucose meter exhibits no interference from the following substances at the normal therapeutic levels found in renal dialysis: D(+) Maltose monohydrate, D(+) Maltotetraose, and D(+) Maltotetrisose.
- d. The blood glucose meter Blood glucose meter meter exhibits no interference in blood specimens with hematocrits from 20% to 65% or with varying oxygen content.

I. REFERENCE INTERVALS:

1. Meter range 10-600 mg/dL
 - a. <10 meter reads LO. Continue with treatment and retest according to standardized procedure for hypoglycemia.
 - b. >600 meter reads HI. Order lab glucose to obtain a valid number for treatment.
2. Reference Range (all in mg/dL)

	NORMAL	CRITICAL LOW	CRITICAL HIGH
a. Adults	70 – 110	≤ 40	≥ 450
b. Neonates	45 – 120	≤ 30	none established
3. Critical Results must have follow up documentation of physician notification and any interventions.
4. Any result that is questionable or does not correlate with patient symptoms or treatment history should be repeated with a new finger puncture to rule out operator, strip, or meter error. If repeat meter value does not 'make sense', order a lab glucose.

J. REFERENCE(S):

1. Nova Biomedical. Blood glucose meter Glucose Test Strips Package Insert. Ref 42214. 2016-03.
2. Nova Biomedical. Blood glucose meter Glucose Control Solution Package Insert. Ref 41741 & 41743. 2017-03.
3. Nova Biomedical. CIB 04-11SS Rev. B. Cleaning and Disinfection Procedure. 2015-06.
4. Nova Biomedical. Blood glucose meter Glucose Hospital Meter IFU 1.86 Ref.55848F 2019-01

K. FORM(S):

1. Point of Care Testing Correction Form

L. RELATED DOCUMENT(S):

1. Online Clinical Skills Arterial Catheter: Blood Sampling
2. PCS Procedure: Central Venous Access Devices, Adults
3. PCS Procedure: Collection of Blood Specimen by Skin Puncture
4. PCS Procedure: Critical Results and Critical Tests/Diagnostic procedure
5. PCS Procedure: Extended Dwell/Midline Catheter, Adults
6. PCS Standardized Procedure Hypoglycemia Management in the Adult Patient
7. PCS Standardized Procedure Newborn Hypoglycemia During Transition to Extrauterine Life
8. PCS Procedure: Venipuncture for Specimen Collection
9. Point of Care Correction Form
10. StatStrip Troubleshooting Guide
11. Nova Biomedical Glucose Meter Instructions for Use

Point of Care Testing Correction Form

NURSING Complete this form when 1. Valid Result was not "Accepted" at meter. 2. Any ID other than the current FIN # (account) was used to identify the patient in the meter/instrument. Complete in full and return to Lab. Result will be charted after the lab resolves the error.

POC Test: <input type="checkbox"/> Glucose (Nova Statstrip) <input checked="" type="checkbox"/> Hemoglobin (Hemocue 201DM) <input type="checkbox"/> Urine Dipstick (Siemens Clinitek) <input type="checkbox"/> ACT (Medtronic ACT Plus)	Reason for Exception: <input type="checkbox"/> Unregistered Patient (scan John/Jane Doe armband) <input type="checkbox"/> Scanned Armband of old encounter, bypassed warning <input type="checkbox"/> Scanned wrong barcode, did not confirm <input type="checkbox"/> Downtime override used <input type="checkbox"/> Scanning function not working <input type="checkbox"/> Manual entry of Patient FIN # not accepted
Date of Test:	Comments:
Time of Test:	Operator Name/ID: (Performed Test)
Result:	Correct Patient ID: (fill out or attach chart label)
Correct Patient ID Verified by:	Name: _____ MRN: _____ FIN: _____
Send to Lab via pneumatic tube or Fax to x4048	
LAB USE ONLY	
Corrected by:	Date/Time:
Comments:	

STANDARDIZED PROCEDURES MANUAL

STANDARDIZED PROCEDURE: ECLAMPSIA MANAGEMENT IN THE ANTEPARTUM, INTRAPARTUM OR POSTPARTUM/POSTPARTUM PERIOD

I. POLICY:

- A. Eclampsia is **defined by new-onset tonic-clonic, focal, or -multifocal seizures** characterized by ~~or~~ convulsions and loss of consciousness in the absence of other causative conditions such as epilepsy, cerebral arterial ischemia and infarction, intracranial hemorrhage, or drug use). It ~~which~~ can occur without warning during the antepartum, intrapartum, or postpartum period. It is the most severe hypertensive syndrome related to pregnancy and the postpartum period and the diagnosis of preeclampsia is usually present (“ACOG Practice”, 202049).
- B. The Eclamptic patient is at risk for **severe maternal hypoxia, trauma, and aspiration pneumonia.** ~~aspiration and cerebral hemorrhage.~~
- C. ~~In a pregnant patient, fetal bradycardia frequently occurs during and following an eclamptic seizure.~~ **During eclamptic seizures, there are usually prolonged fetal heart rate deceleration, even fetal bradycardia, and sometimes an increase in uterine contractility and baseline tone. After a seizure, because of maternal hypoxia and hypercarbia, the fetal heart rate tracing may show recurrent decelerations, tachycardia, and reduced variability (“AGOG Practice”, 2020).**
 1. The best treatment for the fetus is maternal stabilization **with oxygen, and antiseizure drugs and treating hypertension if present,** ~~and with~~ continuous fetal monitoring, as indicated.
 2. Mode of delivery is dependent upon clinical circumstances surrounding the pregnancy and determined by the Obstetrician.
- D. For postpartum patients and/or females reporting to the Emergency Department who have a history of delivering a baby within the last six weeks, early recognition is critical.
 1. Signs and symptoms can include elevated blood pressure, headache, visual complaints, altered mental status, cerebral vascular accident, seizure, right upper quadrant abdominal pain, ~~epigastric pain,~~ **epigastric pain,** persistent nausea and vomiting, shortness of breath, **clonus, brisk deep tendon reflexes, and** pulmonary edema.
 - 4.2. **“Of note, a significant proportion of women (20–38%) do not demonstrate the classic signs of preeclampsia (hypertension or proteinuria) before the seizure episode” (“ACOG Practice”, 202049).**

II. PROCEDURE:

- A. Initial Management:
 1. Call for ~~H~~help. **May** ~~and/or~~ initiate the Rapid Response Team, ~~as indicated~~ **needed as needed.**
 2. Position the patient on her side (**preferably left lateral position**) ~~if possible~~ and protect from injury.
 3. Establish open airway and maintain breathing.
~~Place pulse oxygenation saturation device to obtain oxygenation level.~~
 4. **Check blood pressure and pulse every 5 minutes, with continuous pulse oxygen saturation.**

Patient Care Services Content Department Review	Clinical Policies & Procedures	Nursing Leadership Executive Committee	Department of OB/GYN	Pharmacy & Therapeutics Committee	Interdisciplinary Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
New 01/15, 102/19	1/15, 01/20, 03/20	2/15, 04/20	06/15, 06/21	09/15, 07/21	01/16, 10/21	01/16, 01/22	03/22	02/16, n/a	02/16

5. Obtain intravenous (IV) access, if not in place, ~~with~~ with a minimum of one large bore IV catheter (minimum 18 gauge).
- 5.6. Draw preeclampsia labs: CBC, AST, ALT, ~~UA~~ Urine dip for protein, LDH, Uric Acid, Creatinine.
7. Prepare to administer medications
- 6.8. Apply fetal monitor when possible

~~B.~~ Following Seizure:

1. ~~Suction patient's mouth~~
2. ~~Give oxygen at 10 liters per minute.~~
3. ~~Provide ventilatory support as needed.~~
4. ~~Assess blood pressure, pulse and respirations every 5 minutes until stable.~~
5. ~~Assess oxygen saturation and level of consciousness every 15 minutes until stable for a minimum of one hour.~~
6. ~~If pregnant, monitor fetal heart rate and uterine activity continuously if viable fetus is present, per unit procedure~~
 - a. ~~Delivery decision to be evaluated and determined by Obstetrician.~~
7. ~~Assess for any signs of neurological injury/focal deficit.~~
 - a. ~~Head imaging shall be considered if neurologic injury is suspected.~~

~~C.B.~~ Initial Medication Management:

1. Administer Magnesium Sulfate 64 gram IV loading dose over 20 minutes, followed by a 2 gram/hour maintenance dose if patient's renal function is normal.
 - 4.a. **If patient is already on Magnesium Sulfate, give patient 2 gram bolus over 5 minutes**
2. May give a 2-gram bolus over 5 minutes for a second seizure event.
- 2.3. **May give two doses of 5-gram IM, if no IV access.**
- 3.4. Observe for magnesium sulfate toxicity and follow assessment guidelines per ~~P~~patient ~~C~~care ~~S~~services, ~~M~~magnesium ~~S~~sulfate ~~A~~administration ~~P~~procedure.

~~D.C.~~ Medication Management ~~For~~for ~~r~~Recurrent ~~s~~Seizure ~~a~~Activity **Not r**Resolved ~~w~~With ~~m~~Magnesium:

1. ~~FIRST, g~~**G**ive Midazolam (Versed) 1 mg Intravenous Push (IVP). (~~May~~**Can** repeat dose in 5- 10 minutes). ~~Patient should be on cardiac monitor, continuous O2 monitoring, and frequent blood pressure checks)~~**Monitor respiration and BP, ECG and signs of magnesium toxicity.**
2. If seizure activity continues after Magnesium and Versed are administered **call provider for further orders.**, ~~give Lorazepam (Ativan) 4 mg IV over 2-5 minutes. (Can repeat in 5-15 minutes to a maximum of 8 mg in 12 hours).~~
3. ~~Other medications for seizure activity, if not controlled by the first three listed can include giving Diazepam (Valium) 5 mg IV slowly. (Can repeat every 15 minutes up to 30 mg) OR Phenytoin (Dilantin) 1 gram IV over 20 minutes. (EKG monitoring is required for Dilantin administration)~~
- ~~(Troiano, Witcher, & Baird, 2019)~~

~~E.D.~~ Following Seizure:

1. Suction patient's mouth
2. Give oxygen at 10 liters per minute **via non-rebreather mask.**
3. **Contact Respiratory Therapist (if not already present) to P**provide ventilatory support as needed.
4. Assess blood pressure, pulse and respirations every 5 minutes until stable.
5. Assess oxygen saturation and level of consciousness every 15 minutes until stable for a minimum of one hour.
6. If pregnant, monitor fetal heart rate and uterine activity continuously if viable fetus is present, per unit procedure**Fetal Heart Rate Surveillance/Monitoring Procedure**
 - a. Delivery decision to be evaluated and determined by Obstetrician.
7. Assess for any signs of neurological injury/focal deficit.

- a. Head imaging shall be considered if neurologic injury is suspected.
8. **Insert urinary catheter with a urometer.**

III. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**

- A. Current **unencumbered** California RN license working in Women and Newborns Services, Emergency Department, and Intensive Care Units
- B. Education: Registered Nurse and completion of the Magnesium Sulfate Administration Net Learning Module
- C. Initial Evaluation: Orientation
- D. Ongoing Evaluation: Annual

IV. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**

- A. Method: This standardized Procedure was developed through collaboration with Nursing, Medicine and Administration.
- B. Review: Every two (2) years.

V. **CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:**

- A. All Registered Nurses who have successfully completed the requirements as outlined above are authorized to direct and perform Eclampsia Management in the Antepartum Intrapartum and ~~Postpartum-Period~~ Postpartum Period Standardized Procedure

VI. **RELATED DOCUMENTS**

- A. **Patient Care Services Procedure: Magnesium Sulfate, Administration in Obstetrics Procedure**
- B. **Women and Newborn Services Procedure: Fetal Heart Rate Surveillance/Monitoring Procedure**
- A-C. **Women and Newborn Services Procedure: Preeclampsia Care Guidelines Procedure**

~~VI.~~ VII. **REFERENCES:**

- A. American College of Obstetricians and Gynecologists (ACOG) Practice Bulletin No. 202222. (202019). *Obstetrics & Gynecology*, 135433(64). doi: 10.1097/aog.0000000000003018
- B. Eclampsia Checklist. (2019). *The American College of Obstetricians and Gynecologists*, 1. Retrieved from <https://www.acog.org/-/media/Districts/District-II/Public/SMI/v2/19sm02a170703EclampsiaCheck1.pdf?dmc=1&ts=20191216T0623500370>
- C. Troiano, N. H., Witcher, P. M., & Baird, S. M. M. (2019). *High-risk & critical care obstetrics*. Philadelphia, PA: Wolters Kluwer.
- D. California Maternal Quality Care Collaborative. (2014) *Improving Health Care Response to Preeclampsia: A California Toolkit to Transform Maternity Care*. Retrieved from <https://www.cmqcc.org/resource/cmqqc-preeclampsia-toolkit-errata-51314>
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- B. — ACOG. Diagnosis and Management of Preeclampsia and Eclampsia #33. American Congress of Obstetricians and Gynecologists Practice Bulletin Number 33, 2002. (Reaffirmed 2012)
- C. — ACOG. Committee Opinion no 514. Emergent therapy for acute-onset, severe hypertension with preeclampsia or eclampsia. *Obstet Gynecol*. 2011; 118:1465-1468.
- D. — Simpson, K. R., Creehan, P.A. (2008). *Perinatal Nursing*, Ed 3rd. Philadelphia: Lippincott Williams and Wilkins.

PATIENT CARE SERVICES

ISSUE DATE: 11/02 SUBJECT: Latex Sensitivity/Allergy Management

REVISION DATE(S): 12/02, 4/05, 6/08, 07/11, 02/15
08/18

Department Approval:	03/1806/21
Clinical Policies & Procedures Committee Approval:	04/1811/21
Nursing Leadership Executive Council Approval:	04/1812/21
Medical Staff Department/Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	05/1802/22
Medical Executive Committee Approval:	n/a
Administration Approval:	08/1803/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/18

A. **PURPOSE:**

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

B. **POLICY:**

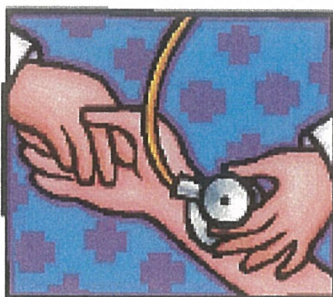
1. The following are possible routes of exposure to latex allergens:
 - a. Skin – via gloves, tapes, masks, tourniquets
 - b. Mucous membranes – via products used in dentistry, anesthesia, rectal examinations, and eye droppers
 - c. Inhalation – via aerosolization of glove powder
 - d. Internal tissue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

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

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

- 1. Latex Allergy Patient Education
- 2. Latex Allergy Signs & Symptoms of an Allergic Reaction

LATEX ALLERGY



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

Many items contain latex

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

Common items made with latex:

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

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

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

Protect yourself from exposure to latex

Remember to report the need for latex precaution in each and every medical visit and in community places. These places include hospitals, clinics, doctor and dentist's offices, pharmacies, nursing homes, day care, schools, and work settings. You have the right to question the latex content of any product used in each setting.

Wear some form of medical identification if you are allergic to latex and follow instructions given to you by your nurse or doctor at all times. This may include taking medication.

Signs and symptoms of an allergic reaction

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

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

- Skin: ☐ Rash, swelling, hives, itching, redness, and irritations.
This reaction may be small or cover large areas of the body.
- Eyes: ☐ Itching, tearing, watering, redness
- Nose/throat: ☐ Runny nose, tightness and/or swelling of the throat, sneezing, itching
- Lungs: ☐ Shortness of breath, difficulty breathing, wheezing
- Heart: ☐ Chest pain, palpitations, lightheaded, fast heart beat, drop in blood pressure
- Intestine: ☐ Abdominal cramping, diarrhea, nausea, vomiting

Food and Latex Allergy



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

Cross-Reactive Foods

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

Administrative Policy Manual
District Operations

ISSUE DATE: 09/96 **SUBJECT:** Charity Care, Uncompensated
Care, Community Service

REVISION DATE: 08/97, 05/99, 08/04, 04/06, 02/07,
01/10, 10/10, 09/13, 06/14, 08/15,
06/17 **POLICY NUMBER:** 8610-285

Department Approval:	06/2102/22
Administrative Policies and Procedures Committee Approval:	08/2103/22
Finance, Operations and Planning Committee Approval:	12/2103/22
Board of Directors Approval:	02/22

A. **PURPOSE:**

1. The Hospital desires to have a clear, well-communicated and documented financial assistance policy consistent with its mission and values, and in compliance with government accounting standards, Federal and State regulations.
2. California acute care Hospitals must comply with Health & Safety Code Section 127400 et. seq. hereinafter referred to as the California Fair Pricing Law, including requirements for written policies providing discounts and charity care to financially-qualified patients. This policy is intended to exceed the legal requirements detailed in the California Fair Pricing Law.

B. **POLICY:**

1. As a benefit to the community, it is the policy of the Hospital to provide free, or partially free, health care services to community members who have demonstrated that they are either financially or medically indigent. The Hospital gives consideration to eligible patients residing within its community and to patients, whether or not they have insurance and regardless of income level, if there are exceptional circumstances.
2. Patients will be treated fairly and respectfully regardless of their ability to pay. The Hospital does not discriminate against any person on the grounds of race, creed, color, national origin, sexual orientation or on the basis of disability or age.
3. Business Office staff will provide interested patients with financial counseling including assistance applying for local, state and federal health programs. Uninsured and underinsured patients will be informed of and assisted in applying for charity/discounted care.
4. Any patient, or legal representative of the patient, seeking financial assistance, shall provide information concerning health benefit coverage, financial status and other pertinent documentation that is necessary to make a determination regarding the patient's status relative to the hospital's charity care policy, discounted payment policy, or eligibility for local, state or federal programs. All information provided by or for the patient, will be confidential and the dignity of the patient will be maintained during this process.
5. The Hospital and/or outside agents working on behalf of the Hospital, shall not use wage garnishments or a lien on the patient's primary residence if the patient or the patient's legal representative are communicating and cooperating with the Hospital and it has been determined that the patient is eligible for charity care or discounted care.
6. An emergency physician, as defined in Section 127450 of California Health & Safety code Chapter 2.5 of Division 107, who provides emergency medical services in a hospital that provides emergency care, is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below ~~400~~350 percent of the federal poverty level. This statement shall not be construed to impose any additional responsibilities upon the hospital

7. All collection agencies working on behalf of the Hospital shall comply with the California Fair Pricing Law.
8. Without the completion of an application for financial assistance, the Hospital, at its discretion, may approve financial assistance outside the scope of this policy. Discretionary full or partial charity write-offs include, but are not limited to, a history of non-payment on the patient account balance, where referral to an outside collection agency would not result in a payment on the patient account, the social situation of the patient, and patients/guarantors who cannot be located

C. **DEFINITIONS AND ELIGIBILITY:**

1. Charity – Financial assistance to qualifying insured and uninsured patients, in whole or in part, to relieve them of their financial obligation for health care services. For individuals who meet the Hospital's charity criteria, charity care results from the Hospital's mission to provide free health care services. Charity care is measured based on revenue forgone, at full established rates. Charity care does not include contractual write-offs, courtesy discounts, prompt pay discounts, employee discounts, or friends and family discounts.
2. Charity care does not include bad debt resulting from a patient's unwillingness to pay or from a failure to meet the definitions in this financial assistance policy.
3. Definitions of Charity include:
 - a. Catastrophic Charity Care - 100% write-off of the patient's liability for a patient with High Medical Cost. All charges are eligible for consideration under the Hospital's definition of High Medical Cost.
 - b. Full Charity Care – 100% write-off of the patient's undiscounted responsibility.
 - c. Partial Charity Care – Partial write-off of the patient's undiscounted responsibility.
 - d. Special Circumstance Charity Care – Patients who do not meet other charity criteria or who are unable to follow specified hospital procedures to receive a full or partial charity care write-off of charges.
 - e. The following is a non-exhaustive list of some situations that may qualify for special circumstance charity care:
 - i. Bankruptcy,
 - ii. Patient without a residential address (homeless), or reasonable efforts are made to locate and contact the patient, and such attempts have been unsuccessful,
 - iii. Deceased patients without an estate,
 - iv. MediCal/Medicaid denials – patients who are eligible for MediCal/Medicaid are also presumed to qualify for full charity care. This definition includes patient's whose MediCal/Medicaid coverage is limited or restricted, TAR denials, medical necessity denials, billing denials (i.e. untimely filing)
 - v. Charges for days exceeding a length-of-stay limit for patients enrolled in MediCal/Medicaid or other state or county indigent care programs,
 - vi. Non-covered services for MediCal/Medicaid eligible patients,
 - vii. The patient has coverage from an entity that does not have a contractual relationship with the provider; this would include Medicaid out of state patients, or situations where the insurance carrier is not under contract with the Hospital and denies the claim.
 - f. Patient Obligations for deductible and coinsurance amounts, non-covered services, or services provided to a patient where the patient's benefits are exhausted, where the insured patient qualifies for full or partial charity care are included in the definition of charity care.
4. Federal Poverty Level (FPL) – Poverty guidelines, updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of subsection (2) of Section 9902 of Title 42 of the United States Code.
5. High Medical Cost – An insured patient with high medical costs (coinsurance, deductible, and/or reached a lifetime limit, non-covered relating to services not medically necessary) High medical costs means:
 - a. Annual out-of-pocket costs incurred by the patient, at the Hospital, that exceeds 10 percent of the patient's family income in the prior 12 months.

- b. Annual out-of-pocket medical expenses by the patient that exceeds 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.
6. Patient's Family and Determination of Family Income – For persons 18 years of age and older: Spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not. For persons under 18 years of age: parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative. Documentation of family income shall be limited to recent pay stubs and tax returns. The patient's assets or the assets of the patient's family may not be considered.
7. Reasonable payment formula - monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses.
 - a. "Essential living expenses" means expenses for all of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses including insurance, gas and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.
8. Self-pay discount – discounts are provided to uninsured patients or to insured patients where the payer does not cover the services provided, or where the insured patient has exhausted their benefits. The discount provided to uninsured patients is the difference between the charges and 125% of the Medicare reimbursement. This excludes self-pay discounts for OB services, which are based upon the type of delivery and the length of stay

D. PROCEDURES:

1. Any uninsured patient who indicates an inability to pay will be screened for charity care. Additionally, at the discretion of the Hospital, any insured patient who indicates an inability to pay their liability, after their insurance has paid, will be screened for charity care. Charity care will be granted based upon the following suggested income levels:

<u>Income Level</u>	<u>Discount Amount</u>
Up to 400% of FPL	100% Discount
401-500% of FPL	75% Discount
Over 500% of FPL	Case by Case Discounts
High Medical Cost	100% Discount
Special Circumstance	Case by Case Discounts

- a. All patients who are registering without insurance will be registered as a self-pay or MediCal/Medicaid-pending patient, and a MediCal/Medicaid application should be taken. Elective patients who have a large deductible and/or coinsurance obligation will meet with a financial counselor and complete the Patient Financial Assessment Form (PFAF). If the patient does not qualify for charity or MediCal/Medicaid, payment will be required in advance of the service. If a charity determination is made and partial payment is required, payment is due in advance of the service unless other arrangements are pre-arranged with the Hospital financial counselor. Charity determinations over \$25,000 require the approval of the Chief Financial Officer or his/her designee.
 - ~~b. All patients with a self-pay balance of \$25 or less and an age of greater than 120 days will be written off to charity.~~
2. Application- Except in those instances where the Hospital has determined that minimal application and documentation requirements apply, in order to qualify for charity care, a PFAF should be completed.
 - a. Family Members – Patient will be required to provide the number of family members in their household.
 - b. Income Calculation – Patient will be required to provide their household's yearly gross income. Adult patient's yearly income on the PFAF means the sum of the total yearly gross income of the patient and the patient's spouse or domestic partner. Minor patient's yearly income on the PFAF means income from the patient, the patient's mother and/or father and/or domestic partner and/or legal guardian.

- c. Income verification – Patients will be required to verify the income set forth in the PFAF. Income documentation will include IRS Form W-2, wage and earnings statement, paycheck stub, tax returns, bank statements, or other appropriate indicators of income. Current participation in a Public Benefit Program including Supplemental Security Income (SSI), Social Security Disability, Unemployment Insurance Benefits, Medicaid, County Indigent, Food Stamps, WIC or other similar indigence related programs can be used to verify indigence.
 - d. Documentation Unavailable – Where the patient is unable to provide documentation verifying income, the following procedures shall be followed:
 - i. Expired patients: Expired patients may be deemed to have no income.
 - ii. Written Attestation: Patient can sign the PFAF attesting to the accuracy of the income information provided.
 - iii. Verbal Attestation: The Hospital financial counselor may provide written attestation that the patient verbally verified the income calculation. Some attempt should be made to document the patient's yearly income before taking a verbal attestation.
 3. Patients unwilling to disclose any financial information as requested by the Hospital financial counselor. The patients will be advised that unless they comply and provide the information, no further consideration for charity care processing will be made and standard Accounts Receivable follow-up will ensue.
 4. Extended Payment Plans, without interest charges, will be made available and negotiated between the Hospital and the patient to allow the patient who is eligible for partial charity to pay over an extended period of time. If the Hospital and the patient cannot agree to a payment plan, the hospital will use the "reasonable payment plan" formula to determine the payment plan.
 5. California Health Benefit Exchange – The Hospital will obtain information as to whether the patient may be eligible for the California Health Benefit Exchange. Information will be provided to a patient that has not shown proof of third party coverage, a statement that the patient may be eligible for coverage through the California Health Benefit Exchange or other State- or County-funded health coverage program.
 6. If the patient applies, or has a pending application, for another health coverage program concurrent with an application for charity care or a discounted payment program, neither the charity care, discounted payment program, or health care coverage program applications preclude eligibility for the other program.
 7. All internal and external collection activity will be based on the written procedures contained herein. The Hospital will maintain a written agreement from any external agency that collects debt that the external agency will adhere to the Hospital's standards and practices. Specifically, the external collection agency will comply with the definition and application of the Hospital's reasonable payment plan, defined herein.

E. NOTICE:

1. Timeframe - There is no rigid limit on the time when the charity determination will be made. In some cases, a patient eligible for charity care may not be identified prior to the initiation of external collection action. The Hospital's collection agencies shall be made aware of this procedure so that the agencies know to refer back to the Hospital patient accounts that may be eligible for charity care.
2. Once a full or partial charity determination has been made, a written notification will be sent to the applicant advising them of the Hospital's decision.

F. COMMUNICATION:

1. Information provided to patient – During registration, or as soon thereafter as practicable, the Hospital shall provide:
 - a. All uninsured patients with written information regarding the Hospital's charity care policies and the appropriate contact information for the patient to obtain further information about these policies. The Hospital will provide the patient with a referral to a local consumer assistance center.
 - b. At the request of the patient, the Charity application will be provided.

- c. Patient statements to patients who have not provided proof of third-party coverage will include information about charity care, the California Health Benefit Exchange and other State- or County- funded health coverage, as well as Medicare, Medi-Cal, Healthy Families and California Children's Services. The patient statement will indicate how the patient may obtain applications for coverage through the California Health Benefit Exchange and other State- or county funded health coverage programs, and the Hospital will provide these applications. Further, this information will have standard language informing patients that they may request financial screening to determine eligibility for charity care. Finally, to the extent possible, these communications will be in the primary language of the patient.
 - d. The patient statement will include information on the availability of charity care and discounted payments from the emergency room physicians. The statement will include contact information for the emergency room physician who treated the patient.
2. Postings and Other Notices – Information about charity care shall also be provided by posting notices in a visible manner in the admitting and registration locations.

G. **FORMS/RELATED DOCUMENTS:**

1. Patient Financial Assessment Form - Sample

H. **REFERENCE:**

1. California Health and Safety Code, Section 127400, et. Seq
2. ACA provisions, IRC §501(r)

Patient Financial Assessment Form - Sample

PATIENT FINANCIAL ASSESSMENT REQUEST FORM



Tri-City Medical Center

Date: _____

PATIENT NAME: LAST		FIRST	MIDDLE
PATIENT ADDRESS:		MEDICAL RECORD #	
CITY, STATE & ZIP	PATIENT SOCIAL SECURITY #		FAMILY SIZE (REQUIRED)
MAIDEN NAME OR OTHER:		PHONE #: ()	
NEXT OF KIN NAME:		PHONE #: ()	WORK PHONE ()
EMERGENCY PHONE	PATIENT DOB		CELL PHONE: #

RESPONSE
NAME
EMPLOYER (IF SELF EMPLOYEE DESCRIBE)
ADDRESS
SUPERVISOR NAME
PHONE
INCOME (REQUIRED) \$ _____ <input type="checkbox"/> HOURLY

WIFE	HUSBAND
NAME	NAME
OCCUPATION	OCCUPATION
DATE OF BIRTH	DATE OF BIRTH
SOCIAL SECURITY #	SOCIAL SECURITY #
YEARS	YEARS
<input type="checkbox"/> WEEKLY <input type="checkbox"/> BIWEEKLY <input type="checkbox"/> MONTHLY	<input type="checkbox"/> WEEKLY <input type="checkbox"/> BIWEEKLY <input type="checkbox"/> MONTHLY

ASSETS
CASH ON HAND
CHECKING ACCOUNT
SAVINGS ACCOUNT
CREDIT UNION ACCOUNT
PROPERTY OWNED VALUE
MOTOR VEHICLES OWNED
MAKE:
MAKE:
HOME OWNER ESTIMATED VALUE
OTHER SOURCES/ (STOCK BONDS)
BANK BRANCH(S) & ACCOUNT NUMBER

LIABILITIES	
\$	
\$	
\$	
\$	
\$	
\$	
\$	
\$	
SEPARATE SHEET IF NECESSARY)	
PAYMENT	BALANCE

I/WE HEREBY DECLARE THE FOR

WS OF THE STATE OF CALIFORNIA.

DATE

350% FPL

HOM:

IF PARTIAL AMOUNT: \$ _____

Rev (3/16)



Tri-City Medical Center

FINANCIAL ASSISTANCE APPLICATION FORM

Provided in Accordance with Cal. Health & Safety Code §127425(e)(5)

Application Date:		Date of Service:	
Patient Name:		Account Number:	
Street Address:		Phone Number:	
City, State, ZIP:		Patient Date of Birth:	

- 1) Was the patient a resident of California at the time of service? Yes No
 2) Did the patient have medical insurance at the time of service? Yes No
 3) Was the patient an active Medicaid recipient at the time of service? Yes No

**If you answered yes to questions 2 or 3, please attach a copy of your insurance or Medicaid card to this application.

INCOME:

- All adult family members' income must be disclosed. Income includes gross (before taxes) wages, rental income, unemployment compensation, social security benefits, public assistance, dividends and interest, etc.
- "Family" is defined as follows: (i) for persons 18 years of age and older, family means spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and (ii) for persons under 18 years of age, family means parents, caretakers, relatives, and other children under 21 years of age of the parent or caretaker relative. If the patient is a minor, the "family" is defined as the patient, the patient's natural or adoptive parents and the parent's other children (natural or adoptive) who live in the patient's home.

Family Member's Name	Age	Date of Birth	Relationship to Parent	Source of Income or Employer Name	Income for 3 months prior to date of service	Income for 12 months prior to date of service

**Please attach additional family member information if applicable.

- Proof of income must be supplied at the time of application (e.g., three months of pay stubs, most recent tax return (IRS Form 1040), etc.).
- If you report \$0 income, please provide a written statement of how you (or the patient) are surviving financially, including who provides food, shelter, transportation, etc. and how long you have been without income.

MONTHLY EXPENSES:		ASSETS	
		This information may be used if your income is above 200% of Federal Poverty Level guidelines to determine whether you may be eligible for discounted care.	
Monthly rent/mortgage	\$	Checking account	\$
Utilities	\$	Savings account	\$
Car payment	\$	Business ownership	\$
Medical expenses	\$	Stocks and bonds	\$
Insurance premiums (life, home, car, medical)	\$	Real estate (excluding primary residence)	\$
Clothing, groceries, household goods	\$		
Other debt/expenses (e.g., child support, loans, other)	\$		

My signature below certifies that everything I have stated on this application is correct and subject to review under audit. I understand that if the information I provide is determined to be false, financial assistance may be denied and I may be responsible to pay for services provided.

Applicant's Signature

Date

Please return completed application to:

TRI-CITY MEDICAL CENTER
ATTENTION: PATIENT ACCOUNTING/CSR
4002 VISTA WAY
OCEANSIDE CA 92056



Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

Tri-City Medical Center
Allied Health Professional

Registered Nurse First Assist (RNFA)
Standardized Procedures

Approvals

Operating Room (Signature):	<u>April 22, 2021</u>
Interdisciplinary Practice Committee (Date):	<u>October 18, 2021</u>
Medical Executive Committee (Date):	<u>February 22, 2022</u>
Administration (Date):	<u>March 21, 2022</u>
Professional Affairs Committee (Date):	<u>n/a</u>
Board of Directors (Date):	<u></u>



Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

Standards for Allied Health Professionals

Registered Nurse First Assist (RNFA)

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Standards for Allied Health Professionals

Registered Nurse First Assist (RNFA)

A. Scope of Service

1. The Registered Nurse First Assist (RNFA) renders direct patient care as part of the perioperative role by assisting the surgeon in the surgical treatment of the patient. The responsibility of functioning as first assistant must be based on documented knowledge and skills acquired after specialized preparation and formal instruction.
2. The RNFA is authorized to perform in an expanded role and may assist on procedures which specify that a first assistant and second assistant is required. The safety and welfare of the patient should be given primary consideration in the selection of a first assistant in surgery. ~~In the absence of a qualified physician, the registered nurse who possesses appropriate knowledge and technical skills is the best qualified non-physician to serve as the first assistant.~~
3. The RNFA may assist the surgeon during a surgical procedure with specified technical functions. These specific technical functions are:
 - a. Intraoperative retraction - Assist with the positioning, prepping and draping of the patient or perform these independently, if so directed by the surgeon.
 - i. Provide retraction by:
 - a. Closely observing the operative field at all times.
 - b. Demonstrating stamina for sustained retraction.
 - c. Retaining manually controlled retractors in the position set by the surgeon with regard to surrounding tissue.
 - d. Managing all instruments in the operative field to prevent obstruction of the surgeon's view.
 - e. Anticipating retraction needs with knowledge of the surgeon's preferences and anatomical structures.
 - b. Intraoperative hemostasis - Provide hemostasis by:
 - a. Applying electrocautery tip to clamps or vessels in a safe and knowledgeable manner as directed by the surgeon.
 - b. Sponging and utilizing pressure as necessary.
 - c. Utilizing suctioning techniques.
 - d. Applying clamps on superficial vessels and the tying off, electrocoagulation of them as directed by the surgeon.
 - e. Placing suture ligatures in the muscle, subcutaneous, and skin layers.
 - f. Placing hemoclips on bleeders as directed by the surgeon.
 - c. Intraoperative tissue manipulation
 - d. Intraoperative wound closure:
 - i. Perform knot tying by:
 - a. Having knowledge of the basic techniques.
 - b. Tying knots firmly to avoid slipping.
 - c. Avoiding undue friction to prevent fraying of suture.
 - d. Carrying knot down to the tissue with the tip of the index finger and laying the strands flat.
 - e. Approximating tissue rather than pulling tightly to prevent tissue necrosis.
 - ii. Provide closure of layers by:
 - a. Correctly approximating the layers under the direction of the surgeon.
 - b. Demonstrating knowledge of different types of closure.



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Oceanside, California

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- c. Correctly approximating skin edges when utilizing skin staples.
- e. Assist the surgeon at the completion of the procedure by:
 - a. Affixing and stabilizing all drains.
 - b. Cleaning the wound and applying the dressing.
 - c. Assist with applying casts or plaster splints.
- f. The RNFA will assist the surgeon with setting up and removing the patient from cardiopulmonary bypass.
- 4. The RNFA practices under the direct supervision of the surgeon during the surgical intervention.
- 5. The RNFA must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nursing Practice Act of the State of California.

NOTE: The above specifications are general guidelines and do not reflect all duties in all specialty areas. Therefore, they should not preclude the performance of other duties, which, in the judgment of the surgeon, can be successfully accomplished by the RN First Assistant. However, the RN First Assistant must know his/her limitations and may refuse to perform those functions for which he/she has not been prepared or which he/she does not feel capable of performing.

B. Qualifications

- 1. Refer to the Medical Staff, "Allied Health Professionals" policy.
- 2. Sponsorship by a Department of Surgery medical staff member who is in good standing of the TCMC Medical Staff.

C. Scope of Practice

- 1. Refer to RNFA Standardized Procedures.

D. Skills

- 1. Refer to RNFA Standardized Procedures.

E. Supervision

- 1. The RNFA shall be supervised by his/her Medical Staff Sponsor.

F. Proctoring

- 1. The RNFA shall be proctored for a minimum of his/her first ten (10) cases using the "Skills Inventory Checklist".
- 2. The written evaluations (Skills Inventory Checklists) must be completed and returned to the Medical Staff Services Office within 30 days of the procedure.

MEDICAL STAFF

STANDARDIZED PROCEDURE: Registered Nurse First Assistant (RNFA)

I. POLICY:

- A. Function: To provide guidelines for the RNFA assisting a surgeon in the first or second assistant role.
- B. Circumstances:
 - 1. Setting: Open Operating Room at Tri-City Medical Center.
 - 2. Supervision: Requires the direct supervision of the primary surgeon.
 - 3. The RNFA must perform only as first assistant and not concurrently as the scrub nurse.
 - 4. Only in extreme emergencies should an RNFA be expected to assist on procedures that present an unusual hazard to life.
 - 5. The RNFA must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nurse Practice Act of the State of California.

II. PROCEDURE:

- A. The RNFA will assist the surgeon by providing intraoperative retraction giving exposure and optimum visualization of the surgical site without subsequent tissue/organ compromise as directed by the surgeon.
 - 1. Retracting tissues or organs by use of the hand.
 - 2. Placing or holding surgical retractors.
 - 3. Packing sponges into body cavities to hold tissues or organs out of the operative field.
 - 4. Managing all instruments in the operative field to prevent obstruction of the surgeons view.
- B. The RNFA will assist the surgeon by providing intraoperative hemostasis promoting adequate visual assessment and access to the surgical site as directed by the surgeon.
 - 1. Aspiration of blood and other fluids from the operative site.
 - 2. Sponging the wound or other area of dissection.
 - 3. Using hemostats or other surgical instruments to clamp bleeding tissue or vessels.
 - 4. Using suture to tie off clamped blood vessels or other bleeding tissue.
 - 5. Using electrocautery to cauterize tissue or surgical instruments clamped to tissue or blood vessels.
 - 6. Place hemoclips or ligating suture on vessels or tissue.
- C. The RNFA will use surgical instruments and surgical materials to manipulate tissue as directed by the surgeon.
 - 1. Expose and retract tissue.
 - 2. Clamp and sever tissue.
 - 3. Grasp and fixate tissue with screws or staples.
 - 4. Cauterize and approximate tissue.
- D. The RNFA will suture tissue to insure hemostasis and wound alignment by using suture material or instruments as directed by the surgeon.
 - 1. Correctly approximate tissue layers.
 - 2. Approximating tissue appropriately to avoid excess tension and tissue necrosis.
 - 3. Tying knots firmly to avoid slipping.
 - 4. Using suture, staples, clips or other devices to approximate tissue.
- E. Assist the surgeon at the completion of the procedure by:
 - 1. Affixing and stabilizing all drains.
 - 2. Cleaning the wound and applying the dressing.
 - 3. Assist with applying casts or plaster splints.
- F. In the event the operating surgeon, during surgery, becomes incapacitated or needs to leave the OR due to an emergency, the responsibility of the RNFA is to:
 - ~~G~~1. Assist the 1st Assistant Surgeon if one is present, in taking over the case.
 - ~~G~~2. Maintain hemostasis, according to the approved standardized procedure.
 - ~~H~~3. Keep the surgical site moistened, as necessary, according to the type of surgery.
 - ~~I~~4. Maintain the integrity of the sterile field.
 - ~~J~~5. Remain scrubbed in appropriate attire (gown, mask, gloves, cap).



Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

- a. Remain at the field while a replacement 1st Assistant is being located.
- b. The RN Circulator will initiate the procedure for obtaining a surgeon in an emergency.

III. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

- A. Current California RN license.
- B. Education: Nationally certified peri-operative nurse (CNOR) through the Association of Operating Room Nurses (AORN).
- C. Initial Evaluation: Successful completion of a structured and approved AORN RNFA course. Three (3) years operating experience. Proof of successful completion of a structured RNFA course and completion of 20 hours or 10 cases of proctoring by the sponsoring physician.
- D. Ongoing Evaluation: Approval from the surgical sub-specialty of the sponsoring physician.

IV. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

- A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
- B. Review: Every two (2) years.

V. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

- A. All healthcare providers who have successfully completed requirements as outlined above are authorized to direct and perform Registered Nurse First Assist Standardized Procedure.

MEDICAL STAFF

STANDARDIZED PROCEDURE: Cardiac Surgery Registered Nurse First Assistant (RNFA)

I. POLICY:

- A. Function: To provide guidelines for the RNFA in placing and removing a patient on and off cardiopulmonary bypass.
- B. Circumstances:
 - 1. Setting: Open Operating Room at Tri-City Medical Center.
 - 2. Supervision: Requires the direct supervision of the primary surgeon.
 - 3. The RNFA must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nurse Practice Act of the State of California.

II. PROCEDURE:

- A. Placement of patient on cardiopulmonary bypass
 - 1. The RNFA shall:
 - a. Provide retraction and suction during sternotomy and cannulation, and assist with pericardial retraction sutures.
 - b. Prepare pump circuit tubing, cardiotomy, and cardioplegia delivery system lines.
 - c. Apply and secure arterial and venous purse string tourniquets.
 - d. Alert surgeon in heparin dose administration has not been initiated.
 - e. Hold cannulae in place while surgeon tightens tourniquets.
 - f. Visually inspect arterial line for the presence of air, and alert the surgeon if observed.
 - 2. Proper placement and removal of is vital to ensure proper cardiopulmonary bypass.
- B. Removal of the patient from cardiopulmonary bypass
 - 1. The RNFA shall:
 - a. Cut suture securing arterial line to sterile field after heparin reversal.
 - b. Hold cannulae in place while surgeon loosens purse string tourniquets.
 - c. Tie arteriotomy suture while the surgeon remove cannulae.
 - d. Visually inspect cannulation sites for hemostasis.

III. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

- A. Current California RN license.
- B. Education: Nationally certified peri-operative nurse (CNOR) through the Association of Operating Room Nurses (AORN).
- C. Initial Evaluation: Successful completion of a structured and approved AORN RNFA course. Three (3) years operating experience. Proof of successful completion of a structured RNFA course and completion of 20 hours or 10 cases of proctoring by the sponsoring physician.
- D. Ongoing Evaluation: Approval from the surgical sub-specialty of the sponsoring physician.

IV. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

- A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
- B. Review: Every two (2) years.

V. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

- A. All healthcare providers who have successfully completed requirements as outlined above are authorized to direct and perform Cardiac Surgery Registered Nurse First Assist Standardized Procedure.

MEDICAL STAFF

STANDARDIZED PROCEDURE: Registered Nurse First Assistant (RNFA) - Surgical Assistant During Surgeon Incapacitation or Emergency Surgical Site Evacuation by Physician

I. POLICY:

- A. Function: To provide guidelines for the RNFA in providing surgical assistance in the event the surgeon becomes incapacitated or needs to leave for an emergency during surgery.
- B. Circumstances:
 - 1. Setting: Open Operating Room at Tri-City Medical Center.
 - 2. Supervision: None required.
 - 3. The RNFA must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nurse Practice Act of the State of California.

II. PROCEDURE:

- A. In the event the operating surgeon, during surgery, becomes incapacitated or needs to leave the OR due to an emergency, the RNFA shall:
 - 1. Maintain hemostasis according to the approved standardized procedure.
 - 2. Keep the surgical site moistened, as necessary, according to the type of surgery.
 - 3. Maintain the integrity of the sterile field.
 - 4. Remain scrubbed in appropriate attire (gown, mask, gloves, cap).
 - 5. Remain at the field while the RN circulator locates a replacement surgeon.

III. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

- A. Current California RN license.
- B. Education: Nationally certified peri-operative nurse (CNOR) through the Association of Operating Room Nurses (AORN).
- C. Initial Evaluation: Successful completion of a structured and approved AORN RNFA course. Three (3) years operating experience. Proof of successful completion of a structured RNFA course and completion of 20 hours or 10 cases of proctoring by the sponsoring physician.
- D. Ongoing Evaluation: Approval from the surgical sub-specialty of the sponsoring physician.

IV. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

- A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
- B. Review: Every two (2) years.

V. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

- A. All healthcare providers who have successfully completed requirements as outlined above are authorized to direct and perform Registered Nurse First Assist - Surgical Assistant During Surgeon Incapacitation or Emergency Surgical Site Evacuation Standardized Procedure.

MEDICAL STAFF

STANDARDIZED PROCEDURE: Registered Nurse First Assistant (RNFA) – Intraoperative Hemostasis

I. POLICY:

- A. Function: To provide guidelines for the RNFA in providing hemostasis of the surgical field to minimize blood loss during surgery.
- B. Circumstances:
 - 1. Setting: Open Operating Room at Tri-City Medical Center.
 - 2. Supervision: Requires the direct supervision of the primary surgeon.
 - 3. The RNFA must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nurse Practice Act of the State of California.
- C. Effective hemostasis is essential to carry out surgery in a time-efficient manner and to prevent excessive blood loss. Providing a dry operative field promotes adequate visual assessment and access to the surgical site.

II. PROCEDURE:

- A. The RNFA shall assist the surgeon by providing intraoperative hemostasis using the following measures:
 - 1. Aspiration of blood and other fluids from the operative site, as directed by the surgeon.
 - 2. Sponging the wound or other area of dissection, as directed by the surgeon.
 - 3. Using hemostasis or other surgical instruments to clamp bleeding tissue, as directed by the surgeon.
 - 4. Using sutures to tie off clamped blood vessels or other tissue, as directed by the surgeon.
 - 5. Using electrocautery or other surgical device to cauterize tissue, or surgical instruments clamped to tissue.
 - 6. Place hemoclip, or other ligating devices on vessels or tissue, as directed by the surgeon.

III. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

- A. Current California RN license.
- B. Education: Nationally certified peri-operative nurse (CNOR) through the Association of Operating Room Nurses (AORN).
- C. Initial Evaluation: Successful completion of a structured and approved AORN RNFA course. Three (3) years operating experience. Proof of successful completion of a structured RNFA course and completion of 20 hours or 10 cases of proctoring by the sponsoring physician.
- D. Ongoing Evaluation: Approval from the surgical sub-specialty of the sponsoring physician.

IV. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

- A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
- B. Review: Every two (2) years.

V. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

- A. All healthcare providers who have successfully completed requirements as outlined above are authorized to direct and perform Registered Nurse First Assist – Intraoperative Hemostasis Standardized Procedure.

MEDICAL STAFF

STANDARDIZED PROCEDURE: Registered Nurse First Assistant (RNFA) – Intraoperative Retracting

I. POLICY:

- A. Function: To provide guidelines for the RNFA in providing retraction of the surgical field to allow adequate surgical exposure without subsequent tissue/organ compromise.
- B. Circumstances:
 - 1. Setting: Open Operating Room at Tri-City Medical Center.
 - 2. Supervision: Requires the direct supervision of the primary surgeon.
 - 3. The RNFA must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nurse Practice Act of the State of California.
- C. Selection and placement of and appropriate retraction instrument will assist the surgeon by providing exposure and optimum visualization of the surgical site.

II. PROCEDURE:

- A. The RNFA shall assist the surgeon by providing intraoperative retraction using the following measures:
 - 1. Retracting tissues or organs by the use of the hand.
 - 2. Placing and holding surgical retractors.
 - 3. Packing sponges or laparotomy pads into body cavities to hold tissues and organs out of the operative field.
 - 4. Managing all instruments in the operative field to prevent obstruction of the surgeon's view.

III. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

- A. Current California RN license.
- B. Education: Nationally certified peri-operative nurse (CNOR) through the Association of Operating Room Nurses (AORN).
- C. Initial Evaluation: Successful completion of a structured and approved AORN RNFA course. Three (3) years operating experience. Proof of successful completion of a structured RNFA course and completion of 20 hours or 10 cases of proctoring by the sponsoring physician.
- D. Ongoing Evaluation: Approval from the surgical sub-specialty of the sponsoring physician.

IV. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

- A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
- B. Review: Every two (2) years.

V. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

- A. All healthcare providers who have successfully completed requirements as outlined above are authorized to direct and perform Registered Nurse First Assist – Intraoperative Retraction Standardized Procedure.

MEDICAL STAFF

STANDARDIZED PROCEDURE: Registered Nurse First Assistant (RNFA) – Intraoperative Wound Closure

I. POLICY:

- A. Function: To provide guidelines for the RNFA in providing proper suturing of tissue during a surgical procedure, so that tissue heals without complications from the suturing process.
- B. Circumstances:
 - 1. Setting: Open Operating Room at Tri-City Medical Center.
 - 2. Supervision: Requires the direct supervision of the primary surgeon.
 - 3. The RNFA must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nurse Practice Act of the State of California.
- C. Proper suturing is vital to ensure hemostasis, wound alignment, and tissue healing.

II. PROCEDURE:

- A. The RNFA shall suture tissue using instruments and suture material as directed by the surgeon by:
 - 1. Correctly approximating tissue layers.
 - 2. Approximating tissue appropriately to avoid excess tension and tissue necrosis.
 - 3. Tying knots firmly to avoid slipping.
 - 4. Using staples, clips, or other devices to approximate tissue.

III. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

- A. Current California RN license.
- B. Education: Nationally certified peri-operative nurse (CNOR) through the Association of Operating Room Nurses (AORN).
- C. Initial Evaluation: Successful completion of a structured and approved AORN RNFA course. Three (3) years operating experience. Proof of successful completion of a structured RNFA course and completion of 20 hours or 10 cases of proctoring by the sponsoring physician.
- D. Ongoing Evaluation: Approval from the surgical sub-specialty of the sponsoring physician.

IV. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

- A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
- B. Review: Every two (2) years.

V. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

- A. All healthcare providers who have successfully completed requirements as outlined above are authorized to direct and perform Registered Nurse First Assist – Intraoperative Wound Closure Standardized Procedure.

CARDIAC REHABILITATION SERVICES

ISSUE DATE: 10/93

SUBJECT: Disaster Plan

REVISION DATE: 6/97, 8/97, 10/00, 11/07, 12/12, 2/20

Cardiac Rehabilitation Approval:	10/20
Division of Cardiology Approval:	n/a
Administrative Approval:	03/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. PURPOSE:

1. To ensure efficient Cardiac Wellness Center Services and to maintain adequate availability of personnel in the event of disaster, to establish, supervise, and maintain safety of the patients we serve.

B. INTRODUCTION:

1. Due to the varying types and magnitudes of emergency events, Tri-City Medical Center has adopted the command structure of Hospital Emergency-Incident Command Systems (HEICS). Once the decision has been made to activate the disaster plan, the HEICS becomes the standard operating procedure. The complete plan is located on the TCMC intranet.

C. NOTIFICATION:

1. The Cardiac Wellness Center shall be notified of the Disaster Plan Activation from the PBX operator announcing "CODE ORANGE" or "CODE YELLOW" using the overhead page.
2. Charge Responsibilities
 - a. Read the Unit Leader Responsibilities found in the Department Disaster packet (This is kept in the Safety and Disaster grey plastic container found under the nurses' station desk). Charge duty shall transfer to the Manager/Director after one arrives.
 - b. Complete and send one employee with the Personnel Inventory Form to the Incident Command Center.
 - i. Personnel Inventory Forms are found on the TCMC intranet. The Incident Command Center is located in the French Rooms. In the Incident Command Center is not set up, contact the Emergency Department.
 - c. Recall staff from breaks for standby to report to disaster priority areas.
 - i. Staff shall return immediately if they hear the overhead page activating the disaster plan.
 - d. Contact Manager/Director and begin call-in procedure. Relay as much information as you can to the Incident Command Center.
 - e. Upon direction of Incident Commander or Department Director, begin call-in procedure.
 - f. Every hour, or more frequently as directed, send status reports to Incident Command Center.

D. STAFF RN RESPONSIBILITIES:

1. Assist in evacuating patients from the Cardiac Wellness Center to their private vehicles, ensuring safety of patients at all times. Patients shall be sent to their homes via private transportation.
2. Facilitate flow of patients out of unit.
3. Facilitate the call-in procedure.
4. Man the telephones for incoming requests
5. Assists in preparing Cardiac Wellness Center for use by other department's personnel as necessary.

E. **EVACUATION OF UNIT:**

1. The decision to evacuate the Cardiac Wellness Center rests with the Incident Commander after an evaluation by Facilities Management.
2. Complete Evacuation:
 - a. All patients shall be evacuated to their private homes unless situation prohibits them from leaving hospital premises.
 - b. Patients shall be assisted to their private vehicles via ambulation; wheelchair assistance or other appropriate “carries” as necessary.
3. All staff shall report to Command Center to assist hospital in appropriate capacity.

**EMERGENCY OPERATIONS PROCEDURE MANUAL
GENERAL INFORMATION**

ISSUE DATE: 02/09

SUBJECT: Evacuation Plan

REVIEW DATE: 03/10

POLICY NUMBER: 4004

REVISION DATE: 03/19

Department Approval:	44/4811/21
Environmental Health & Safety Committee Approval:	42/4803/22
Medical Executive Committee Approval:	n/a
Administration Approval:	03/4903/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/19

A. INTRODUCTION:

1. The Evacuation Plan describes the process followed by the Tri-City Hospital District (TCHD) staff in response to an emergency requiring the evacuation of patients, visitors, and the workforce and their return to the facility after the emergency is resolved.
2. An evacuation in response to an emergency, from initiation to recovery, will be under the instructions of the Incident Commander (IC) see the Emergency Operations Plan.
3. Patient relocation and evacuation is inherently dangerous to patients and staff, and is to be undertaken only when conditions of the environment cannot support care, treatment, and services.
4. All emergencies do not require evacuating, therefore during emergencies, Tri City Hospital District (TCHD) will evaluate the need to remain on the hospital campus (shelter in place {SIP}) or evacuate.
5. In situations where air quality is a primary concern TCHD will assess the ventilation systems and determine the need to implement the mitigation actions to maintain air quality:
 - a. Shut down (turn off) the ventilation system and use High Efficiency Particulate Air (HEPA) units.

B. TYPES AND LEVELS OF EVACUATIONS:

1. Horizontal Evacuation or Relocation
 - a. The actions taken to move patients from the immediate area of the emergency to an area of safety or an adjacent smoke compartment may generally on the same floor.
 - b. Under the direction of the IC/designee, department leaders in an area may implement relocation.
2. Vertical Evacuation
 - a. The actions taken to move patients from one floor to another floor for safety.
3. Building Evacuation
 - a. This involves removal of all persons from a hospital building and requires a plan for its implementation.
 - b. Evacuation should only be performed under the direction of the IC and/or the Fire Department. This would encompass moving all patients, visitors and the workforce to an alternate care site.
4. Levels of Evacuations
 - a. Level 1
 - i. The evacuation of a specific floor or wing to a designated location. This may include both horizontally or vertically for the preservation of the

- patients and workforce members. Horizontal evacuation will be to the area designated by the authority having jurisdiction, e.g., the IC.
- b. Level 2
 - i. The evacuation of an entire building or section of a building to an alternate care site.
 - c. Level 3
 - i. The evacuation of the entire main Tri-City Medical Center (TCMC) buildings or campus to alternate care site(s) or locations.
5. Initiation of Evacuation
- a. The IC is administratively responsible for initiating the Evacuation Plan. Department leaders determine the appropriate procedures required to minimize the impact of the evacuation on their department and will communicate this information to the Hospital Command Center (HCC). To facilitate the orderly initiation of the response to an emergency requiring the evacuation of TCHD buildings and/or locations the following steps will be initiated.
 - i. Information received by the TCHD concerning the evacuation of any portion of the facilities or locations within the district will be communicated directly to the IC. The incidents include but are not limited to the following:
 - 1) External emergency facing the community, or
 - 2) Internal emergency involving the functions of the hospital, or
 - 3) The treatment and care of patients are no longer sustainable at the hospital
 - b. The IC or designee and the IC team will evaluate the information concerning the emergency and determine if initiation of the Evacuation Plan is applicable.
 - c. The information evaluated includes issues such as location of incident (internal or external) requiring an evacuation, the distance from TCMC if an external event, the scope of the incident (single individual, mass casualty, or malicious attack), and weather conditions (seasonal and current).
 - d. If deemed necessary, the IC will initiate the Evacuation Plan, as part of the Emergency Operation Plan along with additional and the appropriate Emergency Response actions that may apply.
6. Implementation and Notification
- a. Upon initiation of the Evacuation Plan, in conjunction with the Emergency Operations Plan, the IC will open the Hospital Command Center (HCC), if not already established.
 - i. The ICC staff report to the HCC, if not already available.
 - ii. Hospital Chiefs or designees shall report to their designated meeting place to receive further instructions.
 - iii. The IC or Liaison Officer, will initiate communication with local emergency response groups as required.
 - iv. Security Leadership will deploy the security staff to the appropriate location as designated in preparation for securing the facility lockdown, if required.
 - v. The Public Information Officer will communicate to the local media as directed by the IC information related to the evacuation.
7. Notification of Staff
- a. During an evacuation, the IC will notify the TCMC Private Branch Exchange (PBX) operator to alert the workforce of the emergency involving an evacuation by announcing a Disaster Code (Code Orange).
 - b. Department leaders will also notify their staff by initiating their department call back list. The methods used to notify the workforce include personal communication devices, such as cellular telephones, text, two-way radios, or land line telephones, social media. Social media on TCMC sites.
8. Routes, Exits, and Congregation Areas
- a. The list of evacuation routes and exits are listed for each building or area and

- b. posted in each department and throughout the hospital.
- b. Once outside, there are several Congregation Areas that can be used based on the emergency requiring the evacuation. (Attachment I- Routes and Exits)

C. SECURING THE FACILITY:

1. **Labor Pool**
 - a. When a disaster code, (Code Orange) is announced, workforce personnel shall report to their respective departments.
 - b. Workforce members not required for their department shall remain in their department until instructions received from the ICC.
 - c. Once notified of need of labor, workforce member reporting to the Labor Pool will sign in and wait for further instructions.
 - d. Workforce members will be assigned to a Department Leader at a designated location
2. **Media Center**
 - a. The Media Center will be located in Assembly Rooms or Classroom identified by the External Affairs Officer (EAO)
 - b. The EAO will be responsible for setting up the room and conducting the distribution of information to the media.
3. **Perimeter around Staging Congregation Areas**
 - a. With cooperative arrangement with the local law enforcement agencies, the TCHD Security Department will establish the perimeters around the Congregation Areas.

D. EVACUATION RESOURCES FOR TRANSPORTING PATIENTS:

1. **Resources and Equipment for Evacuating Patients**
 - a. If there is a need to relocate patients and normal routes can be used, equipment for normal operations will be used for patient transportation. This also includes the usage of elevators and stairs.
 - b. The following are examples of resources that may be used when evacuating patients.
 - i. **Wheelchairs**
 - 1) Used to transport ambulatory and minimally ambulatory patients (patients requiring assistance with ambulation.
 - ii. **Gurneys**
 - 1) Used to transport patients requiring care that prohibits ambulation and non-ambulatory patients.
 - iii. **Beds**
 - 1) Beds may be used to transport patient patients during an evacuation
 - iv. **Special Transportation Equipment:**
 - 1) Some specialized transport equipment, such as stair stretchers, Evacused ® similar equipment is available for specific kinds of patients, and these may be utilized during relocations.
 - v. **Improvised Equipment:**
 - 1) Improvised equipment is only to be used when wheelchairs, gurneys, beds and/or specialized transportation equipment is not available.
 - a) Blanket drags, multi-person carries, utilization of equipment not necessarily used for transportation are not expected to be used in relocation of patients from one zone to another but may be dependent on the situation.
 - b) Lift equipment such as the Stand Aid may be used when wheelchairs, gurneys, beds and/or specialized transportation equipment is not available.
2. **Special Equipment Requirements**
 - a. An assessment of each patient should be conducted to determine the medical and

- transport equipment to continue the care of the patient during the evacuation and at the alternate care or receiving site.
 - b. The equipment will be provided to the patient by the staff prior to removing the patient from the patient care area.
- 3. **Additional Resources for Evacuation (Non-Patient)**
 - a. During the evacuation, equipment will be needed to assist in the removal of patients. This will include flashlight, spotlights and electrical cords, water stations, personnel protective equipment, life-saving equipment and other non-patient related equipment.
- 4. **Assessment of Evacuation Equipment**
 - a. The assessment of and training arrangement of evacuation equipment will be reviewed annually by the Environmental Health and Safety Committee.
- 5. **Communication Resources**
 - a. The communication equipment used while in disaster status will be utilized during an evacuation.
- 6. Resources requested and used during the evacuation will be documented on the Resource Accounting Record.

E. CONTINUITY OF CARE RESOURCES:

- 1. **Medical Equipment for Evacuation of Patients**
 - a. An assessment of the patient needs for continuity of care during evacuation will be conducted by each patient care department leadership team in conjunction with the primary licensed healthcare personnel (HCP) prior to evacuating patients.
- 2. **Equipment and Procedures for Maintaining Patient Isolation**
 - a. The procedure for evacuating isolation patients will also be overseen by an Infection Prevention (IP) professional.

F. PATIENT EVACUATION PROCEDURE:

- 1. **Evacuation Procedure**
 - a. Activation of the Evacuation Plan (via the Emergency Operations Plan) will alert the workforce, law enforcement, Fire Department, Emergency Management System, other emergency agencies and receiving sites.
 - b. Move all patients within TCMC through horizontal exits, if practical (relocation). Where necessary, move patients into stairwells and hold until evacuation can take place. Do not leave patients unattended at any time.
 - c. If patients cannot be moved via elevators within adjacent buildings, move the patients vertically using the secure and safe stairwells.
 - i. Transport non-ambulatory patients via special stair stretchers, etc
 - 1) Do not transport patients in a stairwell on stretchers or gurneys.
 - ii. When no other method is available, use a two-person or three-person carry to transport patients via stairs.
 - d. Patients should be moved in the same order as for relocation (see General Priorities for Patient Relocation and Evacuation from the Hospital).
 - e. Ambulatory patients should be moved to the Med/Surg floor on the Pavilion for assist with relocating outside of the facility.
 - f. Non-ambulatory patients should be moved near the Emergency Department (ED) for transportation via ambulance and van.
 - g. Transport all patients with their paper medical record. Print and place the following in their medical record, face sheet, history and physical, medication record, result of the most current diagnostics, and the most current progress notes. Additional items include but are not limited to medical equipment such as infusion pumps, oxygen require for sustainability.
- 2. **General Priorities for Patient Relocation and Evacuation from the Hospital**
 - a. Ambulatory patients

- i. Relocate one-on-one or in small groups by the department / unit workforce members to the appropriate area.
 - b. Non-ambulatory patients, without attached equipment,
 - i. Relocate on wheelchairs or gurneys, if practical, and on ordinary chairs or using blanket drags, or lift equipment, if necessary. The patients will be moved to the adjacent zones or areas of refuge, or as directed by department leaders.
 - c. Critical patients and those with monitoring and/or multiple IVs, requiring continuous cardiac monitoring, active surgical patients, etc.,
 - i. Relocate last when the maximum numbers of workforce members are available and sufficient transport equipment is available.
 - ii. Note: it may be necessary to move the patients to areas beyond the nearest area of refuge, to ensure appropriate medical services are maintained.
3. Evacuation of Patient in Departments
 - a. Each department leaders will ensure their workforce members are provided education on the department evacuation routes.
 - b. All departments will follow the evacuation procedures outlined in this evacuation plan. Exceptions: Departments that have developed department-based evacuation and/or disaster plans.
 - c. All department-based disaster and/or evacuation plans will be submitted to the EHSC for annual review and posted on the hospital intranet.
4. Patient Care Units
 - a. Each department leaders will ensure their workforce members are provided education on their department evacuation routes.
 - b. All patient care units will follow the evacuation procedures outlined in this evacuation plan.
 - c. The Clinical Nurse Leader in charge will assume control in an emergency and perform the following:
 - i. Ensure all patient rooms are empty, and doors are closed, and will check all automatic doors to ensure they have closed fully.
 - ii. If relocation is required, identify a designate workforce member to ensure:
 - 1) All patients are identified per policy
 - 2) Relocated or evacuated patients' medical records accompany them e.g., Move patient records with the patients if possible.
 - d. Fire or Smoke Evacuation
 - i. If fire or smoke is in a patient's room and is the cause of the evacuation, move the patients immediately. Report the fire or smoke per policy.
 - ii. After all room doors are closed, patients are to be re-assured, giving special attention to the critically ill and apprehensive patients.
 - iii. Relocate patients in immediate danger to a safe area in an adjacent zone on the same floor.
 - e. Oxygen Dependent
 - i. Patients on oxygen may require special attention. Nursing shall assess patients' need for continuous use of oxygen. Consider moving patients with oxygen measurements within normal limits without oxygen if there will be no change in the patient's status.
 - ii. High flow patients / oxygen-dependent patients must be evacuated with temporary oxygen portable cylinders. Oxygen should not be turned off at oxygen zone valves in an area until Nursing and Respiratory workforce members until all workforce members agree all patients are accounted for and are no longer connected to the piped oxygen system.
5. Resources for patients requiring oxygen
 - a. Nurse will assess all patients requiring oxygen and contact Pulmonary for instructions for managing patients.

G. TRACKING OF PATIENTS

1. **Tracking Patients During and After Evacuation**
 - a. The procedures located in the Emergency Operations Plan for tracking patients will continue in the same form and method as if in the hospital.
 - b. A Master Evacuation Tracking Form (HICS 255) will be maintained at all the exit points of the hospital where patients are being transported away from the facility. Each of the forms will be given to the HCC once they are completed.
 - c. The Alternate Care Site Plan will be initiated once the patients are in route to their location.
2. **Hospital Casualty and Mass Casualty Management**
 - a. TCHD will follow Mass-Casualty Incident (MCI) Operations (ANNEX D Plan in the event of mass fatalities during an emergency. ANNEX D “is intended to assist and direct” when any incident occurs that could “strain or overwhelm the workforce response to patients during an emergency e.g., disaster.
 - b. Review the Emergency Department Base Hospital
3. **Fatality Management**
 - a. The workforce will follow TCMC’s policy when there are more fatalities than the hospital morgue capacity can handle. This plan will be coordinated in conjunction with the San Diego County Medical Examiner’s office mass fatality plan.
 - b. In the event of mass-fatalities, notify TCHD IC structure. TCHD casualty incident the IC HISC outlined in the TCHD Emergency Operations Plan. As described in the HICS protocols the Mass Fatality plan requires the assignment of mass fatality branch director, a morgue division leader. Additional job action sheets will be utilized for the positions that are created to manage morgue operations under the operations section of the HICS protocol.
 - c. To ensure humane treatment of the deceased bodies the medical center has written memos of understanding with refrigerator truck vendors to secure bodies until San Diego Medical Examiner is able to transport bodies off site county morgue facilities.
 - d. References – Annex D Mass-Casualty Incident (MCI) Operations
4. **External Communications**
 - a. The medical center will coordinate with local Emergency Medical Services (EMS) agencies via the county of San Diego County Medical Operations Center (MOC). The hospital will notify the MOC via the Web/EOC and other communication means via the county medical alert systems, 800 Mhz and the California Hospital Alert Network (CAHAN).
5. **Confirmation of Room Evacuation**
 - a. **Verification of Room Evacuation**
 - i. The department leader /designee will conduct verification of evacuation from every room, offices and general spaces will verified to be empty of patients, visitors or workforce members. Evacuated patient rooms, offices, and general spaces will be identified by a large X written on the closed-door doorframe.
 - b. **Communication with Local Authorities**
 - i. The department leader / designee will notify the ICC that all patients, visitors, and workforce members are evacuated from their area. The IC / designee will notify the local law enforcement or fire department that the areas have been evacuated.
 - c. **Accounting for the Workforce and Visitors**
 - i. The department leader / designee is responsible for verifying that all workforce, visitors, and non-employees are evacuated from their areas. These individuals will proceed to the designated evacuation route and congregation area.
6. **Testing the Verification of Room Evacuation**

- a. The room verification plan will be tested during some emergency preparedness exercises and fire drills. The critique of the plan will be included in the drill report form and reviewed for improvements. The exercise will include verification of simulated evacuation.
7. Evacuation Training Activities
 - a. See the Emergency Operations Plan for additional details. The training of staff on the evacuation procedures will be provided during orientation and annual.
 - a.b. Evacuation Drills, if conducted, will include the simulation of evacuated patients, tracking, forms, methods of evacuating with use of resources, verification of evacuation, alternate care site establishment and recovery.

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

- 2-1. Emergency Operations Procedure Manual: Emergency Operation Plan

I. **EXTERNAL LINK(S):**

1. Annex D Mass Casualty Incident, retrieved March 17, 2022
https://www.sandiegocounty.gov/content/dam/sdc/oes/emergency_management/plans/op-area-plan/2018/2018-Annex-D-Mass-Casualty-Incident-Operations.pdf

J. **REFERENCE(S):**

1. Hospital Incident Command System – Current Guidebook and Appendices (HICS), <https://emsa.ca.gov/disaster-medical-services-division-hospital-incident-command-system/>, retrieved March 17, 2022
2. Annex D Mass Casualty Incident, retrieved March 17, 2022
https://www.sandiegocounty.gov/content/dam/sdc/oes/emergency_management/plans/op-area-plan/2018/2018-Annex-D-Mass-Casualty-Incident-Operations.pdf

Form #	Form Title
<u>200</u>	<u>Incident Action Plan (IAP) Cover Sheet</u>
<u>IAP Quick Start</u>	<u>Incident Action Plan (IAP) Quick Start</u>
<u>201</u>	<u>Incident Briefing</u>
<u>202</u>	<u>Incident Objectives</u>
<u>203</u>	<u>Organization Assignment List</u>
<u>204</u>	<u>Assignment List</u>
<u>205A</u>	<u>Communications List</u>
<u>206</u>	<u>Staff Medical Plan</u>
<u>207</u>	<u>Hospital Incident Management Team (HIMT) Chart</u>
<u>213</u>	<u>General Message Form</u>
<u>214</u>	<u>Activity Log</u>
<u>215A</u>	<u>Incident Action Plan (IAP) Safety Analysis</u>
<u>221</u>	<u>Demobilization Check-Out</u>
<u>251</u>	<u>Facility System Status Report</u>
<u>252</u>	<u>Section Personnel Timesheet</u>
<u>253</u>	<u>Volunteer Registration</u>
<u>254</u>	<u>Disaster Victim/Patient Tracking</u>
<u>255</u>	<u>Master Patient Evacuation Tracking</u>
<u>256</u>	<u>Procurement Summary Report</u>
<u>257</u>	<u>Resource Accounting Record</u>
<u>258</u>	<u>Hospital Resource Directory</u>
<u>259</u>	<u>Hospital Casualty/Fatality Report</u>
<u>260</u>	<u>Patient Evacuation Tracking</u>

Oceanside CA Emergency Evacuation Plan 2/2009

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Introduction

Patient relocation and evacuation is inherently dangerous to patients and staff, and is to be undertaken only when conditions of the environment cannot support care, treatment, and services. During emergencies, Tri City Medical Center Incident Command Center needs to evaluate options SIP (Shelter In Place) or Evacuation. Depending on the situation, SIP could be a viable option, not all emergencies dictate evacuation. In situations where Air Quality is primary concern Tri City Medical Center will look at the possibility that ventilation systems be shut down and HEPPA units set up to help mitigate the Air Quality issue.

ACTIVATION EVACUATION PLAN

Introduction

Patient relocation and evacuation is inherently dangerous to patients and staff, and is to be undertaken only when conditions of the environment cannot support care, treatment, and services. During emergencies, patients could be relocated to adjacent compartments or areas of safety. If determined by the Incident Commander,

patients could be evacuated from the building to an adjacent building or moved to an alternate care site(s) (Appendix II) for patient care and safety.

The Evacuation Plan describes the overall procedures followed by the Tri City Medical Center staff in response to an emergency requiring the evacuation of patients, staff, and visitors, and their return to the facility after the emergency is resolved. The evacuation in response to an emergency, from initiation to recovery, utilizes the Tri City Medical Center Emergency Operations Plan.

Types and Levels of Evacuations

Horizontal Evacuation or Relocation

The actions taken to move patients from the immediate area of the emergency to an area of safety or an adjacent smoke compartment may generally on the same floor. Staff in the area may implement relocation, if conditions are severe enough.

Vertical Evacuation

The actions taken to move patients from one floor to another floor for safety. The Incident Commander or designee should only determine this type of relocation.

Building Evacuation

This involves removal of all persons from a hospital building and requires a plan for its implementation. Evacuation should only be performed under the direction of the Incident Commander and/or the Fire Department. This would encompass moving all patients to an alternate care site.

Levels of Evacuations

Level 1

The evacuation of a specific floor or wing to a designated location. This can include both horizontally or vertically for the preservation of the patients and staff. Horizontal evacuation will be to the area designated by the authority having jurisdiction, such as the Incident Commander.

Level 2

The evacuation of an entire building or section of a building to an alternate care site.

Level 3

The evacuation of the entire Tri City Medical Center buildings or campus to other alternate care site(s) or locations.

Initiation of Evacuation

The Incident Commander is administratively responsible for the Evacuation Plan, which is an Emergency Response Plan Appendix to the Emergency Operations Plan. The respective Department Heads will determine the appropriate procedures required to minimize the impact of the evacuation on their department and will communicate this information to the Hospital Command Center (HCC).

To facilitate the orderly initiation of the response to an emergency requiring an evacuation, the following steps will be initiated:

1. Information received by the Tri City Medical Center concerning an external emergency facing the community, or an internal emergency involving the function of the hospital, or the treatment and care

~~of patients are no longer sustainable by the facility that requires the evacuation of any portion of Tri City Medical Center. The information will be passed directly to the Incident Commander.~~

- ~~2. This designated individual or group will evaluate the information concerning this emergency and determine if initiation of the Evacuation Plan is applicable.~~
- ~~3. The information evaluated includes issues such as location of incident (internal or external) requiring an evacuation, the distance from the Tri City Medical Center if an external event, the scope of the incident (single individual, mass casualty, or malicious attack), and weather conditions (seasonal and current).~~
- ~~4. If deemed necessary, the Incident Commander will initiate the Evacuation Plan, as part of the Emergency Operation Plan along with additional and the appropriate Emergency Response Plans that may apply.~~

Implementation and Notification

~~Upon initiation of the Evacuation Plan, in conjunction with the Emergency Operations Plan, the Incident Commander will open the Hospital Command Center (HCC) for directing the evacuation for the Tri City Medical Center, if not already established.~~

- ~~1. The Incident Command Center staff report to the HCC, if not already available.~~
- ~~2. Section Chiefs for Operations, Planning, Finance, and Logistics will report to their designated meeting place to receive further instructions.~~
- ~~3. The Incident Commander, or Liaison Officer, initiates communication with local emergency response groups as needed.~~
- ~~4. The Director of Security deploys the Tri City Medical Center security staff to the appropriate location as designated in preparation for securing the facility lockdown if necessary.~~
- ~~5. The Public Information Officer communicates to local media the needed information concerning the evacuation.~~

Notification of Staff

~~During an evacuation, the Incident Commander will notify the Tri City Medical Center telecommunications operator to alert the staff of the emergency involving an evacuation by announcing a code.~~

~~The staff is also notified through alternate announcements including Intranet messages and personal communication devices, such as pagers, two-way radios, or cell phones, as well as call lists.~~

Routes, Exits, and Congregation Areas

~~The list of evacuation routes and exits are listed for each building or area. Once outside, there are several Congregation Areas that can be used based on the emergency requiring the evacuation. (Attachment I Routes and Exits)~~

~~SECURING THE FACILITY~~

~~Labor Pool & Media Center Location~~

~~Labor Pool~~

- ~~1. When a disaster code, *Code-ORANGE* is announced by the alarm system or telephone, appropriate personnel in the departments will report to their respective departments.~~
- ~~2. If the staff member is not needed in the department, they will wait for direction from the Labor Pool Leader before responding to the Labor Pool. The location of the Labor Pool has been established at Assembly Rooms 1, 2 or 3.~~
- ~~3. Once notified of need of labor, each staff member reporting to the Labor Pool will sign in and stand by for further instructions.~~
- ~~4. Staff member will be assigned to a Department Leader at a designated location.~~

~~Media Center~~

- ~~1. The Media Center will be located in Assembly Rooms.~~
- ~~2. The Public Information Officer will be responsible for setting up the room and conducting the distribution of information to the media.~~

~~Perimeter around Staging Congregation Areas~~

~~With cooperative arrangement with the local law enforcement agencies, the Tri City Medical Center Security Department will establish the perimeters around the Congregation Areas listed Attachment II Staging Areas.~~

~~EVACUATION RESOURCES~~

Resources and Equipment for Evacuation of Patients

If there is a need to relocate patients and normal routes can be used, they are generally moved on the normal equipment used for patient transportation. This would also pertain to usage of elevators if the situation warrants. The following are some of the resources that can be used in types of evacuation.

Wheelchairs: Used to move ambulatory and minimally ambulatory patients, and some non-ambulatory patients. These are used for normal transportation and staff are trained and practiced in their use.

Gurneys and Beds: Used to move non-ambulatory patients. These are used for normal transportation and staff are trained and practiced in their use.

Special Transportation Equipment: Some specialized transport equipment may be available for specific kinds of patients, and these may be utilized during relocations. Where necessary, staff is trained about the specific practices needed for their use. Other special equipment, such as stair stretchers, EvacuSled® similar equipment, which is obtained for specific situations and circumstances, must include training for the staff that may be expected to use that equipment.

Improvised Equipment: Improvised equipment is only to be used when equipment that is more normal is not available. In general, beds are not used to move patients, but in special circumstances, such as special care units, it may be less hazardous to the patient to move the entire bed. When this is the case, enough staff must be used to control the equipment so as not to be jammed or block doorways and (as necessary) to control the beds on ramps. Blanket drags, multi-person carries, utilization of equipment not necessarily used for transportation are not expected to be used in relocation of patients from one zone to another but may be dependent on the situation. They might be necessary in special circumstances only.

Special Equipment Requirements

Suggested equipment needed to evacuate the patients from Tri City Medical Center is listed Attachment III. An assessment of each patient should be conducted to determine the medical and transport equipment to continue the care of the patient during the evacuation and at the alternate care or receiving site. The equipment will be provided to the patient by the staff prior to removal from their patient room.

Additional Resources for Evacuation (non-patient)

During the evacuation, equipment will be needed to assist in the removal of patients. This will include flashlight, spotlights and electrical cords, water stations, personnel protective equipment and other non-patient related equipment. (Attachment IV-Additional Equipment)

Procedures for using Evacuation Equipment

The staff will be trained in each department on the procedures for using the equipment on their patients during and evacuation. The procedures will be located in the departmental manual under Evacuation

Assessment of Evacuation Equipment

The Emergency Management Committee will review the use of evacuation equipment periodically. Drills will evaluate the appropriateness of the equipment and address the need for additional or different equipment.

Communication Resources

The communication equipment used while in disaster status will be utilized during an evacuation. The Emergency Operations Plan has the information on the communication equipment systems used during disaster status.

~~CONTINUITY OF CARE RESOURCES~~

~~Medical Equipment for Evacuation of Patients~~

An assessment of the patient needs for continuity of care during evacuation will be conducted on each patient prior to removal from the floor. A list of sample equipment for various patient types is in Attachment V.

~~Equipment and Procedures for Maintaining Patient Isolation~~

The Patient Medical Equipment (Attachment IV) also provides a list of equipment needed for the evacuation of patients under Protective Environment (PE) and Airborne Infectious Isolation (AII) isolation precautions. The procedure for evacuating isolation patients will also be overseen by an Infection Control Professional.

~~PATIENT EVACUATION PROCEDURES~~

~~Evacuation Procedures~~

Activation of the Evacuation Plan (via the Emergency Operations Plan) will alert the Tri City Medical Center staff, local law enforcement, Fire Department, EMS, other emergency agencies, and receiving sites.

- ~~1. Move all patients to Tri City Medical Center through horizontal exits, if practical (relocation). Where necessary, move patients into stairwells and hold until evacuation can take place. Never leave patients unattended at any time.~~
- ~~2. If patients cannot be moved via elevators within adjacent buildings, move them vertically using the secure and safe stairwells. Patients that cannot walk should be transported on special stretchers (Stair stretchers, etc). NEVER move patients in a stairwell on stretchers or gurneys. Where no other method is available, use a two person or three person carry.~~
- ~~3. Patients should be moved in the same order as for relocation (i.e., ambulatory, non-ambulatory, then surgical or special patients).~~

4. Ambulatory patients should be moved to the Med/Surg floor in the Pavillion for moving them out of the building. Non-ambulatory patients should be moved to the Education Center near the Emergency Department for transportation via ambulance and van.
5. Move patients with their medical records, medications and necessary medical equipment for sustainability.

General Priorities for Patient Relocation and Evacuation from the Hospital

- A. Ambulatory patients will be moved, one on one or in small groups by the staff to the appropriate area.
- B. Non-ambulatory patients, without attachments, will be moved next on wheelchairs or gurneys, if practical, and on ordinary chairs or using blanket drags, or multi-staff lifts if necessary. They will be moved to the adjacent zones or areas of refuge, and situated in rooms.
- C. Critical patients and those with monitoring and/or multiple IVs, active surgical patients, etc, will be moved last when the maximum numbers of staff are available, and when gurneys, wheelchairs, or similar equipment is most likely to be available. It may be necessary to move them to areas beyond the nearest area of refuge, to ensure they have the appropriate medical services warranted by their condition.

Evacuation of Patient in Departments

Each department has a unit specific Evacuation Plan. In most cases, this is a brief listing of the evacuation elements, relocation destinations (primary and backup) and other key data. Some department plans have more extensive details of how patients will be handled during an emergency, or response to special hazards contained in their areas. These are found in the individual department manuals along with this Evacuation Plan.

Patient Care Units

The nurse in charge will assume control in an emergency. This nurse will ensure that all patient rooms are empty, and doors are closed, and will check all automatic doors to ensure they have closed fully. If relocation is needed, they will designate someone to take the patients' records with them to ensure patient identification and care if patients need to be moved to another area. Move patient records with the patients if possible.

If fire or smoke in a patient's room is the cause of the evacuation, those patients are to be moved immediately. The fire should be reported as quickly as practical by calling the room number. After all room doors are closed, patients are to be re-assured, giving special attention to the critically ill and apprehensive patients. Other patients in immediate danger shall be relocated to a safe area in an adjacent zone on the same floor.

Patients on oxygen may require some special attention. Low flow oxygen patients may be moved without temporary oxygen tanks if necessary. High flow patients / oxygen dependent patients must have temporary oxygen portable tanks connected by Respiratory Therapy. Oxygen should not be turned off at oxygen zone valves in an area until Nursing and Respiratory agree all patients are accounted for and are no longer connected to the piped oxygen system.

TRACKING OF

PATIENTS

Tracking Patients During & After Evacuation

The procedures located in the Emergency Operations Plan for tracking patients will continue in the same form and method as if in the hospital. A Master Evacuation Tracking Form (HICS 255) will be maintained at all the exit points of the hospital where patients are being transported away from the facility. Each of the forms will be given to the HCC once they are completed. The Alternate Care Site Plan will be initiated once the patients are in route to their location.

Fatality Management Planning

The Mass Fatality plan will be implemented when there are more fatalities that the hospital morgue capacity can handle. This plan will be coordinated in conjunction with the San Diego County Medical Examiners office Mass Fatality Plan protocols.

In the event of Mass fatality incident the medical center will utilize the Hospital Incident Command System (HICS) outlined in the Tri City Medical Center Emergency Operations Plan. As described in the HICS protocols the Mass Fatality plan requires the assignment of mass fatality branch director, a morgue division leader. Additional job action sheets will be utilized for the positions that are created to manage morgue operations under the operations section of the HICS protocol.

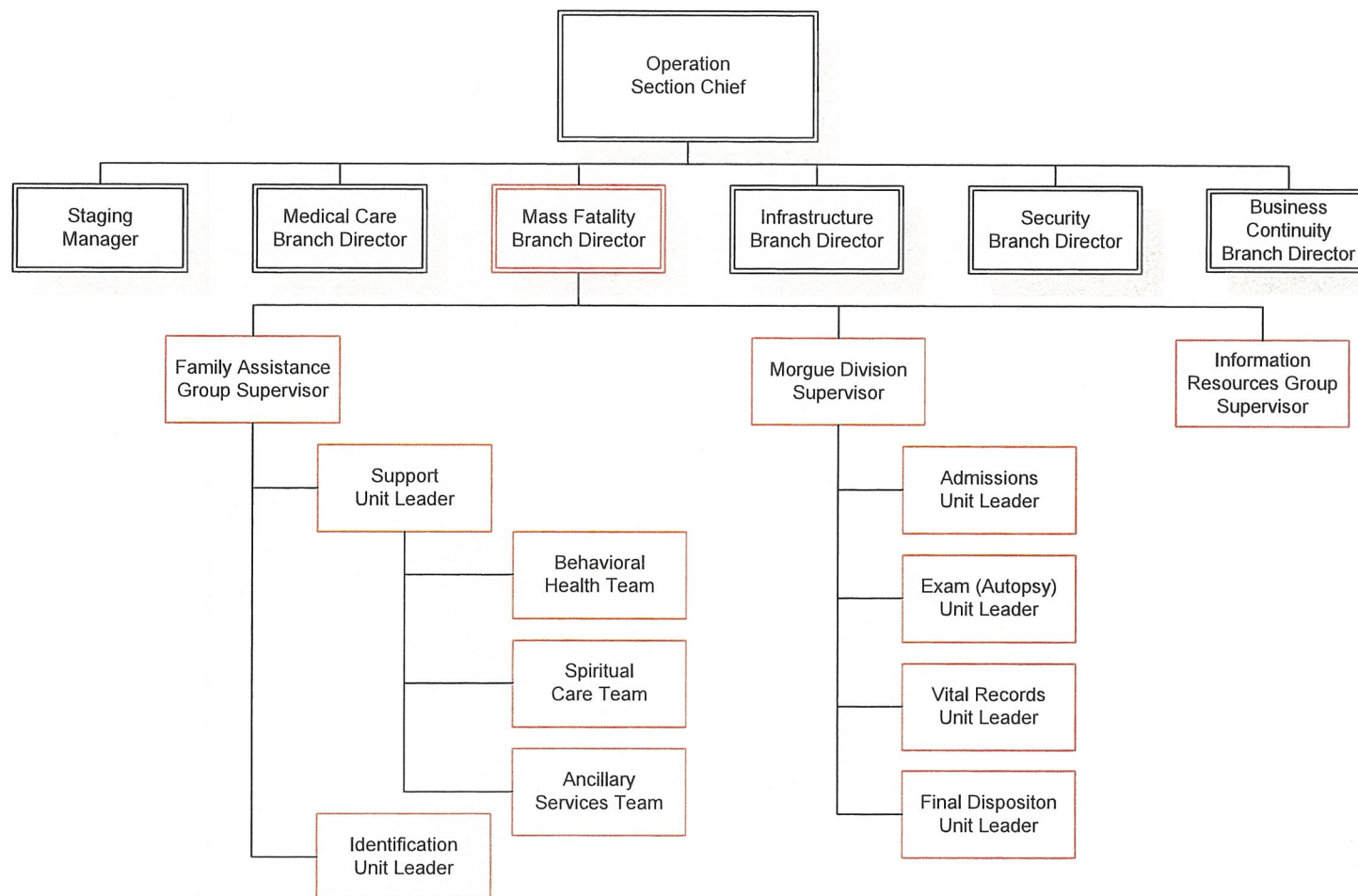
To ensure human treatment of the deceased bodies the medical center has written memos of understanding with refrigerator truck vendors (vendor that will be utilized is Bio Waste disposal vendor Enserv) to secure bodies until San Diego Medical Examiner is able to transport bodies off site county morgue facilities.

External Communications

The medical center will coordinate with local Emergency Medical Services (EMS) agencies via the county of San Diego County Medical Operations Center (MOC). The hospital will notify the MOC via the Web/EOC and other communication means via the county medical alert systems, 800 Mhz and the California Hospital Alert Network (CAHAN).

APPENDIX A

HICS MASS FATALITY MANAGEMENT TABLE OF ORGANIZATION



APPENDIX B

JOB ACTION SHEETS

MASS FATALITY BRANCH DIRECTOR

Mission: The Mass Fatality Branch Director is responsible for managing all aspects of a Mass Fatality Branch from the time of activation through the termination of the incident. The Mass Fatality Branch Director reports directly to the Operations Section Chief.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____ Position Reports to: Operations Section Chief Signature: _____ Hospital Command Center (HCC) Location: _____ Telephone: _____ Fax: _____ Other Contact Info: _____ Radio Title: _____		
Immediate (Operational Period 0-2 Hours)	Time	Initial
Receive appointment and briefing from the Operations Section Chief. Obtain packet containing Operations Section Job Action Sheets.		
Read this entire Job Action Sheet and review incident management team chart (HICS Form 207). Put on position identification.		
Notify your usual supervisor of your HICS assignment.		
Manage and ensure proper and timely completion of the overall Branch function of location, documentation, recovery, transport, identification and mortuary services for deceased victims of a disaster.		
Ensure all assigned personnel are properly credentialed and completes all administrative requirements.		
Ensure proper and timely setup and operation of the morgue operations, family assistance services, and other areas of operation as applicable.		
Ensure that supplies and support necessary to accomplish mission objectives and activities are available.		
Interact with the Operations Section Chief for the coordination of Branch activities and support requirements.		
Attend briefings with the Operations Section Chief and ensures all assigned personnel are kept informed of mission objectives and status changes.		
Brief assigned Branch personnel on the following: o Current situation status o Personnel assignments and duties		
Maintain ongoing communications with ME/Coroner.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit.		

Intermediate (Operational Period 2-12 Hours)	Time	Initial
Continue to meet regularly with Operations Section Chief for status reports, and relay important information to Branch staff.		
Designate time(s) for briefings and updates with Operations Section leadership to develop or update the Section action plan.		
Conduct regular Team meetings and daily briefings. Identify the following: <ul style="list-style-type: none"> • Who should attend • Schedule • Unique agenda items 		
Ensure that Division/Group Supervisors and Unit Leaders develop a process to determine an overall operational assessment process that includes the following: <ul style="list-style-type: none"> • Functional requirements and immediate needs • Work schedules for extended operations • Rest and rotation periods for personnel • Adequacy of support facilities 		
Address issues related to ongoing morgue operations: <ul style="list-style-type: none"> • Primary and secondary/alternate morgue census and available capacity • Identification of deceased • Decedent tracking • Next of kin notification • Decedent transportation • Morgue equipment and supplies • Personnel and resource movement through morgue sites • Linkages with the ME/Coroner, area hospitals, and other healthcare facilities • Documentation 		
Evaluate the capability of resources to complete the assignment. Order additional resources if needed.		
Initiate the Resource Accounting Record (HICS Form 257) to track equipment used during the response.		
Schedule planning meetings with Branch Directors and Staging Manager to update the Section action plan and demobilization procedures.		
Coordinate personnel needs with Labor Pool & Credentialing Unit Leader, supply and equipment needs with the Supply Unit Leader, projections and needs with the Planning Section, and financial matters with the Finance/Administration Section.		
Ensure coordination with any assisting or cooperating agency.		
Extended (Operational Period Beyond 12 Hours)	Time	Initial
Continue to monitor Mass Fatality Branch personnel's ability to meet workload demands, staff health and safety, resource needs and documentation practices.		
Continue to maintain the Resource Accounting Record (HICS Form 257) to track equipment used during the response.		
Ensure the completion of all required reports and maintenance of records.		
Conduct regular meetings and daily briefings with Group/Division Supervisors.		
Address issues related to ongoing morgue operations: <ul style="list-style-type: none"> • Primary and secondary/alternate morgue census and available capacity • Identification of deceased 		

Extended (Operational Period Beyond 12 Hours)	Time	Initial
<ul style="list-style-type: none"> Decedent tracking Next of kin notification Decedent transportation Morgue equipment and supplies Personnel and resource movement through morgue sites Linkages with the ME/Coroner, area hospitals, and other healthcare facilities Documentation 		
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		
Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to the Employee Health & Well Being Unit. Provide for staff rest periods and relief.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		
Demobilization/System Recovery	Time	Initial
As needs decrease, return Morgue Operations staff to their usual jobs and combine or deactivate positions in a phased manner, in coordination with the Demobilization Unit Leader.		
Coordinate demobilization of morgue operations to normal services to include: <ul style="list-style-type: none"> Demobilization of secondary/alternate morgue sites Return primary morgue to normal operations Return and re-supply of all equipment and supplies utilized during event Completion of all appropriate documentation 		
Coordinate final reporting of morgue operations with external agencies through Liaison Officer and Public Information Officer.		
Work with Planning and Finance/Administration Sections to complete cost data information.		
Debrief staff on lessons learned and procedural/equipment changes needed.		
Upon deactivation of your position, brief the Operations Section Chief on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and Operational Logs (HICS Form 214) are submitted to the Documentation Unit.		
Submit comments to the Operations Section Chief for discussion and possible inclusion in an after-action report; topics include: <ul style="list-style-type: none"> Review of pertinent position descriptions and operational checklists Recommendations for procedure changes Section accomplishments and issues 		
Participate in stress management and after action debriefings. Participate in other briefings and meetings as required.		
Documents/Tools		
<ul style="list-style-type: none"> Incident Action Plan HICS Form 204 Branch Assignment Sheet HICS Form 207 Incident Management Team Chart HICS Form 213 Incident Message Form HICS Form 214 Operational Log 		

Documents/Tools

- ◆ ~~HICS Form 257—Resource Accounting Record~~
- ◆ ~~Hospital emergency operations plan~~
- ◆ ~~Hospital organization chart~~
- ◆ ~~Hospital telephone directory~~
- ◆ ~~Radio/satellite phone~~

FAMILY ASSISTANCE GROUP SUPERVISOR

Mission: ~~Ensure the availability of medical, logistical and mental health support for the families of mass fatality victims and staff members. Facilitate the identification process, obtain supportive services and information gathering, if required.~~

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____
Position Reports to: Operations Section Chief Signature: _____
 Hospital Command Center (HCC) Location: _____ Telephone: _____
 Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	Time	Initial
Receive appointment and briefing from the Mass Fatality Branch Director. Obtain packet containing the Unit's Job Action Sheets.		
Read this entire Job Action Sheet and review incident management team chart (HICS Form 207). Put on position identification.		
Notify your usual supervisor of your HICS assignment.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Appoint Support Unit and Identification Unit team members and in collaboration with Mass Fatality Branch Director, complete the Branch Assignment List (HICS Form 204).		
Brief unit members on current situation, incident and strategy; outline unit action plan; and designate time for next briefing.		
Coordinate activities with Morgue Division Unit Leader.		
Activate the Family Assistance Center per the Emergency Management/Operations Plan.		
Oversee the Family Assistance Center activities in collaboration with the Santa Clara County Social Services Agency.		
Ensure 1-2 daily briefings providing accurate and timely information to families prior to media briefings.		
Ensure prioritization of problems when multiple issues are presented.		
Establish and supervise death notification procedures with clinical units and Morgue Division Supervisor, if required.		
Function as a liaison and coordinate essential interactions with outside agencies.		
Meet with the Mass Fatality Branch Director to discuss plan of action and staffing for Family Assistance Center.		
Document all communications (internal and external) on an Incident Message Form (HICS Form		

213). Provide a copy of the Incident Message Form to the Documentation Unit.		
Intermediate (Operational Period 2-12 Hours)		
Coordinate provision of needed support to family members (physical, emotional, refreshment, food and water) of the deceased.	Time	Initial
Coordinate external request for resources with the Liaison Officer; per the community plan if available; develop plan for how outside expertise will be utilized.		
Provide necessary information and access to services to family members and significant others of deceased.		
Provide support for death notifications, as necessary.		
Facilitate the release of personal effects to legal next of kin.		
Meet routinely with unit members for status reports, and relay important information to the Morgue Fatality Branch Director.		
Address security issues as needed with the Security Branch Director; notify Morgue Fatality Branch Director.		
Report equipment and supply needs to the Supply Unit Leader.		
Ensure staff health and safety issues being addressed; resolve with the Support Branch Director, Safety Officer and Employee Health and Well Being Unit, as appropriate.		
Develop and submit an action plan to the Mass Fatality Branch Director when requested.		
Extended (Operational Period Beyond 12 Hours)		
Continue to monitor unit's ability to meet workload demands, staff health and safety, security and resource needs, and documentation practices.	Time	Initial
Continue to facilitate the release of personal effects to legal next of kin.		
Provide regular situation briefings to unit staff and family/dependents under your care.		
Continue to document actions and decisions on an Operational Log (HICS Form 214) and send to the Mass Fatality Branch Director at assigned intervals and as needed.		
Ensure mental health support is available; coordinate with Employee Health & Well Being Unit Leader as necessary.		
Ensure the provision of spiritual support when needed with assistance of the Employee Health & Well Being Unit Leader.		
Continue to provide Mass Fatality Branch Director with periodic situational updates.		
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		
Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to the Employee Health & Well Being Unit Leader. Provide for staff rest periods and relief.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		
Demobilization/System Recovery		
	Time	Initial

Demobilization/System Recovery	Time	Initial
As needs for the unit's staff decrease, return staff to their usual jobs and combine or deactivate positions in a phased manner.		
Anticipate need to provide service to staff/family for an extended period.		
Coordinate long term support needs with local/state and federal mental health officials.		
Provide normal stress reaction information sheets/incident specific education to families/dependents, in coordination with Employee Health and Well Being Unit and Operations Section's Mental Health Unit Leader.		
Compile Unit activity report and submit to the Mass Fatality Branch Director.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Debrief staff on lessons learned and procedural/equipment changes needed.		
Upon deactivation of your position, brief the Mass Fatality Branch Director or Logistics Section Chief, as appropriate, on current problems, outstanding issues, and follow up requirements.		
Upon deactivation of your position, ensure all documentation and Operational Logs (HICS Form 214) are submitted to the Support Branch Director or Logistics Section Chief, as appropriate.		
Submit comments to the Mass Fatality Branch Director for discussion and possible inclusion in the after action report; topics include: <ul style="list-style-type: none"> • Review of pertinent position descriptions and operational checklists • Recommendations for procedure changes • Section accomplishments and issues 		
Participate in stress management and after action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools

- Incident Action Plan
- HICS Form 204—Branch Assignment List
- HICS Form 207—Incident Management Team Chart
- HICS Form 213—Incident Message Form
- HICS Form 214—Operational Log
- Hospital emergency operations plan
- Hospital organization chart
- Hospital telephone directory

SUPPORT UNIT LEADER

Mission: Ensure the ongoing provision of services for the Family Assistance Group pertaining to behavioral health, spiritual care and other ancillary services.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____
Position Reports to: Operations Section Chief _____ Signature: _____
Hospital Command Center (HCC) Location: _____ Telephone: _____
Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	Time	Initial
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Receive appointment and briefing from the Mass Fatality Branch Director. Obtain packet containing the Unit's Job Action Sheets.		
Read this entire Job Action Sheet and review incident management team chart (HICS Form 207). Put on position identification.		
Notify your usual supervisor of your HICS assignment.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Appoint Behavioral Health, Spiritual Care and Ancillary Services team members and in collaboration with Family Assistance Group Supervisor, complete the Branch Assignment List (HICS Form 204).		
Brief unit members on current situation, incident and strategy; outline Unit action plan; and designate time for next briefing.		
Coordinate activities with Family Assistance Group Supervisor.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Coordinate functions of Behavioral Health, Spiritual Care and Ancillary Services Teams under direction from the Family Assistance Group Supervisor.		
Ensure adequate communications resources are available (computers, phones, etc). Communicate additional needs through Family Assistance Group Supervisor.		
Ensure assignment of duties for Family Assistance Group to meet families' behavioral health, psychosocial and spiritual needs.		
Ensure all Family Assistance personnel have appropriate credentials (licensure/certification/approval) to provide services to families.		
Ensure maintenance of strict confidentiality standards of all family assistance support personnel.		
Ensure provision of childcare by approved providers.		
Assess the needs of families and coordinate access to additional services as needed.		

Immediate (Operational Period 0-2 Hours)	Time	Initial
Assess the needs of Family Assistance Support personnel and coordinate access to additional services as needed.		
Functions as liaison between Family Assistance Center and outside human services agencies.		
Coordinate with Santa Clara County Mental Health Department and county faith-based organizations to provide appropriate memorial site visits and services.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit.		

Intermediate (Operational Period 2-12 Hours)	Time	Initial
Continue to coordinate activities with Family Assistance Group Supervisor.		
Monitor the functions of Behavioral Health, Spiritual Care and Ancillary Services Teams under direction from the Family Assistance Group Supervisor.		
Continue to assess the needs of families and coordinate access to additional services as needed.		

Intermediate (Operational Period 2-12 Hours)	Time	Initial
Monitor the needs of Family Assistance Support personnel and coordinate access to additional services as needed.		
Meet routinely with unit members for status reports, and relay important information to the Family Assistance Group Supervisor.		
Ensure documentation is completed correctly and collected.		
Advise the Family Assistance Group Supervisor immediately of any operational issue you are not able to correct or resolve.		
Ensure staff health and safety issues being addressed; resolve with the Safety Officer.		
Meet routinely with unit members for status reports, and relay important information to the Morgue Fatality Branch Director.		
Address security issues as needed with the Security Branch Director; notify Family Assistance Group Supervisor.		
Report equipment and supply needs to the Supply Unit Leader.		
Develop and submit an action plan to the Family Assistance Group Supervisor when requested.		

Extended (Operational Period Beyond 12 Hours)	Time	Initial
Continue to monitor unit's ability to meet workload demands, staff health and safety, security and resource needs, and documentation practices.		
Continue to monitor the unit's ability to meet workload demands, staff health and safety, resource needs, and documentation practices.		
Continue to assess the needs of families and coordinate access to additional services as needed.		
Provide regular situation briefings to unit staff and family/dependents under your care.		
Continue to document actions and decisions on an Operational Log (HICS Form 214) and send to the Mass Fatality Branch Director at assigned intervals and as needed.		
Continue to provide Mass Fatality Branch Director with periodic situational updates.		
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		
Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to the Employee Health & Well Being Unit Leader. Provide for staff rest periods and relief.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		

Demobilization/System Recovery	Time	Initial
As needs for the unit's staff decrease, return staff to their usual jobs and combine or deactivate positions in a phased manner.		
Compile unit activity report and submit to the Mass Fatality Branch Director.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Debrief staff on lessons learned and procedural/equipment changes needed.		

Demobilization/System Recovery	Time	Initial
Upon deactivation of your position, brief the Family Assistance Group Supervisor, as appropriate, on current problems, outstanding issues, and follow up requirements.		
Upon deactivation of your position, ensure all documentation and Operational Logs (HICS Form 214) are submitted to the Support Branch Director or Logistics Section Chief, as appropriate.		
Submit comments to the Family Assistance Group Supervisor for discussion and possible inclusion in the after action report; topics include: <ul style="list-style-type: none"> Review of pertinent position descriptions and operational checklists Recommendations for procedure changes Section accomplishments and issues 		
Participate in stress management and after action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools

- Incident Action Plan
- HICS Form 204 Branch Assignment List
- HICS Form 207 Incident Management Team Chart
- HICS Form 213 Incident Message Form
- HICS Form 214 Operational Log
- Hospital emergency operations plan
- Hospital organization chart
- Hospital telephone directory

BEHAVIORAL HEALTH TEAM LEADER

Mission: Address issues related to mental health / behavioral health emergency response, manage mental health issues within the Family Assistance Center, and coordinate mental health response activities.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____
Position Reports to: Operations Section Chief Signature: _____
Hospital Command Center (HCC) Location: _____ Telephone: _____
Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	Time	Initial
Receive appointment and briefing from the Support Unit Leader. Obtain packet containing the Team's Job Action Sheets.		
Read this entire Job Action Sheet and review incident management team chart (HICS Form 207). Put on position identification.		
Notify your usual supervisor of your HICS assignment.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Participate in briefings and meetings, as requested.		
Provide mental health guidance and recommendations to the Support Unit Leader based on response needs and potential triggers of psychological effects (trauma exposure, perceived risk to family, presumed loss of loved one's life, restrictions on movement, resource limitations, and information		

unavailability).		
Provide mental health support and guidance to staff in the Family Assistance Center.		
<p>Communicate and coordinate with the Support Unit Leader to determine:</p> <ul style="list-style-type: none"> Available staff (Mental health, nursing, chaplains, etc) that can be deployed to key areas of the Family Assistance Center to provide psychological support, and intervention. Locations and type of resources that can be used to assist with a mental health response, such as toys and coloring supplies for children, mental health disaster recovery brochures, fact sheets, private areas in the FAS where family members can wait news regarding their loved ones, etc. Availability of psychotropic medications (particularly anxiolytics) Bed availability in inpatient psychiatric units, if applicable. Additional short and long range mental health response needs. Need to provide appropriate mental health guidance to the medical community as requested. 		
Establish an overall mental health treatment plan for the disaster including priorities for mental health response to families and individuals in the FAS; staffing recommendations; recommended mental health activities/interventions; resources available and needed; and problems to be addressed during the next operational period.		
Immediate (Operational Period 0-2 Hours)	Time	Initial
Function as a liaison and coordinate essential interactions with outside agencies.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit.		
Intermediate (Operational Period 2-12 Hours)	Time	Initial
Ensure documentation is completed correctly and collected.		
Advise the Support Unit Leader immediately of any operational issue you are not able to correct or resolve.		
Ensure staff health and safety issues being addressed; resolve with the Safety Officer.		
Meet routinely with team members for status reports, and relay important information to the Support Unit Leader.		
Ensure that appropriate mental health standards of care are being followed and mental health needs are being met.		
Report equipment and supply needs to the Support Unit Leader.		
Provide information and access to available support groups, services and other resources for family members.		
Provide next of kin notifications, as necessary. Document all notifications appropriately.		
Provide support for next of kin during decedent viewing.		
Assist with the identification and release of personal effects to the legal next of kin.		
Whenever possible, comply with cultural and spiritual norms and customs of the decedent(s) and family.		
Collaborate with the Spiritual Care Team.		
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		

Extended (Operational Period Beyond 12 Hours)	Time	Initial
Continue to monitor team's ability to meet workload demands, staff health and safety, security and resource needs, and documentation practices.		
Provide regular situation briefings to family/dependents under your care.		
Continue to document actions and decisions on an Operational Log (HICS Form 214) and send to the Support Unit Leader at assigned intervals and as needed.		
Continue to provide Support Unit Leader with periodic situational updates.		
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		

Extended (Operational Period Beyond 12 Hours)	Time	Initial
Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to the Employee Health & Well-Being Unit Leader. Provide for staff rest periods and relief.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		

Demobilization/System Recovery	Time	Initial
As needs for the team's staff decrease, return staff to their usual jobs and combine or deactivate positions in a phased manner.		
Anticipate need to provide service to decedents' families for an extended period.		
Compile team activity report and submit to the Support Unit Leader.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Debrief staff on lessons learned and procedural/equipment changes needed.		
Upon deactivation of your position, brief the Support Unit Leader on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and Operational Logs (HICS Form 214) are submitted to the Support Unit Leader.		
Submit comments to the Support Unit Leader for discussion and possible inclusion in the after-action report; topics include: <ul style="list-style-type: none"> — Review of pertinent position descriptions and operational checklists — Recommendations for procedure changes — Section accomplishments and issues 		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools
<ul style="list-style-type: none"> — Incident Action Plan — HICS Form 204—Branch Assignment List — HICS Form 207—Incident Management Team Chart — HICS Form 213—Incident Message Form — HICS Form 214—Operational Log — Hospital emergency operations plan

Documents/Tools

- Hospital organization chart
- Hospital telephone directory

SPIRITUAL CARE TEAM LEADER

Mission: Address issues related to the spiritual care of decedents and their families and loved ones within the Family Assistance Center. Provide spiritual support to staff assigned to the Family Assistance Center.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____
Position Reports to: Operations Section Chief Signature: _____
 Hospital Command Center (HCC) Location: _____ Telephone: _____
 Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	Time	Initial
Receive appointment and briefing from the Support Unit Leader. Obtain packet containing the Team's Job Action Sheets.		
Read this entire Job Action Sheet and review incident management team chart (HICS Form 207). Put on position identification.		
Notify your usual supervisor of your HICS assignment.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Participate in briefings and meetings, as requested.		
Provide spiritual support guidance and recommendations to the Support Unit Leader and Family Support Group Supervisor based on the needs of decedents and their families and loved ones within the Family Assistance Center (see appendix E).		
Communicate and coordinate with the Support Unit Leader to determine: <ul style="list-style-type: none"> • Available staff (chaplains, spiritual leaders, experienced volunteers, etc) that can be deployed to key areas of the Family Assistance Center to provide spiritual care. • Locations and type of resources that can be used to assist with a spiritual care response, such as Bibles, religious articles, mental health disaster recovery brochures, private areas in the FAS where family members can wait news regarding their loved ones, etc... • Need to provide spiritual guidance to the medical community as requested. 		
Function as a liaison and coordinate essential interactions with outside agencies.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit.		

Intermediate (Operational Period 2-12 Hours)	Time	Initial
Ensure documentation is completed correctly and collected.		
Advise the Support Unit Leader immediately of any operational issue you are not able to correct or resolve.		
Ensure staff health and safety issues being addressed; resolve with the Safety Officer.		
Meet routinely with Team members for status reports, and relay important information to the Family		

Intermediate (Operational Period 2-12 Hours)	Time	Initial
Support Unit Leader.		
Report equipment and supply needs to the FAS Support Group Supervisor.		
Provide information and access to available spiritual support groups and services.		
Provide next of kin notifications, as necessary. Document all notifications appropriately.		
Provide spiritual support for next of kin during decedent viewing.		
Whenever possible, comply with cultural and spiritual norms and customs of the decedent(s) and family (see appendix E).		
Collaborate with the Behavioral Health Team to address needs of families and next of kin.		

Extended (Operational Period Beyond 12 Hours)	Time	Initial
Continue to monitor team's ability to meet workload demands, staff health and safety, security and resource needs, and documentation practices.		
Provide regular situation briefings to family/dependents under your care.		
Continue to document actions and decisions on an Operational Log (HICS Form 214) and send to the Support Unit Leader at assigned intervals and as needed.		
Continue to provide Support Unit Leader with periodic situational updates.		
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		
Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to the Employee Health & Well Being Unit Leader. Provide for staff rest periods and relief.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		

Demobilization/System Recovery	Time	Initial
As needs for the team's staff decrease, return staff to their usual jobs and combine or deactivate positions in a phased manner.		
Anticipate need to provide service to decedents' families for an extended period.		
Compile team activity report and submit to the Support Unit Leader.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Debrief staff on lessons learned and procedural/equipment changes needed.		
Upon deactivation of your position, brief the Support Unit Leader on current problems, outstanding issues, and follow up requirements.		
Upon deactivation of your position, ensure all documentation and Operational Logs (HICS Form 214) are submitted to the Support Unit Leader.		
Submit comments to the Support Unit Leader for discussion and possible inclusion in the after action report; topics include: <ul style="list-style-type: none"> Review of pertinent position descriptions and operational checklists Recommendations for procedure changes 		

Demobilization/System Recovery	Time	Initial
◆ Section accomplishments and issues		
Participate in stress management and after action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools
<ul style="list-style-type: none"> ◆ Incident Action Plan ◆ HICS Form 204 Branch Assignment List ◆ HICS Form 207 Incident Management Team Chart ◆ HICS Form 213 Incident Message Form ◆ HICS Form 214 Operational Log ◆ Hospital emergency operations plan ◆ Hospital organization chart ◆ Hospital telephone directory

ANCILLARY SERVICES TEAM LEADER

Mission: Ensure that all ancillary services for the Family Assistance Group Unit are met, including communication/coordination with the Social Services Agency or Agencies, legal representatives, and local/state/out of state mortuary services as needed.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____	
Position Reports to: Operations Section Chief Signature: _____	
Hospital Command Center (HCC) Location: _____ Telephone: _____	
Fax: _____ Other Contact Info: _____ Radio Title: _____	

Immediate (Operational Period 0-2 Hours)	Time	Initial
Receive appointment and briefing from the Support Unit Leader. Obtain packet containing the Unit's Job Action Sheets.		
Read this entire Job Action Sheet and review incident management team chart (HICS Form 207). Put on position identification.		
Notify your usual supervisor of your HICS assignment.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Appoint necessary positions to meet the required responsibilities of the Ancillary Services Unit (HICS Form 204).		
Brief team members on current situation, incident and strategy; outline Unit action plan; and designate time for next briefing.		
Communicate and coordinate with internal/external social services to provide resource and support to the Family Assistance Center.		
Communicate and coordinate with local/state/out of state mortuary services to facilitate final disposition of deceased.		
Assist with the coordination of legal services, as necessary.		
Coordinate activities with Support Unit Leader.		

Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Ensure prioritization of problems when multiple issues are presented.		
Function as a liaison and coordinate essential interactions with outside agencies.		
Meet with the Support Unit Leader to discuss plan of action and staffing for ancillary services.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit.		

Intermediate (Operational Period 2-12 Hours)	Time	Initial
Ensure documentation is completed correctly and collected.		
Advise the Support Unit Leader immediately of any operational issue you are not able to correct or resolve.		
Communicate and coordinate with internal/external social services to provide resource and support to the Family Assistance Center.		
Communicate and coordinate with local/state/out of state mortuary services to facilitate final disposition of deceased.		
Provide referral to legal services, as necessary.		
Coordinate activities with Support Unit Leader.		
Ensure staff health and safety issues being addressed; resolve with the Safety Officer.		
Meet routinely with team members for status reports, and relay important information to the Support Unit Leader.		
Address security issues as needed with the Security Branch Director; notify Family Assistance Group Leader.		
Report equipment and supply needs to the Supply Unit Leader.		

Extended (Operational Period Beyond 12 Hours)	Time	Initial
Continue to monitor team's ability to meet workload demands, staff health and safety, security and resource needs, and documentation practices.		
Continue to monitor the MFI Unit's ability to meet workload demands, staff health and safety, resource needs, and documentation practices.		
Provide regular situation briefings to team staff and family/dependents under your care.		
Continue to document actions and decisions on an Operational Log (HICS Form 214) and send to the Support Unit Leader at assigned intervals and as needed.		
Continue to provide Support Unit Leader with periodic situational updates.		
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		
Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to the Employee Health & Well Being Unit Leader. Provide for staff rest periods and relief.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		

Demobilization/System Recovery	Time	Initial
As needs for the team's staff decrease, return staff to their usual jobs and combine or deactivate positions in a phased manner.		
Anticipate need to provide service to the Family Assistance Center for an extended period.		
Ensure the return/retrieval of equipment/supplies/personnel.		
Compile team activity report and submit to the Support Unit Leader.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Debrief staff on lessons learned and procedural/equipment changes needed.		
Upon deactivation of your position, brief the Support Unit Leader or Logistics Section Chief, as appropriate, on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and Operational Logs (HICS Form 214) are submitted to the Support Branch Director or Logistics Section Chief, as appropriate.		
Submit comments to the Support Unit Leader for discussion and possible inclusion in the after-action report; topics include: <ul style="list-style-type: none"> • Review of pertinent position descriptions and operational checklists • Recommendations for procedure changes • Section accomplishments and issues 		
Participate in stress management and after action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools
<ul style="list-style-type: none"> • Incident Action Plan • HICS Form 204 Branch Assignment List • HICS Form 207 Incident Management Team Chart • HICS Form 213 Incident Message Form • HICS Form 214 Operational Log • Hospital emergency operations plan • Hospital organization chart • Hospital telephone directory

IDENTIFICATION UNIT LEADER

Mission: Oversees activities relating to accurate identification and tracking of all decedents. Assists the Family Assistance Group Supervisor in coordinating with the Morgue Supervisor in monitoring and documenting the location of decedents during a mass fatality event.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____	
Position Reports to: Operations Section Chief Signature: _____	
Hospital Command Center (HCC) Location: _____ Telephone: _____	
Fax: _____ Other Contact Info: _____ Radio Title: _____	

Immediate (Operational Period 0-2 Hours)	Time	Initial
Receive appointment and briefing from the Family Assistance Group Supervisor		

Read this entire Job Action Sheet and review incident management team chart (HICS Form 207). Put on position identification.		
Notify your usual supervisor of your HICS assignment and report to Morgue Supervisor and Family Assistance Supervisor.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Appoint Identification Unit team members if assigned, and complete the Assignment List (HICS Form 204).		
Receive brief from Family Assistance Group Supervisor on current situation; outline team action plan and designate time for next briefing.		
Obtain current decedent census from Admissions Unit Leader and/or other sources.		
Coordinate with the Admissions Unit Leader to assist and implement a system, using the Hospital Casualty/Fatality Report (HICS Form 259)(HICS Form 259, to be maintained by the Admissions Unit Leader), to track and display decedent arrivals, transfers, locations and dispositions.		
Assist with final determination of positive identification of all decedents in collaboration with the Santa Clara County ME/Coroner.		
Determine non-identified decedent tracking mechanism and establish method to ensure integration and continuity with hospital decedent tracking systems.		
Assist with securing and safeguarding all decedent personal effects. In addition, processes must accommodate the potential need to secure personal effects in accordance with "chain of custody" in events that have been deemed as "criminal" (i.e. terrorist attack).		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit.		

Intermediate (Operational Period 2-12 Hours)	Time	Initial
Ensure documentation is completed correctly and collected.		
Advise the Support Unit Leader immediately of any operational issue you are not able to correct or resolve.		
Meet regularly with Admission Unit Leader, and Family Assistant Group Supervisor to update and exchange identified & non-identified decedent tracking information (within HIPAA and local guidelines) and census data.		
Continue to assist with final determination of positive identification of all decedents in collaboration with the Santa Clara County ME/Coroner.		
Assist Family Assistance Group Supervisor and Morgue Division Supervisor to comply with faith-based and/or cultural requirements, as possible.		
Continue to track and display decedent location and time of arrival for all decedents; regularly report status to the Family Assistance Group Supervisor.		
Ensure staff health and safety issues being addressed; resolve with the Safety Officer.		
Report equipment and supply needs to the Supply Unit Leader.		

Extended (Operational Period Beyond 12 Hours)	Time	Initial
Continue to monitor team's ability to meet workload demands, staff health and safety, security and resource needs, and documentation practices.		

Extended (Operational Period Beyond 12 Hours)	Time	Initial
Continue to assist with final determination of positive identification of all decedents in collaboration with the Santa Clara County ME/Coroner.		
Continue to track and display decedent location and time of arrival for all decedents; regularly report status to the Family Assistance Group Supervisor.		
Continue to assist Family Assistance Group Supervisor and Morgue Division Supervisor to comply with faith based and/or cultural requirements, as possible.		
Continue to monitor the staff health and safety, resource needs, and documentation practices.		
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		
Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to appropriate Employee Health & Well Being Unit Leader, and Patient Tracking Leader. Provide for staff rest periods and relief.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		
Demobilization/System Recovery	Time	Initial
As needs for the Decedent Tracking staff decrease, return staff to their usual jobs and combine or deactivate positions in a phased manner.		
Compile and finalize the Hospital Causality /Fatality Patient Tracking Form (HICS Form 259) and submit copies to the Finance/Administration Section Chief for patient billing/collections.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
If IT systems were offline due to the incident, assure appropriate information from Hospital Causality /Fatality Patient Tracking Form (HICS Form 259) is transferred into the normal patient tracking systems as needed.		
Debrief staff on lessons learned and procedural/equipment changes needed.		
Upon deactivation of your position, ensure all documentation and Operational Logs (HICS Form 214) are submitted to the Situation Unit Leader or Planning Section Chief, as appropriate.		
Upon deactivation of your position, brief the Family Assistance Group Supervisor on current and outstanding issues, and follow up requirements.		
Submit comments to the Family Assistance Group Supervisor for discussion and possible inclusion in the after action report; topics include: <ul style="list-style-type: none"> Review of pertinent position descriptions and operational checklists Recommendations for procedure changes Section accomplishments and issues 		
Participate in stress management and after action debriefings. Participate in other briefings and meetings as required.		
Documents/Tools		
<ul style="list-style-type: none"> Incident Action Plan HICS Form 204 Branch Assignment List HICS Form 207 Incident Management Team Chart HICS Form 213 Incident Message Form HICS Form 214 Operational Log 		

Demobilization/System Recovery	Time	Initial
<ul style="list-style-type: none"> ◆ HICS Form 254 — Disaster/Victim Patient Tracking Form ◆ HICS Form 255 — Master Patient Evacuation Tracking Form ◆ HICS Form 259 — Hospital Casualty/Fatality Report ◆ Hospital emergency operations plan ◆ Hospital organization chart ◆ Hospital telephone directory ◆ Radio/satellite phone ◆ Access to IT systems, including hospital admissions/tracking systems 		

MORGUE DIVISION SUPERVISOR

Mission: ~~Responsible for operations within the primary and secondary/alternate morgue facilities to include, the collection, protection, identification and tracking of all decedents.~~

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____	
Position Reports to: Operations Section Chief Signature: _____	
Hospital Command Center (HCC) Location: _____ Telephone: _____	
Fax: _____ Other Contact Info: _____ Radio Title: _____	

Immediate (Operational Period 0-2 Hours)	Time	Initial
Receive appointment and briefing from the Mass Fatality Branch Director. Obtain packet containing the Unit's Job Action Sheets.		
Read this entire Job Action Sheet and review incident management team chart (HICS Form 207). Put on position identification.		
Notify your usual supervisor of your HICS assignment.		
Determine need for and appropriately appoint MFI Unit staff; distribute corresponding Job Action Sheets and position identification. Complete a unit assignment list.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Brief unit staff on current situation; outline unit action plan and designate time for next briefing.		
Mobilize personnel and equipment resources to begin morgue operations. Coordinate with the Mass Fatality Branch Director.		
Regularly report unit status to Mass Fatality Branch Director.		
Assess problems and needs; coordinate resource management.		
Request a physician from the Casualty Care Unit Leader to confirm any resuscitatable casualties in Morgue Area.		
Obtain assistance from the Labor Pool Unit Leader for transporting decedents.		
Assure all transporting devices are removed from under decedents and returned to the Triage Area.		
Instruct all morgue division unit members to periodically evaluate equipment, supply, and staff needs and report status to you; collaborate with Logistics Section Supply Unit Leader to address those needs; report status to Mass Fatality Branch Director.		
Monitor decedent identification process.		

Assess need for establishing secondary/alternate morgue facilities.		
Contact the Security Branch Director for any morgue security needs.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit.		

Intermediate (Operational Period 2-12 Hours)	Time	Initial
Maintain master list of decedents with time of arrival.		
Assure all personal belongings are kept with decedents and/or are secured.		
Assure all decedents in morgue units are covered, tagged and identified where possible.		
Monitor death certificate process.		
Meet regularly with the Mass Fatality Branch Director for update on the number of deceased; status reports, and relay important information to Morgue Unit staff.		
Implement secondary/alternate morgue facilities as needed.		
Continue coordinating activities in the Morgue Unit.		
Coordinate use of external resources; coordinate with Liaison Officer if appropriate.		
Contact the Security Branch Director for any morgue security needs.		
Develop and submit a unit action plan to the Mass Fatality Branch Director when requested.		
Ensure documentation is completed correctly and collected.		
Advise the Mass Fatality Branch Director immediately of any operational issue you are not able to correct or resolve.		
Ensure staff health and safety issues being addressed; resolve with the Safety Officer.		

Extended (Operational Period Beyond 12 Hours)	Time	Initial
Continue to monitor Unit's ability to meet workload demands, staff health and safety, security and resource needs, and documentation practices.		
Continue to facilitate the release of human remains for final disposition.		
Continue to facilitate the release of personal effects to legal next of kin.		
Continue to monitor the unit's ability to meet workload demands, staff health and safety, resource needs, and documentation practices.		
Coordinate assignment and orientation of external personnel sent to assist.		
Work with the Mass Fatality Branch Director and Liaison Officer, as appropriate on the assignment of external resources.		
Rotate staff on a regular basis.		
Document actions and decisions on a continual basis.		
Continue to provide the Mass Fatality Branch Director with periodic situation updates.		
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		
Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to the		

Extended (Operational Period Beyond 12 Hours)	Time	Initial
Employee Health & Well-Being Unit Leader. Provide for staff rest periods and relief.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		

Demobilization/System Recovery	Time	Initial
As needs for the unit decrease, return staff to their normal jobs and combine or deactivate positions in a phased manner, in coordination with the Demobilization Unit Leader.		
Ensure the return/retrieval of equipment/supplies/personnel.		
Compile Unit activity report and submit to the Mass Fatality Branch Director.		
Debrief staff on lessons learned and procedural/equipment changes needed.		
Upon deactivation of your position, brief the Mass Fatality Branch Director on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and MFI Unit Operational Logs (HICS Form 214) are submitted to the Mass Fatality Branch Director.		
Submit comments to the Mass Fatality Branch Director for discussion and possible inclusion in the after-action report; topics include: <ul style="list-style-type: none"> • Review of pertinent position descriptions and operational checklists • Recommendations for procedure changes • Section accomplishments and issues 		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools
Incident Action Plan • HICS Form 207— Incident Management Team Chart • HICS Form 213— Incident Message Form • HICS Form 214— Operational Log • Mass Fatality Incident Activation/Operational Plan • Hospital emergency operations plan • Hospital organization chart • Hospital telephone directory • Key contacts list (including Santa Clara ME/Coroner, DPH, ARC, etc.)

ADMISSIONS UNIT LEADER

Mission: Assist in Monitoring and documenting the location of decedents at all times within the hospital's patient care system, and track the destination of all decedents departing the facility.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____		
Position Reports to: Operations Section Chief Signature: _____		
Hospital Command Center (HCC) Location: _____		Telephone: _____
Fax: _____	Other Contact Info: _____	Radio Title: _____

Immediate (Operational Period 0-2 Hours)	Time	Initial
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Receive appointment and briefing from the Morgue Division Supervisor.		
Read this entire Job Action Sheet and review incident management team chart (HICS Form 207). Put on position identification.		
Notify your usual supervisor of your HICS assignment.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Appoint Admission Unit team members and complete the Branch Assignment List (HICS Form 204).		
Brief team members on current situation; outline team action plan and designate time for next briefing.		
Obtain current in-patient/decedent census from admitting personnel and/or other sources.		
Implement a system, using the Disaster/Victim Patient Tracking Form (HICS Form 254) to track and display decedent arrivals, transfers, locations and dispositions.		
Initiate the Hospital Casualty/Fatality Report (HICS Form 259), in conjunction with Operations Section's Patient Registration Unit Leader.		
Determine decedent tracking mechanism utilized by field providers and establish method to ensure integration and continuity with hospital patient tracking systems.		
If evacuation of the facility is required or is in progress, initiate the Master Decedent Evacuation Tracking Sheet (HICS Form 255).		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit.		

Intermediate (Operational Period 2-12 Hours)	Time	Initial
Meet regularly with Morgue Division Supervisor, Registration Unit Leader, and Identification Unit, to update and exchange patient/Decedent tracking information (within HIPAA and local guidelines) and census data.		
Advise the Morgue Division Supervisor immediately of any operational issue you are not able to correct or resolve.		
Track decedent movement outside of the facility with local authorities and other health systems through morgue and contracted decedent transportation.		
Continue to track and display patient location and time of arrival for all decedents; regularly report status to the Morgue Division Supervisor. If possible try to track patients by religion for and location for use by Hospital and outside chaplains.		
Develop and submit an action plan to the Morgue Division Supervisor when requested.		
Ensure staff health and safety issues being addressed; resolve with the Safety Officer.		
Meet routinely with team members for status reports, and relay important information to the Morgue Division Supervisor.		
Address security issues as needed with the Security Branch Director; notify Morgue Division Supervisor.		
Report equipment and supply needs to the Supply Unit Leader.		

Extended (Operational Period Beyond 12 Hours)	Time	Initial
Meet regularly with Morgue Division Supervisor, Registration Unit Leader, and Morgue Identification		

Extended (Operational Period Beyond 12 Hours)	Time	Initial
Unit, to update and exchange patient/Decedent tracking information (within HIPAA and local guidelines) and census data.		
Advise the Morgue Division Supervisor immediately of any operational issue you are not able to correct or resolve.		
Continue to monitor the decedent's location, staff health and safety, resource needs, and documentation practices.		
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		
Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to appropriate Employee Health & Well Being Unit Leader, and Patient Tracking Leader. Provide for staff rest periods and relief.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		

Demobilization/System Recovery	Time	Initial
As needs for the admissions unit staff decrease, return staff to their usual jobs and combine or deactivate positions in a phased manner.		
Compile and finalize the Hospital Causality /Fatality Patient Tracking Form (HICS Form 259) and submit copies to the Finance/Administration Section Chief for patient billing/collections.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
If IT systems were offline due to the incident, assure appropriate information from Hospital Causality/Fatality Patient Tracking Form (HICS Form 259) is transferred into the normal patient tracking systems.		
Debrief staff on lessons learned and procedural/equipment changes needed.		
Upon deactivation of your position, ensure all documentation and Operational Logs (HICS Form 214) are submitted to the Situation Unit Leader or Planning Section Chief, as appropriate.		
Upon deactivation of your position, brief the Situation Unit Leader or Planning Section Chief, as appropriate, on current problems, outstanding issues, and follow-up requirements.		
Submit comments to the Situation Unit Leader for discussion and possible inclusion in the after action report; topics include: <ul style="list-style-type: none"> • Review of pertinent position descriptions and operational checklists • Recommendations for procedure changes • Section accomplishments and issues 		
Participate in stress management and after action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools
<ul style="list-style-type: none"> • Incident Action Plan • HICS Form 204 Branch Assignment List • HICS Form 207 Incident Management Team Chart • HICS Form 213 Incident Message Form • HICS Form 214 Operational Log • HICS Form 254 Disaster/Victim Patient Tracking Form

Documents/Tools

- HICS Form 255—Master Patient Evacuation Tracking Form
- HICS Form 259—Hospital Casualty/Fatality Report
- Hospital emergency operations plan
- Hospital organization chart
- Hospital telephone directory
- Radio/satellite phone
- Access to IT systems, including hospital admissions/tracking systems

EXAM (AUTOPSY) UNIT LEADER

Mission: Oversee the activities within the Morgue to prepare, manage, and store decedents who have expired in the facility. Collaborate to ensure accurate victim identification and cause of death.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____
Position Reports to: Operations Section Chief Signature: _____
 Hospital Command Center (HCC) Location: _____ Telephone: _____
 Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	Time	Initial
Receive appointment and briefing from the Morgue Division Supervisor. Obtain packet containing the Unit's Job Action Sheets.		
Read this entire Job Action Sheet and review incident management team chart (HICS Form 207). Put on position identification.		
Notify your usual supervisor of your HICS assignment.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Brief unit members on current situation, incident and strategy; outline unit action plan; and designate time for next briefing.		
Ensure systematic processing of victims throughout morgue process.		
Perform/assist with identification of decedents by documentation of physical description, photographs, finger prints, DNA and/or mandible and maxillary x rays if necessary. Coordinate with Santa Clara County Medical Examiner as appropriate.		
Ensure complete and accurate documentation of autopsies and autonomic specimens and articles associated with the deceased.		
Coordinate activities with Morgue Division Unit Leader.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Assess scope of morgue operations and anticipate the need for activation of secondary/alternate morgue facility.		
Assess the supply/equipment needs of the primary and/or secondary/alternate morgue facilities.		
Ensure prioritization of problems when multiple issues are presented.		

Ensure sufficient and proper morgue waste management process.		
Follow all Universal Precautions against exposure to communicable disease and bio hazards.		
Coordinate release of remains with the Morgue Division Supervisor and/or designees.		
Ensure Cleanliness and safety of primary and/or secondary/alternate morgue facility.		
Communicate staffing/resource needs with Morgue Division Supervisor		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit.		

Intermediate (Operational Period 2-12 Hours)	Time	Initial
Continue to ensure systematic processing of victims throughout morgue process.		
Continue to ensure prioritization of problems when multiple issues are presented.		
Continue to ensure sufficient and proper morgue waste management process.		
Ensure complete and accurate documentation of autopsies and autonomic specimens and articles associated with the deceased.		
Monitor the scope of morgue operations and anticipate the need for activation of secondary/alternate morgue facility.		
Monitor the scope the supply/equipment needs of the primary and/or secondary/alternate morgue facilities. Report needs to Supply Unit Leader		
Advise the Mass Fatality Branch Director immediately of any operational issue you are not able to correct or resolve.		
Ensure staff health and safety issues being addressed; resolve with the Safety Officer.		
Meet routinely with Unit members for status reports, and relay important information to the Morgue Fatality Branch Director.		
Address security issues as needed with the Security Branch Director; notify Morgue Fatality Branch Director.		
Report equipment and supply needs to the Supply Unit Leader.		

Extended (Operational Period Beyond 12 Hours)	Time	Initial
Continue to monitor Unit's ability to meet workload demands, staff health and safety, security and resource needs, and documentation practices.		
Continue to monitor the MFI Unit's ability to meet workload demands, staff health and safety, resource needs, and documentation practices.		
Continue to ensure sufficient and proper morgue waste management process.		
Continue to ensure complete and accurate documentation of autopsies and autonomic specimens and articles associated with the deceased.		
Continue to monitor the scope of morgue operations and anticipate the need for activation of secondary/alternate morgue facility.		
Continue to monitor the scope the supply/equipment needs of the primary and/or secondary/alternate morgue facilities. Report needs to Supply Unit Leader.		
Provide regular situation briefings to Unit Staff and family/dependents under your care.		

Extended (Operational Period Beyond 12 Hours)	Time	Initial
Continue to document actions and decisions on an Operational Log (HICS Form 214) and send to the Mass Fatality Branch Director at assigned intervals and as needed.		
Continue to provide Mass Fatality Branch Director with periodic situational updates.		
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		
Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to the Employee Health & Well-Being Unit Leader. Provide for staff rest periods and relief.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		

Demobilization/System Recovery	Time	Initial
As needs for the Unit's staff decrease, return staff to their usual jobs and combine or deactivate positions in a phased manner.		
Assist with the demobilization of secondary/alternate morgue site operations.		
Ensure the return/retrieval of equipment/supplies/personnel.		
Compile Unit activity report and submit to the Mass Fatality Branch Director.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Debrief staff on lessons learned and procedural/equipment changes needed.		
Upon deactivation of your position, brief the Mass Fatality Branch Director or Logistics Section Chief, as appropriate, on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and Operational Logs (HICS Form 214) are submitted to the Support Branch Director or Logistics Section Chief, as appropriate.		
Submit comments to the Mass Fatality Branch Director for discussion and possible inclusion in the after action report; topics include: <ul style="list-style-type: none"> • Review of pertinent position descriptions and operational checklists • Recommendations for procedure changes • Section accomplishments and issues 		
Participate in stress management and after action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools
<ul style="list-style-type: none"> • Incident Action Plan • HICS Form 204 Branch Assignment List • HICS Form 207 Incident Management Team Chart • HICS Form 213 Incident Message Form • HICS Form 214 Operational Log • Hospital emergency operations plan • Hospital organization chart • Hospital telephone directory

VITAL RECORDS UNIT LEADER

Mission: Maintain accurate and complete decedent records, including death certificates; provide duplication services to incident personnel; and file, maintain, and store decedent files for legal, analytical, and historical purposes.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____
Position Reports to: Operations Section Chief Signature: _____
 Hospital Command Center (HCC) Location: _____ Telephone: _____
 Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	Time	Initial
Receive appointment and briefing from the Mass Fatality Branch Director. Obtain packet containing the Unit's Job Action Sheets.		
Read this entire Job Action Sheet and review incident management team chart (HICS Form 207). Put on position identification.		
Notify your usual supervisor of your HICS assignment.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Coordinate with IT/IS Unit to ensure access to IT systems with e mail/intranet communication to increase communication and document sharing with all Sections (if available).		
Prepare a system to receive decedent records and death certificates from all Sections over the course of the mass fatality activation.		
Provide duplicates of forms and reports to authorized hospital incident command requestors.		
Ensure accountability and security of all decedent records and death certificates.		
Collaborate with Identification Unit Leader to ensure accurate identification and tracking of all decedents.		
In conjunction with the Santa Clara County ME/Coroner ensure all death certificates are completed in accordance with current guidances.		
Brief Unit members on current situation, incident and strategy; outline Unit action plan; and designate time for next briefing.		
Coordinate activities with Morgue Division Supervisor.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Ensure prioritization of problems when multiple issues are presented.		
Meet with the Morgue Division Supervisor to discuss plan of action and staffing for Vital Records Unit.		

Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit.

Intermediate (Operational Period 2-12 Hours)	Time	Initial
Continue to accept and organize all documentation and forms submitted to the Vital Records Unit.		
Check the accuracy and completeness of records submitted. Correct errors or omissions by contacting appropriate HIC Section staff.		

Intermediate (Operational Period 2-12 Hours)	Time	Initial
Monitor the system to receive decedent records and death certificates from all Sections over the course of the mass fatality activation.		
In conjunction with the Santa Clara County ME/Coroner continue to ensure all death certificates are completed in accordance with current guidances.		
Ensure accountability and security of all decedent records and death certificates.		
Ensure documentation is completed correctly and collected.		
Advise the Morgue Division Supervisor immediately of any operational issue you are not able to correct or resolve.		
Ensure staff health and safety issues being addressed; resolve with the Safety Officer.		
Meet routinely with Unit members for status reports, and relay important information to the Morgue Division Supervisor.		
Address security issues as needed with the Security Branch Director; notify Morgue Division Supervisor.		
Report equipment and supply needs to the Supply Unit Leader.		
Extended (Operational Period Beyond 12 Hours)	Time	Initial
Continue to monitor Unit's ability to meet workload demands, staff health and safety, security and resource needs, and documentation practices.		
Continue to monitor the MFI Unit's ability to meet workload demands, staff health and safety, resource needs, and documentation practices.		
Continue to accept and organize all documentation and forms submitted to the Vital Records Unit.		
Check the accuracy and completeness of records submitted. Correct errors or omissions by contacting appropriate HIC Section staff.		
Monitor the system to receive decedent records and death certificates from all Sections over the course of the mass fatality activation.		
In conjunction with the Santa Clara County ME/Coroner continue to ensure all death certificates are completed in accordance with current guidances.		
Ensure accountability and security of all decedent records and death certificates.		
Extended (Operational Period Beyond 12 Hours)	Time	Initial
Provide regular situation briefings to Unit Staff and family/dependents under your care.		
Continue to document actions and decisions on an Operational Log (HICS Form 214) and send to the Morgue Division Supervisor at assigned intervals and as needed.		
Continue to provide Morgue Division Supervisor with periodic situational updates.		
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		
Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to the Employee Health & Well Being Unit Leader. Provide for staff rest periods and relief.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		

Demobilization/System Recovery	Time	Initial
As needs for the Unit's staff decrease, return staff to their usual jobs and combine or deactivate positions in a phased manner.		
Ensure the return/retrieval of equipment/supplies/personnel.		
Ensure all appropriate documentation to include death certificates have been forwarded to SCC ME/Coroner, as requested.		
Compile Unit activity report and submit to the Mass Fatality Branch Director.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Debrief staff on lessons learned and procedural/equipment changes needed.		
Upon deactivation of your position, brief the Mass Fatality Branch Director or Logistics Section Chief, as appropriate, on current problems, outstanding issues, and follow up requirements.		
Upon deactivation of your position, ensure all documentation and Operational Logs (HICS Form 214) are submitted to the Support Branch Director or Logistics Section Chief, as appropriate.		
Submit comments to the Morgue Division Supervisor for discussion and possible inclusion in the after-action report; topics include: <ul style="list-style-type: none"> — Review of pertinent position descriptions and operational checklists — Recommendations for procedure changes — Section accomplishments and issues 		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools

- Incident Action Plan
- HICS Form 204 — Branch Assignment List
- HICS Form 207 — Incident Management Team Chart
- HICS Form 213 — Incident Message Form
- HICS Form 214 — Operational Log
- Hospital emergency operations plan
- Hospital organization chart
- Hospital telephone directory

FINAL DISPOSITION UNIT LEADER

Mission: — Coordinate with community mortuaries for final disposition of decedents within the community, state and out of state (as necessary). Ensure that all personal effects are released with the decedents properly, and that when possible, family needs are met with regard to final disposition.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____
Position Reports to: Operations Section Chief Signature: _____
Hospital Command Center (HCC) Location: _____ Telephone: _____
Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	Time	Initial
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Receive appointment and briefing from the Morgue Division Supervisor. Obtain packet containing the Unit's Job Action Sheets.		
Read this entire Job Action Sheet and review incident management team chart (HICS Form 207). Put on position identification.		
Notify your usual supervisor of your HICS assignment.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Appoint any additional positions needed to meet the Final Disposition Unit's responsibilities		
Brief unit members on current situation, incident and strategy; outline Unit action plan; and designate time for next briefing.		
Coordinate with Santa Clara County Medical Examiner's Office for transportation and disposition of decedents		
Coordinate with community, county, state and out of state mortuaries for disposition of decedents, as necessary		
Provide information of decedent disposition for family members to the Family Assistance Center.		
Coordinate activities with Morgue Division Unit Leader.		
Ensure that all personal effects are released with the decedents upon release to mortuaries.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Ensure prioritization of problems when multiple issues are presented.		
Function as a liaison and coordinate essential interactions with outside agencies.		
Meet with the Morgue Division Supervisor to discuss plan of action and staffing for Final Disposition Unit activities.		
Immediate (Operational Period 0-2 Hours)	Time	Initial
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit.		
Intermediate (Operational Period 2-12 Hours)	Time	Initial
Ensure documentation is completed correctly and collected.		
Coordinate with Santa Clara County Medical Examiner's Office for transportation and disposition of decedents		
Coordinate with community, county, state and out of state mortuaries for disposition as necessary		
Ensure that all personal effects are released with the decedents upon release to mortuaries.		
Provide information of decedent disposition for family members to the Family Assistance Center.		
Advise the Morgue Division Unit Leader immediately of any operational issue you are not able to correct or resolve.		
Ensure staff health and safety issues being addressed; resolve with the Safety Officer.		
Meet routinely with unit members for status reports, and relay important information to the Morgue Division Unit Supervisor.		

Intermediate (Operational Period 2-12 Hours)	Time	Initial
Address security issues as needed with the Security Branch Director; notify Morgue Division Unit Supervisor.		
Report equipment and supply needs to the Supply Unit Leader.		
Develop and submit an action plan to the Morgue Division Unit Supervisor when requested.		
Extended (Operational Period Beyond 12 Hours)	Time	Initial
Continue to monitor Unit's ability to meet workload demands, staff health and safety, security and resource needs, and documentation practices.		
Continue to monitor the ability to meet workload demands, staff health and safety, resource needs, and documentation practices.		
Continue to coordinate with Santa Clara County Medical Examiner's Office for transportation and disposition of decedents		
Continue to coordinate with community, county state and out of state mortuaries for disposition as necessary.		
Provide information of decedent disposition for family members to the Family Assistance Center.		
Provide regular situation briefings to Unit Staff and family/dependents under your care.		
Continue to document actions and decisions on an Operational Log (HICS Form 214) and send to the Morgue Division Unit Leader at assigned intervals and as needed.		
Continue to provide Morgue Division Unit Supervisor with periodic situational updates.		
Ensure both yourself and your unit's physical readiness through proper nutrition, water intake, rest, and stress management techniques.		
Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to the Employee Health & Well Being Unit Leader. Provide for staff rest periods and relief.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		
Demobilization/System Recovery	Time	Initial
As needs for the Unit's staff decrease, return staff to their usual jobs and combine or deactivate positions in a phased manner.		
Anticipate need to provide service to other units under the Morgue Division Unit for an extended period.		
Ensure the return/retrieval of equipment/supplies/personnel.		
Compile Unit activity report and submit to the Morgue Division Unit Supervisor.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Debrief staff on lessons learned and procedural/equipment changes needed.		
Upon deactivation of your position, brief the Morgue Division Unit Supervisor or Logistics Section Chief, as appropriate, on current problems, outstanding issues, and follow up requirements.		
Upon deactivation of your position, ensure all documentation and Operational Logs (HICS Form 214) are submitted to the Support Branch Director or Logistics Section Chief, as appropriate.		

Demobilization/System Recovery	Time	Initial
Submit comments to the Morgue Division Unit Leader for discussion and possible inclusion in the after-action report; topics include: <ul style="list-style-type: none"> Review of pertinent position descriptions and operational checklists Recommendations for procedure changes Section accomplishments and issues 		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools
<ul style="list-style-type: none"> Incident Action Plan HIICS Form 204 Branch Assignment List HIICS Form 207 Incident Management Team Chart HIICS Form 213 Incident Message Form HIICS Form 214 Operational Log Hospital emergency operations plan Hospital organization chart Hospital telephone directory

INFORMATION RESOURCES GROUP SUPERVISOR

Mission: Organizes and maintains unprocessed data, computer programs, and computerized entry of all ante- and post mortem data for the purpose of victim identification.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____	
Position Reports to: Operations Section Chief Signature: _____	
Hospital Command Center (HCC) Location: _____ Telephone: _____	
Fax: _____ Other Contact Info: _____ Radio Title: _____	

Immediate (Operational Period 0-2 Hours)	Time	Initial
Receive appointment and briefing from the Mass Fatality Branch Director. Obtain packet containing the Unit's Job Action Sheets.		
Read this entire Job Action Sheet and review incident management team chart (HIICS Form 207). Put on position identification.		
Notify your usual supervisor of your HIICS assignment.		
Document all key activities, actions, and decisions in an Operational Log (HIICS Form 214) on a continual basis.		
Appoint Support Unit and Identification Unit team members and in collaboration with Mass Fatality Branch Director, complete the Branch Assignment List (HIICS Form 204).		
Brief Unit members on current situation, incident and strategy; outline Unit action plan; and designate time for next briefing.		
Coordinate activities with Morgue Division Unit Leader.		
Document all key activities, actions, and decisions in an Operational Log (HIICS Form 214) on a continual basis.		

Supervise the overall set up, operation, and deactivation of the Mass Fatality ante and post mortem information management system and the final transfer to local ME/Coroner.		
Ensure data collection format and records are modified to meet the information requirements of the specific disaster and makes changes as necessary.		
Ensure all information management system equipment is set up at the Family Assistance Center and functioning properly.		
Oversee all ante and post mortem data entries.		
Serve as Liaison with the Morgue Division Supervisor, Family Assistance Group Unit Leader, and other relevant agencies (FBI), to ensure the necessary information is collected properly and communicated by approved means.		
Transition data from Mass Fatality operation to the local ME/Coroner after termination of Mass Fatality event.		
Ensure prioritization of problems when multiple issues are presented.		
Function as a liaison and coordinate essential interactions with outside agencies.		
Meet with the Mass Fatality Branch Director to discuss plan of action and staffing for —		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit.		
Organize and prioritize tasks for the specific disaster (e.g., record keeping systems etc.).		
Adapt information collection and record keeping system to include the information needs of the specific disaster, (e.g. cultural and religious customs).		
Ensure accurate and timely entry of ante and post mortem data as it becomes available.		
Ensure documentation is completed correctly and collected.		
Advise the Mass Fatality Branch Director immediately of any operational issue you are not able to correct or resolve.		
Ensure staff health and safety issues being addressed; resolve with the Safety Officer.		
Meet routinely with Unit members for status reports, and relay important information to the Mass Fatality Branch Director.		
Address security issues as needed with the Security Branch Director; notify Morgue Fatality Branch Director.		
Report equipment and supply needs to the Supply Unit Leader.		
Develop and submit an action plan to the Mass Fatality Branch Director when requested.		

Extended (Operational Period Beyond 12 Hours)	Time	Initial
Continue to monitor Unit's ability to meet workload demands, staff health and safety, security and resource needs, and documentation practices.		
Continue to monitor the MFI Unit's ability to meet workload demands, staff health and safety, resource needs, and documentation practices.		
Organize and prioritize tasks for the specific disaster (e.g., record keeping systems etc.).		
Ensure accurate and timely entry of ante and post mortem data as it becomes available.		
Provide regular situation briefings to Unit Staff and family/dependents under your care.		

Extended (Operational Period Beyond 12 Hours)	Time	Initial
Continue to document actions and decisions on an Operational Log (HICS Form 214) and send to the Mass Fatality Branch Director at assigned intervals and as needed.		
Extended (Operational Period Beyond 12 Hours)	Time	Initial
Continue to provide Mass Fatality Branch Director with periodic situational updates.		
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		
Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to the Employee Health & Well Being Unit Leader. Provide for staff rest periods and relief.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		
Demobilization/System Recovery	Time	Initial
As needs for the Unit's staff decrease, return staff to their usual jobs and combine or deactivate positions in a phased manner.		
Ensure database contains complete information from incident.		
Provide the local ME/Coroner with database and physical records as requested.		
Ensure access to data through training local end users on applicable information systems so that data may be updated and effectively used by local authorities.		
Ensure the return/retrieval of equipment/supplies/personnel.		
Compile Unit activity report and submit to the Mass Fatality Branch Director.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Debrief staff on lessons learned and procedural/equipment changes needed.		
Upon deactivation of your position, brief the Mass Fatality Branch Director or Logistics Section Chief, as appropriate, on current problems, outstanding issues, and follow up requirements.		
Upon deactivation of your position, ensure all documentation and Operational Logs (HICS Form 214) are submitted to the Support Branch Director or Logistics Section Chief, as appropriate.		
Submit comments to the Mass Fatality Branch Director for discussion and possible inclusion in the after action report; topics include: <ul style="list-style-type: none"> • Review of pertinent position descriptions and operational checklists • Recommendations for procedure changes • Section accomplishments and issues 		
Participate in stress management and after action debriefings. Participate in other briefings and meetings as required.		
Documents/Tools		
<ul style="list-style-type: none"> • Incident Action Plan • HICS Form 204 Branch Assignment List • HICS Form 207 Incident Management Team Chart • HICS Form 213 Incident Message Form • HICS Form 214 Operational Log 		

Documents/Tools

- ◆ Hospital emergency operations plan
- ◆ Hospital organization chart
- ◆ Hospital telephone directory

APPENDIX C

EQUIPMENT/SUPPLIES LIST

Staff Protection <input type="checkbox"/> Personal protective equipment (minimum standard precautions) <input type="checkbox"/> Worker safety and comfort supplies <input type="checkbox"/> Communication (radio, phone)	◆ Storage area: ◆ How to access: ◆ Notes:
Decedent Identification <input type="checkbox"/> Identification wristbands or other identification <input type="checkbox"/> Method to identify each decedent (pouch label, tag or rack location) <input type="checkbox"/> Cameras (may use dedicated digital, disposable or instant photo camera) <input type="checkbox"/> Fingerprints <input type="checkbox"/> X rays or dental records <input type="checkbox"/> Personal belongings bags / evidence bags	◆ Storage area: ◆ How to access: ◆ Notes:
Decedent Protection <input type="checkbox"/> Human remains pouches <input type="checkbox"/> Plastic sheeting <input type="checkbox"/> Sheets	◆ Storage area: ◆ How to access: ◆ Notes:
Decedent Storage <input type="checkbox"/> Identified morgue overflow area <input type="checkbox"/> Portable refrigeration equipment <input type="checkbox"/> Generators for lights or air conditioning <input type="checkbox"/> Ropes, caution tape, other barricade equipment	◆ Storage area: ◆ How to access: ◆ Notes:

APPENDIX D

FORMS

Decedent Information and Tracking Form

Incident Name		Operational Period		
Date	Time	Medical Record/Triage #	Hospital Location (prior to Morgue)	
First Name	Middle Name	Last Name	Age	Gender
ID Verified by: <input type="checkbox"/> Drivers License <input type="checkbox"/> State ID <input type="checkbox"/> Passport <input type="checkbox"/> Birth Certificate <input type="checkbox"/> Other _____ Identification # _____ 				
Address (Street Address, City, State, ZIP)				
List Personal Belongings		Storage Location		
Next of Kin Notified <input type="checkbox"/> Yes <input type="checkbox"/> No	Name	Relation	Contact #	
Status	Location	Date / Time IN	Date / Time Out	
Hospital Morgue				
Alternate Morgue				
Alternate Morgue				
Alternate Morgue				
Record Created in EDRS <input type="checkbox"/> Yes <input type="checkbox"/> No	Death Certificate Signed <input type="checkbox"/> Yes <input type="checkbox"/> No	Photo Attached <input type="checkbox"/> Yes <input type="checkbox"/> No	Fingerprints Attached <input type="checkbox"/> Yes <input type="checkbox"/> No	
Final Disposition	Date/Time	Name of Recipient	Signature of Recipient	
Released to: <input type="checkbox"/> Coroner <input type="checkbox"/> County Morgue <input type="checkbox"/> Mortuary <input type="checkbox"/> Other _____				

File Original with Medical Record
Copy with Decedent
Copy to Mass Fatality Branch Director

[illegible]

~~File with Mass Fatality Branch Director~~

~~Family Assistance Center~~ Family/Friend Registration Form

Last Name			First Name			MI		
Last Name			First Name			MI		
SS#			Relationship to Potential Victim					
Permanent Street Address								
City			State			Zip		
Phone Number(s)								
Photo Identification Verification (type, #, state/country)								
Medication/Medical Needs <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe below:								
Physicians Name					Physicians Phone #			
Next of Kin to Potential Victim <input type="checkbox"/> Yes <input type="checkbox"/> No If no, name next of kin:								
Other Notes								
Last Name			First Name			MI		
Last Name			First Name			MI		
Last Name			First Name			MI		
Last Name			First Name			MI		

APPENDIX

FAITH BASED AND CULTURAL ISSUES

BUDDHIST

- After death, the body of the deceased may be handled by non Buddhists. In some cases a monk may perform some additional chanting, but this is not a universal practice. There are no objections to post mortems.

- Preparation of the body for the funeral is generally left to the undertaker, but in some instances relatives may also wish to be involved. The deceased may be put in a coffin, or wrapped in cloth (sometimes white), or dressed in the deceased's own clothes. The deceased may be surrounded by candles, flowers, incense, photographs and colored lights, but this is a matter of individual choice and there are no hard and fast rules. The deceased is usually cremated, at a time dependent upon the undertaker and the availability of the crematorium's facilities.

CHINESE (CONFUCIANISM, TAOISM, ASTROLOGY, CHRISTIANITY)

- After death, undertakers handle the deceased. Some undertakers in areas with long established Chinese populations are accustomed to Chinese needs such as embalming and the deceased being fully dressed in best clothes including shoes and jewelry. In such areas some cemeteries have a Chinese section.
- Burial or cremation may take place a week after the person has died. If the deceased is a child, parents usually do not want to visit the mortuary. A sibling or close relative would be asked to deal with any viewing of the deceased.

CHRISTIANS

- The choice between cremation and burial can either be a matter of personal choice or a denominational requirement. In all cases, the wishes of the deceased's family, or friends, should be sought if possible. If this cannot be done, then Christians should be buried.

CHRISTIAN SCIENTISTS

- Questions relating to care of the body should be answered by the individual's partner/ family. In general, Christian Scientists request that, whenever possible, the body of a female should be prepared for burial by a female. The individual's family should answer questions relating to post mortem examinations.

CHURCH OF JESUS CHRIST OF LATTER-DAY SAINTS (MORMONS)

- The Church takes no position on post mortem examinations. Church or family members will usually arrange for the deceased to be clothed for burial.
- Burial rather than cremation is recommended by the Church, but the final decision is left for the family of the deceased.

HINDUS

- It is preferred if all Hindu bodies can be kept together after death. A deceased Hindu should be placed with the head facing north and the feet south.
- Cleanliness is important and the body can be undressed and cleaned, but the family should be consulted where possible. The arms should be placed to the sides and the legs should be straightened. The face should be pointed upward with eyes closed and the whole body must be covered with white cloth. Any detached body parts must be treated with respect as if they were a complete body. Post mortems are permitted, usually with prior agreement of the immediate family.
- When a person dies their body is washed, dressed in new clothes and flowers are placed around it.
- The bereavement in the family lasts a minimum of two weeks during which several rituals are followed. Hindus believe in cremating the body so that the soul is completely free of any attachment to the past physical matter.

HUMANIST

- No specific requirements. The choice between cremation and burial is a personal one, although cremation is more common. Most will want a humanist funeral, and crosses and other religious emblems should be avoided. However, since many humanists believe that when someone dies the needs of the bereaved are more important than their own beliefs, some may wish decisions about their funeral and related matters to be left to their closest relatives.

JAIN

- There are no specific rituals in Jain philosophy for this event. Bodies are always cremated and never buried except for infants. Cremation must be performed as soon as practicable, even within hours if possible, without any pomp. Many Jains still pursue Hindu customs as a family preference. All normal practices of undertakers are acceptable if handled with respect. The family normally provides the dress and accessories for the preparation and final placement in the coffin.

JEHOVAH WITNESS

- If a post mortem is required by law, the wishes of an appropriate relative should be ascertained and, if possible, their wishes observed. The dead may be buried or cremated, depending on personal or family preferences and local circumstances.

JEWISH

- The prompt and accurate identification of the dead is particularly important for the position of a widow in Jewish law. Post mortems are forbidden unless ordered by the civil authorities. Body parts must be treated with respect and remain with the corpse if possible. When a person dies, eyes should be closed and the jaws tied; fingers should be straight. The body is washed and wrapped in a plain white sheet, and placed with the feet towards the doorway. If possible it should not be left unattended. For men a prayer shawl, *tallit*, is placed around the body and the fringes on the four corners cut off.
- The *Chavra Kadisha* (Holy Brotherhood) should be notified immediately after death. They will arrange the funeral, if possible before sunset on the day of death, but will not move the body on the Sabbath. Coffins are plain and wooden (without a Christian cross). Someone remains with the body constantly until the funeral. It is not usual to have floral tributes. Orthodox Jews require burial but Reform and Liberal Jews permit cremation.
- The burial should take place as quickly as possible after death. The body should not be left alone as this is thought to be disrespectful. The body will be washed thoroughly, male bodies by men and female bodies by women. It is then placed in a simple unpolished box with no handles and padding. This is to symbolize that in death all are equal, despite personal wealth.

MUSLIM

- As a Chaplain, in a death situation you should **NEVER** touch the body, whether male or female. The safest guideline is also to never touch a family member. The best advice for viewing the deceased after death would be to escort the family in and then stand off to the side, out of the line of sight. You are there to help if needed, not pretend to be part of the family. Try to identify who is the effective leader within the family. That person should be the one approached with practical details, rather than presuming that it would be the next of kin.
- Muslim dead should be placed in Holding Areas or temporary mortuaries, and ideally be kept together in a designated area (with male and female bodies separated). Post mortems are acceptable only where necessary for the issue of a death certificate or if required by the coroner.
- Ideally only male Muslims should handle a male body and female Muslims a female body. The body should be laid on a clean surface and covered with a plain cloth, three pieces for a man and five for a woman. The head should be turned on the right shoulder and the face positioned towards Makkah.
- As soon as possible after death the body is given a ritual washing called Ghusl. This is to wash away all sin so the body can meet Allah in a pure state. The deceased is anointed with perfumes and spices and wrapped in white cloth, usually the Ihram clothes used for the Hajj. This ritual is the same for rich and poor, in death, Muslims believe all are equal.
- Muslims try to bury the deceased within 24 hours of death if possible. They believe that the soul departs at the moment of death. The deceased is placed with their head facing the Muslim holy city of Makkah.
- Ritual washing is performed usually by family members or close friends, usually according to the sex of the deceased. The body is wrapped in a shroud of usually simple, white material. Afterwards, salat (prayers) will be said for the deceased.
- Next of kin or the local Muslim community will make arrangements to prepare the body for burial. Muslims believe in burying their dead and would never cremate a body. Burial takes place quickly, preferably within 24 hours.

SIKH

- The five Ks (5 Ks are five physical symbols worn by Sikhs i.e. underwear 'kaachha'; wristband 'kara'; sword 'kirpan' unshorn hair 'kes' and comb 'kanga') should be left on the dead body, which should, if possible, be cleaned and clothed, in clean garments before being placed in a coffin or on a bier. According to Sikh etiquette, comforting a member of the opposite sex by physical contact should be avoided, unless those involved are closely related. Deliberate expressions of grief or mourning by bereaved relatives are discouraged, though the bereaved will want to seek comfort from the Sikh scriptures. The dead person should always be cremated, with a close relative lighting the funeral pyre or activating the machinery. This may be carried out at any convenient time. The ashes of the deceased may be disposed of through immersion in flowing water or dispersal.

Source: London Mass Fatality Plan, March 2007, Version 2.

APPENDIX F
INFORMATION RESOURCES

- American Board of Forensic Anthropology (ABFA)
<http://www.csuchico.edu/anth/ABFA>
- American Board of Forensic Odontology (ABFO)
<http://www.abfo.org>
- American Red Cross
<http://www.redcross.org>
- American Society of Forensic Society of Forensic Odontology (ASFO)
<http://www.asfo.org>
- Centers for Disease Control and Prevention (CDC)
<http://www.cdc.gov>
- Disaster Mortuary Operational Response Teams (DMORT)
<http://www.dmort.org>
- Environmental Protection Agency
<http://www.epa.gov>
- Federal Bureau of Investigation
<http://www.fbi.gov>
- Federal Emergency Management Agency
<http://www.fema.gov>
- Federal Aviation Administration
<http://www.faa.gov>
- National Association of Medical Examiners (NAME)
<http://www.thename.org>
- National Transportation Safety Board (NTSB)
<http://www.nts.gov>
- Occupational Health and Safety Administration (OSHA)
<http://www.osha.gov>
- US Department of Transportation (DOT)
<http://www.dot.gov>

**CONFIRMATION
OF**

~~ROOM EVACUATION~~

~~Verification of Room Evacuation~~

The supervisor or designee in the department will conduct verification of evacuation from every room. The rooms, offices and general spaces will be verified to be empty of patients, visitors or staff and would be identified with a large X, on the closed door doorframe.

~~Patient Care Units~~

The Charge Nurse will assume responsibility of evacuation verification of their department. This nurse will ensure that all patient rooms are empty, and doors are closed, and will check all automatic doors to ensure they have closed fully. If relocation is required, they will designate someone to take the patients' records with them to ensure patient identification and care if patients need to be moved to another area. Move patient records with the patients if possible. The closed and evacuated door will be indicated with a large X, placed on the door-frame.

~~Testing the Verification of Room Evacuation~~

The room verification plan will be tested during some emergency preparedness exercises and fire drills. The critique of the plan will be included in the drill report form and reviewed for improvements. The exercise will include a post it note or sticker for verification of simulated evacuation.

~~Communication with Local Authorities~~

The department manager or senior staff member will notify the command center that all patients, staff, and visitors have been evacuated from the area. The Incident Commander or designee will notify the local law enforcement or fire department that the areas have been evacuated.

~~Accounting for Staff, Visitors, and Non-employees~~

The department manager will be responsible for verifying that all staff, visitors, and non-employees are evacuated from their areas. These individuals will proceed to the designated evacuation route and congregation area.

~~TRAINING ACTIVITIES~~

~~Evacuation Training Activities~~

The training of staff on the evacuation procedures will be provided during orientation and departmental training sessions as well as during fire and disaster drills. If conducted, the evacuation drill will include the simulation of evacuated patients, tracking, forms, methods of evacuating with use of resources, verification of evacuation, alternate care site establishment and recovery.

EMERGENCY OPERATIONS PROCEDURE MANUAL

TRI-CITY MEDICAL CENTER Emergency Preparedness	Section: Emergency Preparedness Management Disaster Plan Subject: Acute Care, Orthopedics, and Rehabilitation Unit Specific Policy Number: 4014 Page 1 of 2
Department: Department Specific	EFFECTIVE: 10/88 REVISED: /91, 3/97, 2/00, 10/02, 4/03, 10/05, 11/05

ISSUE DATE: 10/88

SUBJECT: Emergency Management Plan:
 Inpatient Nursing Units ~~Acute Care,~~
~~Orthopedics and Rehabilitation Unit~~
 Specific

REVISION DATE: 10/91, 9/97, 2/00, 10/02, 4/03, 10/05, 11/05 **POLICY NUMBER:** 4014

Department Approval: 02/22
 Environmental Health and Safety Committee Approval: 03/15
 Medical Executive Committee Approval: n/a
 Administration Approval: 03/22
 Professional Affairs Committee Approval: n/a
 Board of Directors Approval:

A. PURPOSE:

1. To provide guidelines for inpatient units in the event of an emergency formerly known as disaster. Inpatient units include the following:
 - a. Intensive Care Unit (ICU), 1-East, 1-West
 - b. Telemetry: 2-East, 2-West, 4-East, 4-West, and 3 Pavilion
 - c. Progressive Care Unit (PCU)
 - d. Acute Care Services (ACS): 2 Pavilion, 4 Pavilion, 1-North
 - e. Acute Rehabilitation Unit (ARU)
- ~~1. To establish clear guidelines for staff to follow during a disaster.~~
- ~~2. To ensure continuance of efficient and effective Acute Care, Orthopedic, and rehabilitation Unit Services (including the Pavilion, One North, and the Rehabilitation Unit) during a disaster~~
2. To maintain adequate availability of personnel and supplies during an internal or external disaster.

B. DEFINITIONS:

1. Emergency Types:
 - a. External emergency facing the community
 - b. Internal emergency involving the functions of the hospital, or the treatment and care of patients are no longer sustainable at the hospital
- 3-2. Department Leaders: Directors, Clinical Manager, Supervisors, Educators, Charge Nurse on duty
3. Workforce Member: Employees, Medical Staff, Allied Health Professionals (AHP), volunteers, trainees, Business Visitors, Covered Contractors and other persons whose

conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.

B.C. PROCEDURE:

1. Due to the varying types and magnitudes of emergency events, Tri-City Healthcare District (TCHD) has adopted the command structure of Hospital Incident Command System (HICS).
 - a. Once the decision has been made to activate the emergency management plan, the HICS becomes the standard operating procedure.
 - b. The complete plan is located in the TCHD Emergency Operations Plan Management Manual (formerly known as Disaster Plan).
 - c. **French Rooms 1 and 2 are designated as the Incident Command Center (ICC).**

C. INTRODUCTION Director

Clinical Manager
Charge Nurse
RN
LVN
ACT
Unit Secretary
Orthopedic Technician

D. NOTIFICATION:

1. ~~The Acute Care, Orthopedic, and the Rehabilitation Units will be notified of the Disaster Plan Activation from the PBX operator announcing "CODE ORANGE" or "CODE YELLOW" using the overhead page. Following announcement of the "CODE ORANGE" or "CODE YELLOW", the HEICS system is immediately activated. The Incident Command Center is located in French Room 1.~~
1. **In the event of an internal or external emergency, departments will be notified via the overhead paging system.**
2. **Management of staff**
 - a. **Staff will be notified by their respective area lead staff via telephone / text 24 hours per day, 7 days per week.**
3. **Management (department/unit leaders) responsibilities following the activation of the Emergency Management plan or drill include, but is not limited to the following:**
 - a. **Department Clinical Leaders: On Campus (within facility)**
 - i. **Respond to ICC and assume responsibilities as directed by the Incident Commander (IC)**
 - b. **Department Clinical Leaders: Off Campus (not within facility)**
4. **Clinical Leader or designee will:**
 - a. **Assign a workforce member to begin the call back process (calling staff off-duty) as instructed by the IC.**
 - b. **Workforce members' task assignments include but are not limited to the following:**
 - i. **Complete the workforce member inventory list**
 - ii. **Provide a copy of the workforce member inventory list to the Labor Pool leader.**
 - c. **Assign workforce member(s):**
 - i. **To the Labor Pool located in Assembly Room (AR) 3, this room is subject to change and if change, will be identified by the ICC.**
 - ii. **As a runner**
 - iii. **To continue to provide patient care**
 - d. **Request all patients and visitors remain in the patient's room**
 - e. **Assess and identify the following:**
 - i. **Current unit census**
 - ii. **Bed availability**

- iii. Patient requiring supplementation treatment devices such as ventilators, oxygen
 - iv. Patients that may be:
 - 1) Discharged, transferred or relocated to another location for care.
 - a) Patients will be discharged from a location identified by the IC to ensure there is adequate patient egress. This also includes visitors on the unit.
 - f. Maintain a list of the discharged, transferred and relocated patients. Inform the Administrative Supervisor of each patient status.
 - i. Ensure the patient's support person(s) are notified of their plan for discharge, transfer or relocation.
 - g. Identify the workforce members that will be responsible for meeting patients' immediate needs.
 - 1) Routine patient care will be re-prioritized based on the nature of the emergency. Routine care may be discontinued until all casualties from the emergency are admitted or until the emergency no longer exists.
 - h. Collect emergency equipment such as flash lights, Cerner downtime forms, etc.
 - i. Assign a workforce member to perform the following:
 - i. Registered Nurse - Inventory of supplies. Ensure the inventory include supplies located in the Pyxi
 - ii. Advanced Care Technician, Unit Secretary and Patient Mobility Technician (PMT) task may include the following:
 - 1) Collecting all of the vital machines, manual blood pressure devices, intravenous pumps, portable pulse oximeter and other equipment as instructed by the Clinical Leader or designee
 - j. Prepare staff to receive patients from the Emergency Department, Surgical Services, and higher levels of care as necessary
5. In the event that the department is the location of the emergency, prepare patients for evacuation as directed by the IC. (See the Evacuation Plan for details on evacuating patients).
6. Workforce Members Responsibilities
- a. Staff
 - i. On duty workforce members:
 - 1) if off the unit will return to the unit/department immediately
 - 2) Assume duties as assigned by clinical leaders.
 - 3) Re-prioritize patient care as directed based on the nature of the emergency
 - ii. Off duty workforce members:
 - 1) On arrival to the hospital, report the Labor Pool
 - b. Leadership
 - i. Orient and educate staff to the unit and hospital's Emergency Management Plan
 - ii. Maintain and update the unit's emergency Management plans
 - iii. Maintain and update the unit's call-back emergency list
7. Contact off duty staff if required using the call back emergency list.
8. Ensure staff are familiar with their responsibilities

E. RELATED DOCUMENT(S):

2-1. Emergency Operations Procedures Manual: Emergency Operations Plan

Director Responsibilities:

4.1.1 Respond to the Incident Commander if in-house. Assume responsibilities as directed by the Incident Commander.

4.1.2 Respond to Department if not assigned responsibility by the Incident Commander.

~~4.1.3 If notified of a Disaster while away from the facility, respond to the Incident Command Center as soon as possible and if able.~~

~~4.2 Clinical Manager/Charge Nurse Responsibilities:~~

~~4.2.1 The Clinical Manager/Charge Nurse is in charge of the department during a disaster.~~

~~4.2.2 Assign a staff member to report to the Incident Command Center to obtain a briefing about the extent of the Disaster and to receive an assignment if indicated.~~

~~4.2.3 Assign a staff member to begin call back process (calling staff in via call back phone list) as instructed.~~

~~4.2.4 Forward staff personnel inventory list to the Labor Pool.~~

~~4.2.5 Assign a staff member to obtain the HEICS emergency box (located above the staff lockers) and place at the nursing station.~~

~~4.2.6 Assess available staff and assign 1 RN from 1 N, 2, 3 and 4 Pav. And 2 ACTs, to report to Labor Pool (Assembly Rooms 3). Assess accurate unit census and immediate available beds. Evaluate patients who could be discharged, transferred or moved to another area for care. Discharge patients from the PT Gym to make room for minor care patient egress. Maintain list and notify Patient Placement Coordinator of status.~~

~~4.2.7 Assign a staff member to perform inventory of supplies. Inventory should include assessment of available Pyxis supplies and a list of anticipated additional supplies as needed.~~

~~4.2.8 Assign a staff person to be a runner if needed.~~

~~4.2.9 Assign ACT to round up all available B/P, IV Pump equipment.~~

~~4.2.10 Ensure staff have notified patients and visitors of events and re-assured that their needs will be met. Request patients remain in their room.~~

~~4.2.11 Assist staff to re-prioritize patient care based on the nature of the disaster. Routine patient care may be discontinued until all disaster casualties have been admitted to the unit or until the emergency no longer exists.~~

~~4.2.12 Prepare staff to receive patients from the Emergency Department, Surgery, and higher levels of care as necessary.~~

~~4.2.13 In the event that the department is the location of the disaster, patients will be appropriately evacuated, horizontally or vertically, and all available employees will report to the Labor Pool, (Assembly Room 3) for re-assignment.~~

~~4.3 Staff Responsibilities:~~

~~4.3.1 On duty staff off the unit will return to the unit immediately.~~

~~4.3.2 Assume duties as assigned by Clinical Manager/ Charge Nurse. Re-prioritizes patient care as directed based on the nature of the disaster.~~

~~4.3.3 Off duty staff are responsible to report to the Labor Pool (Assembly Room 3) if called in, unless otherwise directed by the Clinical Manager/ designee. Acute Care Staff are responsible for the Minor Care Triage and Treatment Areas.~~

~~4.3.4 Off duty staff are responsible to wear their I. D. badges in order to be admitted to the facility. Staff should bring a stethoscope if available.~~

~~4.4 Clinical Manager Responsibilities:~~

~~4.4.1 Orient and educate the staff to the disaster plan.~~

~~4.4.2 Maintain an updated version of the disaster plan and call-back roster.~~

Emergency Preparedness Management

EFFECTIVE DATE: 6/03

SUBJECT: Identification of Staff and
Incident Command Leaders Staff:
Hospital Wide

REVISION DATE:

REVIEW DATE: 10/05

POLICY NUMBER: 4074

Department Approval:

02/22

Environmental Health and Safety Committee Approval: 03/1503/22

Medical Executive Committee Approval:

n/a

Administration Approval:

03/22

Professional Affairs Committee Approval:

n/a

Board of Directors Approval:

CROSS REFERENCE: APPROVAL:

1.0 PURPOSE:

~~To Establish Identification Criteria and Roles of TCMC Staff During a Disaster.~~

A. PURPOSE:

1. To identify the process for identifying Hospital Incident Command System (HICS) staff roles during an internal or external disaster.

B. DEFINITION(S):

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

C. POLICY:

1. HICS staff will be identify as outlined in the HICS Command Structure Hospital Wide policy.
2. Colored vest will be provided to each HICS staff, as warranted, with the following assigned titles:
 - a. Incident Commander
 - b. Safety and Security Officer
 - c. Liaison Officer
 - d. Public Information Officer
 - e. Operations Chief
 - f. Logistics Chief
 - g. Planning Chief
 - h. Finance Chief
3. Each vests will be:
 - a. Issued by the Incident Commander or designee
 - b. Maintained within the Incident Command Kit, located in the Incident Command Center e.g., the French Rooms 1 & 2
 - a-c. Issued with the following:
 - i. Job Action Sheet Package
 - ii. A clipboard with its respective Job Action Sheet
 - iii. Pens
 - iv. Flashlight and other relevant supplies

- d. May be assigned to staff not listed above per the Incident Commander or designee
- 4. Identification of Employees
 - a. All employees are required to wear their photo identification (ID) badge
 - b. ~~Staff~~Workforce members without their hospital issues ID badge will be required to obtain temporary badges from Security after presenting appropriate alternative identification and the identification is vested by department leaders or designee
 - 2-c. Hospital badges will be worn per policy.
- 5. Identification of Outside Agencies
 - a. Uniformed outside agencies, including police, fire and other public safety agencies in uniform will be allowed in the facility during emergencies without further identification.
 - i. If there are questions, they will be requested to provide official identification (ID)
- 6. Outside Agency Staff Not in Uniform:
 - a. Representatives of outside agencies who are not in a clearly defined uniform will be asked to provide appropriate identification, such as an official badge or ID card.
 - b. They will be provided with a "Disaster ID Badge" maintained by Security
 - i. The badges will be available at the Main Entrance Security Desk
 - ii. The outside agency staff will required to check-in with Security
- 7. Other Special Visitors or Authorities:
 - a.i. Others who have an appropriate reason to be within the facility during emergency situations, will also be asked to identify themselves at the Main Entrance Security Desk, and will be issued badges as deemed appropriate by the Incident Commander, the Liaison Officer or Safety/Security Officer.

2.0 — POLICY:

To assist with external volunteer identification during a disaster.

2.1 Incident Command Staff

2.1.1 Colored vests identify Incident Command Staff with job title tags during emergencies for ease of identification. These vests are used by:

2.1.1.1 Incident Commander

2.1.1.2 Safety and Security Officer

2.1.1.3 Liaison Officer

2.1.1.4 Public Information Officer

2.1.1.5 Operations Chief 2.1.1.6 Logistics Chief 2.1.1.7 Planning Chief 2.1.1.8 Finance Chief

2.1.2 Vests are maintained with the Incident Command Kit, kept in the Incident Command Center located in the French Rooms 1 & 2 and issued with the Job Action Sheet Packages by the Incident Commander, or on their authority.

2.1.3 Each vest is packaged with a clipboard with its respective Job Action Sheet, pens, flashlight and other relevant supplies, in readiness for immediate use. Upon activation of the Incident Command System, the Incident Commander or other designated staff will distribute the vests and supplies to the appropriate staff.

2.1.4 Other identified jobs may use vests for ease of recognition by hospital staff, and the public.

2.2 — Disaster Identification of Staff

2.2.1 During an implementation of the Incident Command System, or other emergency event, Tri-City Medical Center Photo Identification Badge is used for access to the facility. Staff and Physicians without badges will not be admitted. Security Staff, as available during the event, may be authorized to issue temporary badges to staff who can demonstrate appropriate alternate identification and are identified and vetted by staff available in house.

2.2.2 Hospital staff member and other care providers will be required to carry their ID

badges, and have them available if called back into the facility during emergencies. If staff personnel are present without ID cards, they will be directed to the Main Entrance Security Desk, who will be charged with issuing emergency temporary badges as deemed appropriate. Staff without badges will not be admitted without emergency temporary badges.

23 Disaster Identification of Outside Agencies

2.3.1 Uniformed Outside Agencies, including police, fire and other public safety agencies in uniform will be allowed in the facility during emergencies without further identification. If there are questions, they will be requested to provide official ID cards.

2.3.2 Outside Agency Staff Not In Uniform: Representatives of outside agencies who are not in a clearly defined uniform will be asked to provide appropriate identification, such as an official badge or ID card. They will be provided with a "Disaster ID Badge" maintained by Security for this situation. As practical, these badges will be available at the Main Entrance Security Desk, and persons with such badges or ID cards will be asked to check in at that location.

2.3.3 Other Special Visitors or Authorities: Others who have an appropriate reason to be within the facility during emergency situations, will also be asked to identify themselves at the Main Entrance Security Desk, and will be issued badges as deemed appropriate by the Incident Commander, the Liaison Officer or Safety/Security Officer.

TRI-CITY MEDICAL CENTER Emergency Preparedness	Section: Emergency Preparedness Management Disaster Plan Subject: Administrative Coordinators Policy Number: 4086 Page 1 of 2
Department: Department Specific	EFFECTIVE: 10/05 REVISED: 2/06



Tri-City Medical Center
Oceanside, California

EMERGENCY OPERATIONS PROCEDURE MANUAL

ISSUE DATE: 10/05 **SUBJECT:** Administrative Supervisors

REVIEW DATE: **POLICY NUMBER:** 4086
REVISION DATE: 2/06

Department Approval Date: 02/22
Environmental Health and Safety Committee Approval: 03/15
Medical Executive Committee Approval: n/a
Administration Approval: 03/22
Professional Affairs Committee Approval: n/a
Board of Directors Approval:

A. PURPOSE:

1. To establish the responsibilities of the Administrative **Supervisor (AS)** Coordinator and to ensure efficiency and proficiency setting up and supervising the command center (until relieved by an Administrator) in the event of a disaster.

B. INTRODUCTION:

1. Due to the varying types and magnitudes of emergency events, Tri-City Medical Center has adopted the command structure of the Hospital ~~Emergency Incident Command System (HEICS)~~. Once the decision has been made to activate the disaster plan, the HEICS becomes the standard operating procedure. ~~The complete plan is located in the TCMC Fire Safety and Disaster Plan Manual located in the Blood Bank.~~

C. NOTIFICATION:

1. MICN to activate Annex D (mass casualty).
- ~~1-2.~~ **Emergency Department (ED)** ~~D~~ will notify the **AS** ~~calls AC to~~ to activate a disaster using the appropriate code i.e., -Code Orange/Yellow.

D. DISASTER PLAN PROCEDURE:

1. Get scenario.
2. Call the **Public Broadcast Exchange (PBX)** X – 66
 - a. Page Code Orange/Yellow
 - b. Turn on red phones (numbers are in Chapter 2).
 - c. Call ~~s~~Security (66) for lockdown if event is unknown.
3. Get disaster manual.
4. Go to French Room
 - a. Get out box/radios
 - b. Assign Recorder/Secretary role(s)
 - c. Assign 5 other main roles and hand out batteries for radios as needed.
 - i. **Safety/Security**
 - ii. **Logistics** (Communication, Transportation, Supplies, Damage

- Assessment, Sanitation, Nutrition)
- iii. **Planning** (Labor Pool, Medical Staff)
- iv. **Operations** (Medical Staff Director, Surgical, **Women's Children Services, MCH Intensive Care Unit, ACCU, Lab, Radiology, Cath Lab, Triage**)
- v. **Liaison** (in communication with county/other hospitals)
- d. Tell leaders to read information sheet completely.
- e. Send Immediate Treatment Area Leader to ED to open their box (given them radio for communication)
- f. Gather information from messages sent from units
- 5. Turn over Incident Commander role to Administrator upon their arrival and return to role as **ASG**.

E. **MISCELLANEOUS:**

1. If 6 or more contaminated patients, activate "Code Orange Decon" team via PBX (66), **if 16 or greater** activate **"Code Orange Decon Tent"** Team via PBX (66).
2. Identify resources, evaluate scenario, control situation.
3. Utilize SPRA for urgent (yellow) patients; ED Patio for 'green/walking wounded' Triage and Rehab treatment of the walking wounded, if needed. They can be blocked off.
4. Radios will be labeled with proper channels.
5. Labor Pool to gather in assembly rooms (Staff Support).
6. MD's to gather in Physician's Dining Room (extension 7424).
7. Decon Team consists of EVS, Lift Team, Security and Food/Nutrition
8. If biological event occurs, shut off **Heating Ventilation and Air Condition** (HVAC (air intake) by Engineering.
9. Psych liaison/chaplain to support as needed. ~~BHU for those in need of Mental Health evaluation after rapid triage/medical clearance by assigned Physician.~~
10. Disaster Call-back list in Staffing Office.

Emergency Operations Procedure Manual
Special Circumstances

ISSUE DATE: NEW

**SUBJECT: Code Yellow – Radiation Disaster,
Treatment of the Contaminated
Patient**

REVISION DATE:

Department Approval:	07/21
Environmental Health & Safety Committee Approval:	03/15
Medical Executive Committee Approval:	n/a
Administration Approval:	03/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. PURPOSE:

1. To outline the facilities:
 - a. Radiation disaster response plan and the process for identifying and treating contaminated patients in the event of a disaster or emergency involving radioactive materials.
 - b. Basic approach to a radiological incident that will ensure that the safety and health of staff, patients, the public and the environment are protected.

B. DEFINITIONS:

1. External Contamination – Radioactive material that gets on your skin, hair, or clothing
2. External Radiation Emergency – Radiation emergency occurring in the community
3. Internal Contamination – Radioactive material that gets inside your body
4. Internal Radiation Emergency – Radiation emergency occurring within Tri-City Hospital District's (TCHD) campus
5. Radiation (Ionizing) – Alpha particles, beta particles, gamma rays, x-rays, neutrons, high-speed electron, high-speed protons, and other particles capable of producing ions. Radiation used in this part, does not include non-ionizing radiation, such as radio or microwaves, or visible infrared, or ultraviolet light (Title 10 Code of Federal Regulations, Part 20).
6. Radiation Exposure – A measure of the amount of ionizing radiation that interacts with your body
7. Ionizing Radiation – Energy that is given off from radioactive materials that is strong enough to damage cells in the body. High doses of ionizing radiation can cause serious illness or even death.
8. Thermoluminescent dosimeter (TLD) – A device (badge) worn and used to measure the radiation dose that an individual may receive while attending patients undergoing therapeutic or diagnostic procedures with radionuclides or while working with x-ray generating devices.
9. Code Yellow – Alert title used to notify hospital staff of radiation emergencies.

C. POLICY:

1. TCHD shall provide radiological support for individuals contaminated internally and externally with radioactive material.
2. In the event of a radiation emergency, TCHD staff will immediately:
 - a. Call a Code Yellow by dialing "66" to inform the Public Broadcasting Exchange (PBX) operator.
 - b. The PBX operator announce three (3) times over the PBX system.
 - c. PBX operators will notify the Code Yellow response call list.

3. The following external support resources will be notified by the Emergency Department (ED) designated staff:
 - i. San Onofre Nuclear Generating Station (SONGS)
 - 1) If a SONGS support staff is not available contact one of the following:
 - a) Quality Assurance Services, Inc. (619) 428-1003
 - b) Radiation Management Consultants (619) 481-1000
4. The Administrative Supervisor (AS) or designee will assume the role of Incident Commander administrator-on-call (AOC) or delegate the responsibility to the most qualified individual.
5. The Incident Commander will
 - a. Activate the Command Center (CC)
 - b. Activate the positions identified within the Hospital Incident Command System (HICS) that are necessary as determined by the situation
6. Available members of the Code Yellow response list will meet in the Command Center
7. The ED designee will verify security received notification, contact SONGS and initiate the Initial Notification Log.
8. All staff entering the Contamination Injury Room will don protective clothing per the package insert instructions and label the front and back of the protective clothing with the initials of their title e.g., MD, RN, EMT, ACT, RT.
9. All protective clothing will be removed per the Removal Sequence listed on the Protective Clothing package insert.
10. Public Relations / External Affairs
 - a. The External Affairs Director or designee designated TCHD spokesperson in conjunction with the Incident Command Center will:
 - i. Organize and control all contact with the news media
 - ii. Setup a press room and identify a designated entrance for the news media personnel
 - iii. Control the designated press rooms and main lobby media traffic.
 - iv. Verify news media personnel identification
 - v. Ensure the release and flow of information to the media is according to TCMC policy press releases and press conferences in coordination with the Disaster Control Center.
11. Staff roles and responsibilities see Addendum A
12. Decontamination,
13. Staff Education
 - a. Education for radiation safety will be provided annually for all staff using a computer base learning (CBL) module
 - b. Disaster (radioactive emergency) drills will be conducted per regulatory and state requirements.

D. **FORM(S):**

1. Initiation Notification Log
2. Dosimetry Issue Log
3. Decontamination Log
4. The Emergency Care of the Contaminated Patient, Responding to Radiation Accidents – Dressing Sequence

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

1. Addendum A – Radiation Disaster (Code Yellow) Response Team Responsibilities
2. Addendum B – Decontamination, Patient Egress and Recovery
3. Addendum C – Donning and Doffing for Radiation Emergencies

F. **REFERENCES:**

1. Title 17, California Code of Regulations, Division 1, Chapter 5
2. Title 10 Code of Federal Regulations, Part 20 (10 CFR 20)
3. Title 10 Code of Federal Regulations, Part 35 (10 CFR 35)

Addendum A

Radiation Disaster (Code Yellow) Team Responsibilities

All staff

- Verify the room designated as the Contamination Injury Room.
 - Don protective clothing per the package insert instructions.
 - Label the front and back of the protective clothing with the initials of their title e.g., MD, RN, EMT, ACT, RT prior to entering the patient treatment area and the Contamination Injury Room.
1. Security
 - a. Contact the Emergency Department (ED) charge nurse to identify if the patient will arrive by air or ground.
 - b. Secure the patient treatment area and restrict access to the area to all but required personnel.
 2. Environmental Services (EVS)
 - a. Retrieve Disaster Carts (2 each) from lower-level storage room and deliver to the patient treatment area in the ED.
 - b. Assist with the setup of the patient treatment area and Contaminated Injury Room Setup
 - c. Place decontamination wash down device on the gurney and secure.
 - i. Ensure the drain port is at the foot end (bottom) of the gurney.
 - d. Remove unnecessary items from the room and cover equipment that cannot be removed from the room with a plastic.
 - e. Tape edges of floor coverings
 - f. Rope off restricted area(s)
 - g. Assist with preparing the buffer zone
 - h. Place plastic liners in all barrels
 - i. Post instruction signage
 3. Facility
 - a. Verify the room assigned as the Contaminated Injury Room.
 - b. Assist with the setup of patient treatment area and Contaminated Injury Room.
 4. Radiation Safety Officer (RSO) or Nuclear Medicine (NM) Technician
 - a. Ensures all radiological safety practices are implemented.
 - b. Perform a battery check on all survey instruments e.g., dosimeters
 - i. Dosimeters shall be checked per manufacture recommendations
 1. Remove all dosimeters that are not within the acceptable range for use
 - c. Prior to entering the Contaminated Injury Room cover probe of GM with a glove to protect it from contamination
 - d. Turn on dosimeter and suspend approximately 5 feet above the center of the Contaminated Injury room.
 - i. Check dosimeter hanging in the room every 15 minutes for exposure reading
 1. Monitor dosimeter readings to limit staff exposure e.g., 100mR
 - ii. Ensure the GM probe is consistently one inch above patient at all times. Move the probe at an approximate rate of 2 inches per second.
 - e. Issue a thermoluminescent dosimeter (TLD) to all staff entering the Contaminated Injury treatment area.
 - f. Document on the following Dosimeter Issue Log
 - i. Name of staff
 - ii. TLD badge number
 - iii. Initial reading
 - g. Perform radiation surveys of staff using the GM meter as requested by the treatment team or radiation support staff.
 - h. Surveyed all staff entering and leaving the Contaminated Injury Room and surrounding contaminated zones.
 - i. Monitoring patient and perform other duties as directed by the ED physician, SONGS personnel, or the RSO.
 - j. Patient Surveys and Decontamination Attempts Responsibilities

- i. Perform an initial survey of the patient upon arrival. Document results on the Decontamination Record.
 - ii. Perform additional surveys as requested. After each decontamination attempt record all results on the Decontamination Record.
 - k. Ensure staff are scanned using GM meter for radioactive contamination before allowing them to leave the treatment area.
 - i. Staff must be free of radioactive contamination.
 - l. Survey equipment
 - m. Collect TLD badges and document the Dosimeter Final reading on the Dosimetry Issue Log
5. Patient Treatment Team (Emergency Department Staff)
 - a. ED Personnel shall consist of the following:
 - i. Physician
 - ii. Registered Nurses (RN)
 - iii. Emergency Medical Technicians (EMT)s
 - iv. Respiratory Therapist (RT)
 - b. Ensure the Contamination Injury Room is clear of unnecessary equipment and equipment that cannot be moved is covered with plastic.
 - c. Treat patient using suggested guidelines posted in the Contaminated Injury Room and per physician's order.
 - d. Maintain standard precautions when caring for contaminated patient.
 - e. If seriously injured, give lifesaving assistance immediately, always prioritized medical care over radiological care.
 - f. If conditions permit, allow NM Technologist to survey patient on stretcher upon arrival to the ED for contamination.
 - g. Document the survey results using the Decontamination Record as instructed
 - i. Collect specimens as ordered.
 - ii. Wound Care
 1. Cover patient wounds, if present, with waterproof drapes and tape in place.
 2. Irrigate wounds with water or saline.
 3. Blot dry after each washing and ask NM Technologist to survey for contamination.
 4. Repeat as necessary and avoid breaking the skin.
 - iii. Staff not directly involved with patient care should maintain a safe distance from the patient to limit exposure.
 - iv. Ensure a scribe is identified
 1. The scribe should be positioned outside of the treatment area.
 - v. Start decontamination procedures when patient is medically stable.
6. Radiology
 - a. X-ray machine and technologist will remain in the Buffer Zone.
 - b. Ensure gurney with patient will positioned in doorway of Contaminated Injury Room so required x-ray view(s) may be obtained without bringing portable x-ray machine into room.
 - c. Ensure the following:
 - i. Drape film cassette(s) in protective covering and hand to assistant in the treatment room who will place the cassette in position for the desired x-ray view.
 - ii. All personnel in the treatment room will move to a far corner of the room before taking the x-ray. Repeat views as needed.
 - d. As each film cassette is exposed, hand the film cassette out to the x-ray technologist. Fold the protective cover back so part of the film cassette is uncovered.
 - e. Grip the end of the cassette while the assistant retains possession of the drape used for the cassette.
 - f. Ensure the RSO or nuclear medicine staff survey the film cassette(s) for contamination
 - i. If no contamination is found, develop the x-ray film cassette.
 - ii. If contaminated, use a new cassette and retake x-ray.
 1. The contaminated film cassette will be held for decontamination.

- g. Ensure the gurney with the patient is moved back to the center of the Contaminated Injury Room.
- 7. Pulmonary
 - a. Verify respiratory equipment is available.
 - b. Assist with pulmonary assessment of patient are instructed.
 - c. Obtain arterial blood gasses as directed by ED physician.
 - d. Ensure equipment and personnel are checked for contamination. If contamination is found appropriate, decontamination steps will be undertaken.
- 8. Laboratory
 - a. Obtain blood specimens as directed by ED physician.
 - b. Ensure equipment and personnel are checked for contamination. If contamination is found appropriate, decontamination steps will be undertaken.

Addendum B

Decontamination, Patient Egress and Recovery Procedure

1. Decontamination Procedures
 - a. The decontamination process will be initiated once the physician determines the patient to be medically stable.
 - b. No items or personnel will be allowed outside the patient treatment area or the controlled area outside the ED entrance (including the ambulance or helicopter) without a contamination survey being performed.
 - c. Each step in the decontamination process should be followed by survey; recording in the location and extent of the contamination.
 - d. Decontamination can be done using the decontamination bed or the decontamination shower.
 - e. Clean areas outside these boundaries will also be periodically surveyed to ensure contamination has not spread.
 - f. The decontamination process is considered complete when the patient's contamination levels stabilize and fall below 200 counts per minute (cpm).
 - i. Contamination above 200 cpm will be cleaned, bagged or isolated for disposition later.
 - ii. Nuclear Medicine personnel will contact an agency listed in section 3.0, notes section of this policy for guidance if contamination levels remain above 200 cpm.
 - g. If external contamination is involved:
 - i. Save all clothing and bedding from the ambulance, blood, urine, stool, vomit, and all metal objects (i.e., jewelry, belt buckles, and dentures).
 - ii. Save each in a sealed container with the name, location, time and date.
 - h. When irrigating the face or head, place nose clips and surgical cap to head, if facial wound, to prevent contaminated water from absorbing into hair follicles.
 - i. If a wound is involved prepare and cover the wound with self-adhering disposable surgical drapes.
 - i. Remove wound covering and irrigate wound
 - ii. Catch irrigation fluid in a plastic basin, sink, or shower drain
 - j. Nuclear Medicine Personnel or designee will document each step of the decontamination process on the Personnel Decontamination Record.
2. Patient Egress from Contaminated Injury Room (Treatment Area)
 - a. After completing the decontamination process, move the patient on the far side of the room
 - b. The treatment team preparing to transfer patient to a clean gurney:
 - i. Remove outer gown and outer gloves and discard in the appropriate receptacle.
 - ii. Don another pair of clean gloves.
 - iii. Prepare to assist with the transfer of the patient to a clean gurney.
 - iv. The RSO or designee will roll clean herculite into the treatment room. Roll the herculite out in front of staff in the buffer zone and continue to roll the herculite it into the treatment room.
 1. Carefully, with the assistance of the people in the buffer zone, unfold the herculite to cover the treatment room floor
 - a. RSO or designee may will leave the treatment room
 - v. Wheel a clean gurney onto the herculite and place it in close proximity to the patient. Do not allow the clean gurney to touch the dirty gurney.
 - vi. The clean team will enter the Contaminated Injury Room to transfer the patient from the contaminated (dirty) gurney onto the clean gurney. Required personal protective equipment = gloves only.
 - vii. Transfer patient to the clean gurney.
 - viii. Once patient is on clean gurney and prior to moving the gurney out of the treatment room to the buffer zone, the NM Technician will:
 1. survey the patient and logged the results on the Decontamination Record
 2. survey the wheels of the gurney for contamination

- a. If contaminated, a new gurney will be necessary to continue egress

3. Recovery

- a. All internal and external patient care team members must be surveyed by the RSO or designee prior to leaving the Contaminated Injury Room and surrounding contaminated zones.
- b. Doff protective clothing
 - i. Remove protective clothing per the instructions posted in the Contaminated Injury Room
- c. Egress from the room.
- d. All involved personnel, including ambulance personnel, will be monitored for contamination prior to leaving controlled areas.
- e. Anyone contaminated above 200 cpm must follow the same decontamination and monitoring routine as recommended for the patient.
- f. Ambulance, helicopter, equipment, and all affected areas to include helicopter pad will be surveyed for contamination.
- g. Anything less than 200 cpm may be released.
- h. Anything above 200 cpm will be bagged or isolated.
- i. Return all TLD badges to the RSO or designee.
- j. Ensure all logs are completed.

Addendum C Radiation Team Roles

1. Incident Commander
 - a. The incident commander ensures the policy's procedures are adhered to and is informed of all medical and operational decisions.
2. Medical Response Team Leader
 - a. The medical response team leader is in charge of coordinating the needs of the medical response team.
3. Medical Response Team
 - a. The medical response team renders medical care to the contaminated person(s). The medical response team consist of the following departments:
 - i. Emergency Department (ED) Physician
 - ii. ED Registered Nurses
 - iii. ED Emergency Medical Technicians
 - iv. Laboratory
 - v. Nuclear Medicine
 - vi. Radiology
 - vii. Pulmonary
4. Radiation Safety Officer (RSO)
 - a. The radiation safety officer ensures that all radiological safety-practices and parameters are followed. The RSO works along-side the medical response team leader.
5. Operations/Controlled Area Team Leader (
 - a. The operations / controlled area team leader is charge of coordinating and maintaining that the affected-area is safe and controlled.
6. Controlled Area Team
 - a. The controlled area team retrieves the yellow carts, sets up the environment / equipment, and monitors who may safely enter and leave the area; the departments involved are listed below.
 - i. Environmental Services
 - ii. Facilities Management
 - iii. Security
7. Documentation – Recorder/Scribe
 - a. The documentation recorder makes certain all applicable forms are updated during the event and completed after its conclusion.
8. Information Liaison (IL)
 - a. The information liaison is the singular communication channel between the Code Yellow, the incident commander, people-in-the-know, applicable departments and Administration. The IL is not in charge of media relations but works with the External Affairs Department.



Tri-City Medical Center's Initial Notification Log

Initial Notification

Date	Time	Name of Person Making Notification	Title	Telephone

Patients' Data

Name	Injury / Illness	Radiological Information
		Radiation Exposure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown External Contamination <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Radiological Survey <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
		Radiation Exposure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown External Contamination <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Radiological Survey <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
		Radiation Exposure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown External Contamination <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Radiological Survey <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
		Radiation Exposure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown External Contamination <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Radiological Survey <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Nature of Accident

Additional Radiological Information

Expected Time of Arrival / Notification Taken By



Tri-City Medical Center's Dosimetry Issue Log

Date:	TLD Badge Number	Dosimeter Initial Reading	Dosimeter Final Reading
Name			



Tri-City Medical Center's Decontamination Record

Patient:	Physician:	Date:
Initial Evaluation	After First Decontamination Attempt	After Second Decontamination Attempt
Radiological Survey Results:	Radiological Survey Results:	Radiological Survey Results:
Acceptable Contamination Level is Less Than 200 cpm [counts per minutes]		



Tri-City Medical Center's Decontamination Record

Patient:	Physician:	Date:
After Third Decontamination Attempt	After Fourth Decontamination Attempt	After Fifth Decontamination Attempt
Radiological Survey Results:	Radiological Survey Results:	Radiological Survey Results:
Acceptable Contamination Level is Less Than 200 cpm [counts per minute]		



Tri-City Medical Center's Radiation PPE Dressing Sequence

CONTENTS

2 long-sleeve gowns / 2 shoe covers / 2 pairs of gloves / 1 head cover / 1 face mask with shield

DRESSING SEQUENCE

- 1.] Shoe Covers (tape to pant leg and "tab" the tape ends)
- 2.] TLD (attach to scrubs/clothes)
- 3.] Inner Gown
- 4.] Inner Pair of Gloves (tape to inner gown sleeves and "tab" the tape ends)
- 5.] Outer Gown (attach dosimetry to out gown if used)
- 6.] Outer Pair of Gloves
- 7.] Head Cover
- 8.] Face Mask with Shield

REMOVAL SEQUENCE

- 1.] Outer Gloves
- 2.] All Tape
- 3.] Head Cover (lead head back to avoid contaminating face)
- 4.] Face Mask with Shield
- 5.] Dosimeter (hand-off)
- 6.] Outer Gown
- 7.] Inner Gown
- 8.] Shoe Covers (after removal, place each foot onto "clean" step-off pad)
- 9.] Inner Gloves
- 10.] Perform Radiation Survey
- 11.] Turn in TLD badge

EMERGENCY OPERATIONS PROCEDURE MANUAL
GENERAL INFORMATION

ISSUE DATE: 06/08

SUBJECT: Emergency Operations Plan

REVIEW DATE: 06/11

POLICY NUMBER: 4001

REVISION DATE: 01/17, 03/19

Department Approval: ~~44/48~~11/21

Environmental Health & Safety Committee Approval: ~~42/48~~03/22

Medical Executive Committee Approval: n/a

Administration Approval: ~~03/49~~03/22

Professional Affairs Committee Approval: n/a

Board of Directors Approval: 03/19

A. PURPOSE:

1. The purpose of the Emergency Operations Plan (EOP) is to define strategies and activities designed to prevent, prepare for, respond to, and recover from adverse events that may occur within the hospital and its campus (internal incident) or outside of the hospital and its immediate campus (external incident) that cause or have the potential to cause a negative impact on normal hospital operations or services. The plan is based on a dynamic, functional, and practical emergency management approach that is founded on:
 - a. Preventing or minimizing the loss of life and injuries
 - b. Ensuring personnel safety
 - c. Minimizing disruptions to the organization's critical operations
Comprehensive emergency management practices
 - d. Flexible, scalable plan activation
 - e. Integrated command, control, and communications
 - f. Fully implementing the Hospital Incident Command System (HICS)
 - g. Integrating the hospital's mitigation, preparedness, response, and recovery efforts with those of its community

B. SCOPE:

1. The plan is designed to provide guidance and direction for the establishment, management, maintenance, and oversight of the EOP and, as such, applies to all hospital staff. The EOP establishes policies for response and recovery activities associated with any emergency activation. This plan supersedes all previous hospital emergency operations plans. Changes to any portion of this plan shall be submitted in writing to the hospital Emergency Operations Coordinator or designee.
- A.2. This plan applies to Tri-City Hospital District (TCHD) and its affiliated clinics/offices.

C. PLANNING ASSUMPTIONS:

1. TCHD will continue to be exposed to the impact of hazards described in the Hazard Vulnerability Analysis (HVA) as well as others previously unidentified or that may develop in the future.
2. It is possible for an emergency or major disaster to occur at any time. In some cases, advance warning and implementation of increased preparedness measures may be possible. However, many events could occur with little or no warning.

3. State and local governments will have limited resources to support initial hospital response operations.
4. Federal emergency response assets may not be available within the first 96 hours following an event.
5. Emergency conditions may require modification of normal patient care activities. Conditions may require discontinuation of services, patient transfer or early discharge, establishment of alternative care sites, or facility evacuation.
6. Preparedness activities and strategies based on the most plausible worst-case scenario for each hazard strengthen response and recovery capabilities.
7. Preparedness initiatives pursued in collaboration with the local community further enhance hospital response capabilities and promote community resilience.
8. TCHD will utilize the four phases of emergency management-mitigation, preparedness, response, and recovery-to frame its approach to emergency events.
9. TCHD has adopted an all-hazards approach to emergency management planning—one that supports a general response capability sufficiently nimble to address a wide range of emergencies of various duration, scale, and cause.
- B-10. The recovery period may be longer in duration than the response period and may result in prolonged disruption of normal operations.

A.D. KEY ROLES AND RESPONSIBILITIES:

Executive Leaders	Reviews reports, as appropriate, communicates concerns about identified issues and regulatory compliance. Provides support for ongoing activities of the EOP
Senior Leaders	Ensure EOP policies are establish Authorize mitigation and preparedness strategies Assume responsibility for the overall response and recovery operations. Identify individuals (by title or position) responsible for serving as Incident Command Management Team (IMT) members.
Emergency Operations Coordinator/Designee	Provides overall management and oversight for the EOP Coordinates the development and implementation of emergency management plans, policies and procedures Ensures that all emergency management-related regulatory requirements are satisfied and routinely monitored for continued compliance. Champions the ongoing implementation and sustainment of the Hospital Incident Command System (HICS) throughout the organization. Serves as the hospital's emergency management liaison with external entities (e.g., local/state emergency management entities, regional healthcare planning groups, volunteer and support organizations). Chairs the Environmental Health and Safety Committee (EHSC)
Emergency Health and Safety Committee	Conducts an annual review and revision of the Hazardous Vulnerability Analysis (HVA), and EOP. Works closely with all department leaders to identify department-specific planning and training requirements. Develops a training and exercise plan that focuses on high-priority hazards from the hospital's HVA; findings from previous drills, exercises, and actual events; newly developed plans and procedures; current grant guidance; and changes in regulatory requirements. Conducts after-action analysis and reporting for emergency drills/exercises and actual events and develops corrective actions plans, as required. Proposes and incorporates changes to policies, plans, and procedures based on identified findings. Tracks and reports on progress of corrective actions.

	Leads emergency management program improvement initiatives. Investigates, researches, and incorporates industry best practices into the emergency management program.
Department Leadership	Develop and maintain current personnel notification rosters. Reviews and provides input to the EHSC to ensure department-specific emergency plans are updated annually and as required. Ensures staff complete and participate in emergency management specific education and training. Ensures staff understand their roles during EOP activation. Provide personnel, equipment, and supplies to support emergency operations upon request. Report changes in operational status to the Incident Commander (IC)
All Hospital Staff	Complete annual emergency management training. Identify their roles and responsibilities during EOP activation. Participate in emergency preparedness activities, as assigned. Provide current emergency notification information to department manager. Accomplish emergency response and recovery tasks, as assigned.

E. CONCEPTS OF OPERATIONS:

1. TCHD will respond to an emergency by activating its EOP using a scalable. The event will be managed by a pre-identified, trained Incident Management Team (IMT) using the HICS. Designated incident operating locations will be activated by the Incident Commander as required. The initial response by hospital departments will be guided by their department leaders or incident command structure. Related policies and procedures may be activated to provide event-specific guidance for hospital responders. A demobilization and recovery plan will be developed to provide an orderly return to normal operations. After-action analysis and reporting will be conducted to identify lessons learned and opportunities for improvement. The EHSC will develop a corrective action plan and track progress. Emergency management program improvements will be implemented and tested.

F. PLAN ORGANIZATION:

1. The TCHD EOP is organized in three principal sections:
 - a. Emergency Management Program: Description of the hospital's comprehensive emergency management program, core elements of the all-hazards planning framework, and Incident Command System (ICS).
 - b. Emergency Operations Base Plan—Provides an overall systems description of how TCHD resources are organized during response, and then describes how they interact during emergency response and initial recovery.
 - c. Policies and Procedures – Hospital policies and procedures that provide specific information and direction.
2. National Incident Management System (NIMS)
 - a. Adoption of NIMS
 - b. NIMS is implemented throughout the healthcare organization including all appropriate departments and business units.
 - c. Education is provided to hospital leadership on the benefits of interoperability and coordination for effective incident management across jurisdictions.
 - d. Accordingly, elements of the Five-Year NIMS Training Plan that are applicable to healthcare facilities are addressed (such as completion of required NIMS training, tracking and complying with personnel qualification requirements for emergency management/response personnel). This structure provides a cohesive disaster management structure, and integrates directly into the cities plan, as well as fire,

law enforcement, the federal government, emergency medical services and the military.

G. EMERGENCY OPERATIONS PLAN – MISSION:

1. The mission of the EOP is to provide leadership and management of a coordinated and organized effort to mitigate, prepare for, respond to, and recover from any emergency with varying degrees of complexity, scope, or duration.
2. Objectives
 - a. Utilize the four phases of emergency management—mitigation, preparedness, response, and recovery—to frame its approach to wide range of emergency events.
 - b. Utilize an all-hazards approach to emergency management that are applicable to any type of situation or event, whether pre-identified or not.
 - c. An HVA is completed to assess the impact of likely emergencies. The HVA is used to guide the development of the EOP. The HVA is reviewed at least annually to determine if the likely emergencies have changed.
 - d. Define and prepare for the service needs created by the hazard impact on the healthcare organization and the community.
 - e. Utilize the National Incident Management System (NIMS) and the national standard Hospital Incident Command System (HICS) as the command and management model for emergency response.
 - f. Orient and educate leadership and staff to their emergency management roles.
 - g. Facilitate community emergency management, integrating the hospital's activities with emergency management programs across the region, thereby fostering the coordination of medical planning, preparedness, response, information sharing, and recovery throughout the region.
 - h. Leaders are active participants in TCMC's EOP. The signatories of this plan, members of the Environmental Health and Safety Committee, and other key department managers have been involved in the Hazard Vulnerability Analysis (HVA) development/revision, plan development, training, and implementation and routinely provide management oversight and input for program improvement.
3. Coordinator
 - a. See the EHSC Coordinator/ Designee outlined in Key Roles and Responsibilities
4. Committee
 - a. See the Environmental Health and Safety Committee roles and responsibilities outlined in Key Roles and Responsibilities

a-H. TRAINING AND EXERCISES:

1. Education and in-service training is provided during the onboarding process for new employees, annually, using periodic drills and tabletop exercises. Education is provided using computer-based training.
2. Emergency Preparedness and Response Capabilities
 - a. The ability of a hospital to respond to an emergency depends upon staff knowing their roles and responsibilities during an emergency. Education is provided to all staff annually using computer based learning (CBL) module, hospital newsletters, policy reviews and/or unit base meetings. Additional education and training is provided during drills and actual emergencies.
Staff and Leadership Competencies
 - i. Staff are required to completed an annual CBL that provides education on the EOP.
 - ii. Staff are responsible for identifying their roles and responsibilities during and emergency.

- iii. Examples of education provided to all staff include but is not limited to the following:
 - 1) Equipment use e.g., personal protective equipment
 - 2) Communication methods
 - 3) Implementing the chain of command
 - b. Leadership additional responsibilities may include the following:
 - i. Describe the mission of the hospital during response to emergencies of all kinds, including the emergency response chain of command and the HICS system.
 - ii. Manage and implement the EOP during drills or actual emergencies within an assigned functional role and chain of command.
 - iii. Describe the key elements of the hospital's emergency preparedness and response roles and policies to other agencies and community partners.
 - iv. Initiate and maintain communication with other emergency response agencies as appropriate to assigned management responsibilities.
 - v. Demonstrate flexible thinking and use of resources in responding to problems that arise carrying out their functional role during emergency situations or drills.
 - vi. Evaluate the effectiveness of the response within their area of management responsibility in drills or actual emergencies and identify improvements needed.
- 3. Drills and Exercises
 - a. Drills are conducted throughout to year to assess the appropriateness, adequacy, and effectiveness of mitigation strategies.
 - i. Drills are coordinated, supervised activities to test a single, specific operation or function and are conducted periodically to assess staff training, alert/notification systems e.g., fire drills, radiation decontamination.
 - ii. Participation in countywide tabletop exercise are conducted to assess and if required develop and/or revise policies and procedures.
- 4. Program Evaluation and Improvement
 - a. Effectiveness Measures
 - i. The EHSC Coordinator/designee has overall responsibility for:
 - 1) Coordinating all EOP performance improvement activities.
 - 2) Establishing performance improvement standards to objectively measure the effectiveness of the EOP.
 - 3) Coordinating the evaluation of equipment and process performance opportunities.
 - 4) Assisting with the development of corrective action plans, if deficiencies are identified as outlined in the EHSC charter.
 - b. The performance improvement measurement process is one part of the evaluation of the effectiveness of the EOP. Each year, a performance improvement standard is identified based on deficiencies or opportunities for improvement.
 - c. The current performance improvement measure:
 - i. Revise current process for reviewing all elements of the EOP.
 - ii. Conduct one actual emergency drill.
- 5. Critique and After-Action Reporting
 - a. An important component of this plan is the review and critique of each EOP activation (actual or simulated) by hospital staff and appropriate outside agencies with analysis of response documentation. The information shall be documented and disseminated as part of the ongoing performance improvement process and incorporated into the plan as indicated.

- b. The EHSC Coordinator/designee shall compile the results of the written reviews and critique proceedings reporting the outcomes to the EHSC and other committees as outlined the EHSC charter.
- 6. **Plan Review and Revision**
 - a. The EOP shall be reviewed annually. Related policies and procedures shall be reviewed and revised according to hospital policy.
 - b. Reassessment of the HVA based on experience and input from local/county/tribal/state external response partners.
 - i. Development or revision of any incident-specific plans necessitated by the revised HVA.
 - c. Revision of response procedures based on actual experiences and new information, standards, or best practices in the emergency management (EM) community;
 - d. Coordination with the San Diego County Office of Emergency Services (OES) to assure consistency with their plans and coordination of the hospital's role in community plans
 - e. Establishment of the EM training and exercise objectives and plan for the upcoming year.
 - f. Department-specific plans shall be reviewed annually. At a minimum, an updated a current telephone notification list for all department personnel.
- 7. **Mitigation**
 - a. Mitigation measures are designed to reduce or eliminate hazards or lessen the actual or potential effects or consequences of a hazard. Infrastructure and critical systems are routinely evaluated to ensure required performance during potential events. Mitigation activities are undertaken based on vulnerabilities identified in the HVA.
 - b. **Community/Regional Planning Initiatives**
 - i. TCHD actively participates in emergency management initiatives at the local, state, and regional levels. Hospital representatives meet regularly with their emergency management colleagues from public safety e.g., law enforcement, Emergency Medical Services, and fire, public health, emergency management, other hospitals and healthcare facilities, and appropriate private and nongovernmental entities.
 - ii. TCHD is a member of the San Diego Healthcare Disaster Coalition (SDHDC) whose mission is to define organizational roles and responsibilities; develop regional response plans and procedures; seek available funding; and plan, conduct, and evaluate joint training and exercises. On a periodic basis, TCMC meets, under the auspices of the SDHDC, California Hospital Association (CHA), and Department of Homeland Security, with other healthcare agencies to share information, and discuss their resources. This meeting focuses on the essential elements of their command structures and control centers for emergency response. The names and roles of individuals in their command structures and command center telephone numbers, the resources and assets that could potentially be shared in an emergency response and the processes by which names of patients and deceased individuals brought to their organizations can be shared to facilitate identifying and locating victims of the emergency.
 - c. **External Support Agreement**
 - i. TCHD has negotiated various external support agreements (e.g., Memorandum of understanding (MOU), memorandum of agreement (MOA,) with local, state, and regional entities to obtain and/or share critical resources during emergencies. During community-wide emergency events, resource inventories are monitored, updated, and shared. All external

- support agreements are reviewed annually and updated as capabilities and/or organizational needs change.
 - ii. TCHD has reviewed its contracts with vendors and suppliers of essential supplies, services, and equipment that may be needed to support emergency response and recovery operations. Where possible, contracts have been modified to identify TCHD as a priority client during emergencies.
 - 1) At a minimum, vendor/supplier points of contact, after-hours contact information, and alternate order/delivery modes have been identified.
 - d. Hazard Vulnerability Analysis
 - i. Annually a Hazard Vulnerability Analysis (HVA) is performed to identify potential emergencies that could affect demand for the hospital's services or its ability to provide those services, likelihood of those events occurring, and consequences of those events.
 - ii. The HVA is used as the basis for developing emergency plans and procedures, conducting training and exercises, budgeting for and acquiring resources and assets, establishing external support agreements, and prioritizing mitigation and preparedness activities.
 - iii. The EHSC Coordinator/designee consults with the San Diego Healthcare Disaster Coalition (SDHDC) at least annually regarding the HVA—and whenever the hospital's needs or vulnerabilities change – to review probability, impact, level of preparedness, and vulnerability scores; communicate the hospital's needs and vulnerabilities to the appropriate community emergency response agencies; and identify the community capabilities needed to meet its needs during an event. These organizations include:
 - iv. Public safety (fire, law enforcement, Emergency Medical Services [EMS])
 - v. Neighboring hospitals
 - vi. Local/county/state public health departments
 - Public works/utilities
 - vii. Local/state emergency management
 - viii. EHSC coordinator/designee maintains documentation of all external review and coordination efforts. The HVA is reviewed and updated in conjunction with annual EOP review and revision, after each EOP activation, and whenever the hospital's hazards, capabilities, or vulnerabilities change.
 - 8. Preparedness
 - a. Advanced Preparations
 - i. Although many incidents occur with little or no warning, there are others where advance notice is provided to the hospital hours, days, or longer ahead of an occurrence. For such situations, there are actions that may need to be implemented by the hospital in advance of the event to prepare the organization to respond when and if the threat materializes or an adverse impact occurs. As an event approaches, general readiness measures may include but are not limited to:
 - 1) Activating the EOP
 - 2) Establishing a planning section to prepare specific contingency plans for the impending situation.
 - 3) Activating the ICC to monitor evolving conditions.
 - 4) Activating external support agreements (e.g., security augmentation, staff transportation, staff lodging, and dependent/pet care) or placing in alert status.

- 5) Maintaining monitoring of local and/or relevant news media and weather forecasting for updates and status changes.
 - 6) Reviewing emergency plans and procedures with staff and other stakeholders
 - b. Department-Level Preparedness
 - i. Each nursing unit/department EOP included within this plan leadership team will maintain the following at the unit/department level:
Current call back list
 - 1) Ensure that complete address information, including apartment numbers, and contact information, including cell phone, pager, numbers, and e-mail and text messaging addresses are updated
 - 2) Maintain a posted evacuation plan visible to staff.
 - 3) Ensure staff review the EOP and can identify their roles and responsibilities as outlined in this EOP.
 - 4) Informed of the location to assemble.
 - 5) Ensure their staff complete new hire and annual education on the EOP.
 - ii. Departments leaders with approved unit/department emergency plans not outlined in this plan shall follow the requirements outlined for nursing unit/departments listed in b.1. and the following:
 - 1) Maintain electronic emergency policy/procedures
 - 2) Reviewed annually and updated as needed the unit/department plan
 - 3) Submit a copy of the plan to the EHSC for review prior to completing the hospital approval process
9. Communications
 - a. Communicate information with staff regarding the impending event, hospital and community activities being undertaken, staff/ family personal preparedness measures.
 - b. Test radio, paging mass notification satellite phone, government emergency telecommunications service (GETS) and alternate communications plans and equipment.
 - i. Ensure all batteries are fully charged.
 - c. Establish contact with the Corporate EM team, the SD County Medical Operations Center (MOC) and San Diego County Department of Health and Office of Emergency Management.
 - d. Maintain effective communications with all involved parties: staff, patients, patient families, vendors, assisting and cooperating agencies, and the community.
10. Resources and Assets
 - a. Review inventory of critical supplies to support loss of community support lasting more than 96 hours.
 - b. Inventory and replenish (as necessary) resource stockpiles, including food, potable water, linen, pharmaceuticals, medical supplies, spare batteries, generator fuel, and damage control materials.
 - c. Place advance or accelerated orders to reinforce stockpiles as needed/anticipated.
 - d. Activate or mobilize emergency stores and/or vendor-managed inventories.
 - e. Review status of emergency purchase orders and standing order deliveries.
 - f. Service and fuel hospital vehicles and generators.
 - g. Stock food and bedding or make preliminary arrangements for staff lodging and hygiene.
 - h. Secure or consolidate supplies of scarce resources (e.g., antibiotics, fuel).
 - i. Consider fiscal needs, including availability of cash reserves to support post-event purchases and staff cash advances.
 - j. Relocate critical assets to safer/more secure areas.

11. Security and Safety

- a. Secure materials (e.g., pharmaceuticals, narcotics, radioisotopes) requiring special handling or security measures.
- b. Evaluate parking areas for restriction or traffic flow adjustment.
- c. Establish staging areas for incoming resources.
- d. Review procedures for security reinforcement (including external vendor and law enforcement contacts).
- e. Consider plans for restriction of facility access/egress and traffic flow
- f. Activate surge traffic plan as needed.

12. Staff Management

- a. Prepare staff scheduling enhancements during the event, including shift alterations, extended shifts, and additional contracted coverage.
- b. Place off-duty/on-call staff in alert status.
- c. Implement denial of leave requests, cancellation of prescheduled leaves and days off, and medical clearance for use of sick leave.
- d. Update lists of employees. Ensure that complete address information, including apartment numbers, and contact information, including cell phone, pager numbers, and e-mail and text messaging addresses are updated.
- e. Create sleeping arrangements or reserve hotel accommodations for key staff as needed.
- f. Identify potential need for staff dependent care (including pets) and activate plans as needed.

13. Utility Management

- a. Review and practice event-specific utility management, shutdown, restoration, and recovery procedures.
- b. Activate protective air filtration systems or ventilation zoning controls.
- c. Activate systems requiring advance priming before operations (e.g., generators, utility backup, and electronics).
- d. Consider engineered pre-event shutdown or controlled degradation of utilities and/or critical systems (e.g., medical gases, vacuum).
- e. Establish contact with service and support vendors and public utilities.

14. Patient Management

- a. Prepare modifications of clinical scheduling, including cancellation of elective procedures, census reduction, and discontinuation of outpatient activities. Pre-assign available staff to meet projected facility staffing needs.
- b. Notify patients regarding the potential cancellation/suspension/delay in planned services (e.g., admission, treatment, procedure).
- c. Prepare home care clients for extended periods without staff visitation. Identify those clients who will be leaving the area or who will be assisted by an alternate caretaker. Identify clients who may require assistance with shelter-in-place and/or evacuation plans. Prioritize service needs for scheduling purposes when visits can be resumed.
- d. Prepare to activate surge-capacity spaces (alternate care sites) for intake of evacuated special needs populations, overflow, evacuees from other impacted medical facilities, or patients generated by the event

I. RESPONSE:

1. Plan Activation

- a. The EOP will be activated in response to internal or external threats to the facility.
 - i. Internal threats could include fire, bomb threat, loss of power or other infrastructure, or other incidents that threaten the well-being of patients, staff, and/or the facility itself.
 - ii. External threats include events that may not affect the facility directly but have the potential to overwhelm facility resources or put the facility on alert.

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their departments. Once notification of the incident has occurred, the EOP has been activated, and command assumed, further plan implementation will occur based on the situation.

- c. **Delegation of Authority –**
 - i. Delegation is the downward transfer of authority from a supervisor to a subordinate in a management organization. When such authority is delegated, the subordinate is empowered to carry out the work on the supervisor's behalf, while the supervisor remains accountable for the outcome. As with any management system, HICS leaders may delegate their authority to carry out certain functions by establishing a lower level in the IMT. During EOP activation, delegation of authority will occur based upon the needs of the incident (i.e., the quantity and complexity of the objectives to be met), the facility resources, and the available personnel. This may be an ongoing and dynamic process. The IC is ultimately responsible for all incident functions, although the IC delegates authority for activities and functions to Section Chiefs and Unit Leaders to carry out. Both clinical and operational functions will be managed administratively in the same manner.
 - d. **Transfer of Command –**
 - i. As conditions evolve or higher-level leadership arrives at the hospital, command may be transferred between leaders. The decision to do so is generally at the discretion of the higher-ranking leader. The transfer of command is accomplished following a face-to-face briefing, during which the IC informs the person relieving him or her of conditions at the hospital, impacts, problems, progress, the strategy for managing the incident, and any other pertinent information. As an incident de-escalates, consideration may be given to having lower-level leadership assume command roles, both for relief purposes and for ongoing leadership development.
 - e. **Integration with Unified Command –**
 - i. Depending on the nature and extent of the incident, it is likely that a wide variety of agencies will be engaged to some degree in the response effort; therefore, the hospital must be effectively integrated into the community response, including the overall incident command structure. This integration begins before an incident occurs, through the hospital's regular participation in community preparedness meetings, training, and exercises.
 - f. **Order of Succession –**
 - i. Orders of succession show who assumes authority and responsibility if leadership is incapacitated or unavailable. The Emergency Management Committee has pre-identified internal hospital positions that could be potential candidates for various HICS positions. In doing so, the committee has created an Order of Succession chart
 - g. **Escalation of Response**
 - i. An incident may be appropriately handled with the initial response activities, but it may also require escalation due to a need for additional resources, personnel, or because of incident scope or duration. Escalation of plan activation is at the discretion of the IC, based on the impact that an event actually or potentially has on the organization. The rationale for escalating plan activation is that at each level of activation, additional sets of nonessential functions may be set aside in each department, making staff and other resources available for higher-priority assignments.
5. **Planned Degradation of Services**
- a. In the event that demand exceeds capabilities and external support and solutions (including patient transfer or evacuation) are not available, a plan for degradation

of services shall be developed and initiated by the IC. Such degradation of services may include (but are not limited to):

- i. Conserving, consolidating, and/or rationing scarce resources
- ii. Reducing or curtailing services, capacity, and capabilities
- iii. Closing the hospital to new patients
- iv. Altering standards of care
- v. Staged or partial evacuation
- vi. Full facility evacuation and relocation

J. PUBLIC INFORMATION:

1. Media Relations

a. When an incident involving EOP activation generates media interest, the IC shall assign a Public Information Officer (PIO). The mission of the PIO, is to serve as the conduit for information to internal and external stakeholders, including staff, visitors and families, and the news media. The following general policies apply to any situations involving the media during EOP activation:

- i. Members of the press will not be allowed elsewhere inside the hospital without prior approval from the IC.
- ii. In the event that a member of the press is granted access to any part of the facility, they shall be accompanied and escorted at all times by the PIO or an assigned assistant.
- iii. Still or video photography is only permitted with signed written authorization from Corporate Communications. .

2. Written consents will be required prior to any photographs or video taken of people (including patients, staff, and visitors) on the hospital campus.

3. Public Information System

- a. During an incident involving multiple agencies or organizations, it is vital that public information be consistently communicated across all participating community response entities.
- b. A Public Information System (PIS) provides accurate, timely, and coordinated information to incident leadership and the public.
- c. When a PIS is established—as directed by the San Diego County Office of Emergency Services (OES), Department of Health, or other authority—TCMC will ensure any information released is only done in coordination with the PIS guidelines as established at the time of the incident.

4. Support to the Joint Information Center

- a. At the discretion of OES or Department of Health, a PIS may be supported through the establishment of a Joint Information Center (JIC). In a JIC, the Public Information Officers of all healthcare partners and jurisdictional authorities, including TCMC, collocate and develop a joint public information message for dissemination. Under those circumstances, all media releases shall be coordinated through the JIC.

5. Communication and Information Management

a. Common Communications

- i. When establishing HICS, the IC shall ensure that a common communications plan is utilized. (HICS 205A) The common communications plan must ensure that all operating elements of HICS are able to maintain a common operating picture and consistent situational awareness, and are able to share information effectively across the organization, as well as with any external partners or agencies who may be participating in the response. All communications with external entities shall be in plain English, without the use of codes or ambiguous language.

b. Backup Communications

- i. Backup communication systems include:

Basic Telephone System	Overhead Announcement
Nurse Call System	E-Mail
Overhead Announcement	Text Messaging
Cell Phones	Communications Systems for Hearing Impaired
Telephone Translation Lines & Services	Communication with Emergency Operations Centers
Fax Machines	Intranet Messaging Posting
Access Control Systems	Emergency Medical Services Communication
Hand Held Radios	Public Health Monitoring & Notification, CAHAN)
Runners	Hand-Held Radios

6. Staff Notifications and Communications

- a. The person receiving the first notification that an emergency incident has taken place will quickly obtain as much information as possible on the situation. The person receiving notification shall immediately contact the, Administrative Supervisor. ~~the Operations Supervisor and/or the Administrator on Call. -The Administrative Supervisor on Call (in his or her absence, the Operations Supervisor)~~ will ascertain the facts, assess the situation, notifies the administrator on call, and makes the decision to assume command and activate the EOP.

7. Intradepartmental Notifications

- a. **On-Duty Personnel Notified of an Emergency**
 - i. On-duty personnel (including licensed independent practitioners) will be notified either by overhead page, e-mail, in-house cell phones, pagers, or via direct supervisor.
 - ii. When notified of EOP activation, all personnel shall:
 - 1) Cooperate and comply with directions of person assuming command of the department.
 - 2) End all nonemergency telephone conversations.
 - 3) Avoid using telephones or elevators.
 - 4) Continue working in usual areas unless otherwise instructed.
 - 5) Wear Hospital Identification (ID) badge conspicuously for clear identification.
 - 6) Remain on duty until released by immediate supervisor.
 - 7) Refer to the supervisor ~~DEAP~~ in assigned area for immediate actions.
 - 8) If reassigned by immediate supervisor, follow instructions of supervisor in new area.
- b. The Logistics Section Chief shall ensure that ongoing communication of information and instructions is accomplished by the most appropriate available communication mechanism (e.g., public address announcement, text message, e-mail)
 - i. ~~For~~ longer-term incidents, the Public Information Officer is responsible for updating and communicating with employees, patients, patients' families, and other stakeholders to ensure a flow of accurate, consistent information through the course of the incident.
- c. **Off-Duty Personnel Notified of an Emergency**
 - i. Off-duty personnel (including licensed independent practitioners) will be notified in a tiered manner; that is, those who are expected to report for duty during the activation or for the next shift will be notified first.
 - 1) If available, mass notification systems will be used.

- 2) Should manual telephone calls be required, those will occur at the direction of the IC and be conducted by each department.
 - 3) Messaging will be at the discretion of the IC or his or her designee.
 - ii. Off-duty personnel notified of an emergency at the hospital or in the community shall:
 - 1) ~~Keep home or cell~~ phone lines open for updates and await a call from ICC or department leaders.
 - 2) Make arrangements for child/dependent care in the event employees are called to report to work.
 - 3) Turn on local radio news station to listen for announcements requesting hospital employees to report to work.
 - 4) Not respond to the scene of an emergency or disaster as a medical care provider unless properly trained, equipped, and part of the community's organized emergency response.
- d. Off-Duty Mobilization
 - i. If the response of off-duty personnel becomes necessary, the IC will notify the Communications Unit Leader and direct the activation of the Emergency Disaster Call Back Procedure. This procedure enables each department's personnel to be mobilized as needed, quickly and efficiently.
 - ii. The plan consists of notification of affected department leaders and, if they cannot be reached, an alternate. It then becomes the responsibility of the department leaders or designees to mobilize their departments' off-duty personnel as necessary. The plan minimizes impact on any one person for contacting personnel.
- e. Patient and Family Communications
 - i. Only those patients and families affected will be notified as determined by the IC. Should notifications be necessary, supportive and consistent messages will be directed by Corporate Communications. It is the job of the Logistics Section to handle communications with family members of staff, whereas Operations is responsible for notifications to patient next of kin. Outpatients will only be notified if it is necessary to cancel or reschedule appointments during the activation, as directed by the IC.
 - ii. When a patient is relocated, for any reason, the family will be notified (via telephone) of the patient's new location and the phone number if available. Actual telephone notifications will be handled by the designated hospital staff (per the IC) or in the case of a mass casualty event or large evacuation, the Logistics section may coordinate family notifications with the American Red Cross (ARC) or other appropriate outside agencies.
 - iii. Patient Information Sharing
 - iv. Patient information will be provided to third parties (e.g., other healthcare organizations, state or county health departments, law enforcement entities) when such information is required to stop the spread of disease, protect the lives and safety of the general population, and/or preserve evidence. In addition, during large-scale regional incidents, patient tracking and decedent information will be shared with other local healthcare facilities identified in regional Memorandum of Understanding (MOU). Requests for patient information will be processed through and documented by the Planning Section within the ICC.
 - v. There are two scenarios for communicating patient information to third parties under this section, in accordance with hospital policy and the Health Insurance Portability and Accountability Act (HIPAA) guidelines:
 - 1) During the response phase of an incident.
 - 2) During the recovery phase of an incident.
- f. Information Sharing during Response Phase

- i. Protected information such as, but not limited to, the personal identity information, clinical diagnosis and services or resources needed, and patient disposition, may be immediately and readily shared by and between incident response participants with a clear and evident “need to know.” Such recipients should be reminded that patient-specific information is considered “protected” and is not appropriate for release to the media or for public information. Note: the media or general public releases of information are never considered “incident response participants” or appropriate recipients of protected information under this section.
- g. Information Sharing during Recovery Phase
 - i. During the recovery phase and/or following the termination of incident activities, any requests for patient information shall be managed in accordance with routine hospital policy, and all HIPAA compliance regulations shall be in effect. Requests for unusual or special consideration shall be referred to the Planning Section Chief for action.
- h. Clinical Information Management
 - i. Clinical Information will be managed using the hospital’s electronic medical record (EMR), as appropriate. In certain circumstances (e.g., rapid volume of incoming victims, large number of unidentified individuals) the IC may direct staff to use downtime paper records. The use of downtime paper records will be consistent with the facility’s computer downtime procedure.
- i. HIPAA Privacy Rule and Disclosures during Emergency Operations
 - i. The HIPAA Privacy Rule allows patient information to be shared to assist in disaster relief efforts. Healthcare providers can share patient information as necessary to:
 - 1) Treatment -Provide treatment
 - 2) Notification - Identify, locate, and notify family members, guardians, or anyone else responsible for the individual’s care or the individual’s location general condition, or death.
 - 3) Imminent Danger - Share information with anyone as necessary to prevent or lessen a serious and imminent threat.
- j. Community Liaison
 - i. Mutual Aid
 - 1) TCMC participates in local/regional preparedness and response initiatives and is prepared to share resources and assets both within its local jurisdiction and within its region. Inventories of critical resources (e.g., beds, linens, transportation, fuel, pPersonal pProtective eEquipment [PPE], medical equipment, supplies) and access to incident-specific Medical/Technical Specialists are tracked by the ICC. Requests for mutual aid will be processed through the ICC as approved by the IC.
 - ii. State/County/Local
 - 1) Appropriate state/county/local entities will be notified upon activation of the EOP, but are not limited to:
 - a) San Diego Office of Emergency Services
 - b) Law Enforcement
 - c) Fire Services
 - d) Emergency Medical Services
 - e) Department of Health
 - f) San Diego County Department Operations Center (DOC)/Medical Operations Center (MOC)
 - 2) Initial event notifications may be made by the IC or designee.

- 3) Ongoing communications with appropriate state/county/local entities will be managed through the ICC. Primary and alternate communication modes have been established and are periodically tested during drills and exercises. When necessary, TCMC will provide a hospital liaison to the local/state DOC and/or MOC to serve as a conduit between the hospital and supporting agency/entity.
- iii. Federal
 - 1) Federal assets may be deployed to San Diego County to support incident response and recovery operations. Requests for assistance will be developed by the IMT, approved by senior leadership, and communicated to the San Diego County DOC for processing, consolidation with other local/regional requests for assistance, and forwarding to the Governor or other appropriate elected official for transmission to the federal entity. These federal entities may include but are not limited to:
 - a) Department of Health and Human Services
 - i) National Disaster Medical System (NDMS)
 - ii) California National Guard
 - iii) Strategic National Stockpile (SNS)
 - iv) Laboratory Response Network (LRN)
 - b) Law Enforcement
 - i) Federal Bureau of Investigation (FBI)
 - ii) Drug Enforcement Agency (DEA)
 - iii) Bureau of Alcohol, Tobacco, and Firearms (ATF)
 - iv) United States Marshalls

K. PATIENT CARE & CLINICAL SUPPORT ACTIVITIES:

1. Patient Scheduling, Triage, Assessment, Treatment, Admission, Transfer & Discharge
 - a. Upon activation of the EOP, normal admission requirements will be determined by the IC, Outpatient care will be restricted as identified by the IC.
 - b. All elective admissions, procedures, elective surgery, non-emergency outpatient procedures, transferring patients who are stable for discharge will be canceled per the IC
 - c. Transferring patients to other facilities to accommodate emergency victims will be determined by the IC.
 - d. In the event that the hospital's EOP is activated, persons may be transferred prior to being stabilized if, based upon the circumstances of the emergency the hospital is unable to provide proper care, treatment or services. (Section 1135(b) of the Social Security Act §489.24(a)(2)).
2. Evacuation Plan
 - a. See TCHD Evacuation Plan.
 - b. Pediatric, Geriatric and Other Vulnerable Populations
 - c. ED providers are board certified to care for all emergency patients. All ED nurses are required to complete annual age specific competency testing. Clinical activities for vulnerable patient populations including pediatric, geriatric, disabled, or have serious chronic conditions (example: dialysis patients, respiratory patients, transplant unit patient, etc.) and psychiatric and addiction patients will be provided in the customary way but additional emphasis will be placed on security, safety, mobility in terms of evacuation should it become necessary during an emergency.
3. Patient Mental Health Support
 - a. The Mental Health Unit Leader is responsible for coordinating care for the mental health needs of patients.

4. **Infectious Disease Patients**
 - a. For contagious patients in need of isolation the Infection Prevention department has guidelines for isolation and standard precautions to adhere.
5. **Mortuary Services**
 - a. The hospital has limited resources to handle mass fatalities. The Casualty Care Unit Leader will identify the morgue area and appoint a Morgue Team Leader. The mass fatality plan can be implemented as needed and will address:
 - i. Family notification
 - ii. Family information center
 - iii. Safe and respectful storage
 - iv. Security
 - v. Evidence preservation/chain of custody
 - vi. Preservation of personal effects
 - vii. Documentation
 - viii. Integration with medical examiner/coroner
 - b. The San Diego County Office of the Medical Examiner is responsible for developing, activating and implementing the County of San Diego Mass Fatality Plan. The Mass Fatality Plan will be activated if there is an increase in the number of deaths in the operational area due to a disaster or public health emergency which is expected to continue over a period of time and to:
 - i. Overwhelm local system resources, including hospitals, mortuaries and Medical Examiner; or,
 - ii. Overwhelm the Medical Examiner when all event victims are identified as Medical Examiner cases.
6. **Personal Hygiene and Sanitary Needs**
 - a. Personal hygiene and sanitary needs of patients during emergencies will be provided. Availability of water supply used for personal hygiene and sanitary water pumps / lift stations at the hospital are connected to emergency power sources. In addition, when water intended for hand washing is not available, the hospital utilizes waterless alcohol based hand rub, which is maintained in ample supply at the hospital.
 - b. The alternative means to personal hygiene can be baby wipes, personal wipes, or alcohol-based rubs.
 - c. The alternative means to sanitation, if toilets are inoperable include the use of portable bed side commodes, ~~is kitty litter,~~ and red bags in toilets. ~~or bucket brigade.~~
 - d. ~~Limit changes of bed linen to those patients who have gross soiling from draining wounds, catheters, etc.~~
 - e. Environmental Services use of water will be curtailed to the extent of one change of water per day for mopping except in surgery, delivery rooms, and isolation areas.
7. **Departmental Roles & Responsibilities**
 - a. **Departmental Status Reporting**
 - i. Within 15 minutes of EOP activation, each on-duty department leader or designee, shall submit the Emergency Incident Message Form to the ICC. This form will be faxed (see fax number on form) or delivered by runner. The following information should be submitted:
 - 1) Department/Unit
 - 2) Emergency Department Capacity
 - 3) Number of:
 - a) Available beds
 - b) Staff on duty
 - c) Staff for the labor pool
 - d) Patients that can be discharge

- e) Vents
 - f) Patients that can be transferred to lower level of care
 - g) Tracking (patient count)
 - h) Comments/questions
 - ii. Status reports should be communicated to the ICC periodically through the incident. Problems encountered shall be communicated immediately.
- 8. Departmental Plans/Preparedness
 - a. ~~Specific~~ Each department shall have a department plan to implement during an emergency incident. ~~This plan, called a Department Emergency Action Plan (DEAP), shall be prepared by the department leadership. Department specific plans shall be reviewed annually and update at least every three years. , and updated annually or as needed. The plans at~~ At a minimum , each DEAP should ~~includes~~shall include the following:
 - i. Process for reporting status to the ICHCC
 - ii. Notification process for departmental staff, including staff augmentation process
 - iii. Process for terminating and reactivating nonessential functions
 - ~~Process and location of department Emergency Evacuation Assembly Area~~
 - ~~Shelter in Place plan~~
- 9. Safety and Security
 - a. Safety
 - i. The Safety Officer/designee is assigned to ensure the safety of staff, patients, and visitors, conduct a safety assessment, and to monitor and correct hazardous conditions related to the incident. The Safety Officer/designee has the authority to halt any incident-related activity that poses an immediate threat to life and health.
 - ii. Some activities include, assessing and understanding the situation and the hospital's response, conducting a focused safety threat/risk assessment, determining and directing implementation of necessary risk reduction and protective measures (including use of personal protective equipment), and maintaining situational awareness of self and others regarding safety risks and evolving hazards or their mitigation.
 - b. Security
 - i. Security Officers or designees shall:
 - 1) ~~Be~~ deployed to the Emergency Department's (ED) point of entry to monitor access and restrict it to employees
 - 2) ~~Security officers shall~~ Be assigned to provide crowd control at incident-related/affected areas per policy
 - 3) ~~Officers should~~ Establish contact with on-scene police department representatives immediately upon their arrival.
- 10. Coordination of Security Activities with Community Security Agencies
 - a. Coordination Activities
 - i. The TCMC's Security Departments maintains an ongoing relationship with the community security agencies in San Diego County. For an incident with a primary security focus, the Security Supervisor / designee shall establish a Security Command Post (SCP).
 - ii. Each community security agency participating in on-site security activities shall assign a radio-equipped senior officer to the SCP as a liaison to ensure optimal coordination and maximize effectiveness. As needed, the SCP may issue hospital security radios to ensure interoperability and coordination with community security agency liaisons.

- iii. The Security Supervisor /designee shall participate in a unified command structure with the responding community security agency commanders, where possible.
- b. Control of Facility Access, Egress, and Individual Movement
 - i. Review the Security Traffic Control in the Event of a Disaster policy
 - ii. During a disaster the following actions will be implemented:
 - 1) Access Restriction - Workforce members will display their hospital photo-identification badge prominently on their outermost garments during EOP activation. Security officers will stop and deny access to incident facilities to any staff member not properly identified.
 - 2) Signage - appropriate signage will be posted to secure entrances. Only workforce members with proper identification will be allowed access to the facility. Security officers and designated staff members will be assigned to all entrances to control visitors. Non-direct patient care personnel, hospital volunteers, and chaplains will be assigned to assist visitors as needed.
 - iii. Facility Visitor Control
 - 1) As directed by the IC, Security Officers prepare to institute 100 percent-identification checks of all personnel every person entering hospital buildings.
 - 2) Only individuals people wearing hospital identification (ID) badges or accompanied by such a person wearing a hospital ID will be allowed in the hospital.
 - 3) Relatives of incident victims will be directed to an identified location.
 - 4) Direct deliveries (e.g., food, flowers) will not be permitted; items will be left in a designated location for staff delivery within the building.
 - iv. Media Access
 - 1) Security Officers should be alert to the potential for news media presence, be prepared to escort credentialed members of the press to the Media Staging/Briefing Area where press briefings will be given, and keep news media away from family members. At no time will members of the press be permitted access to the facility without authorized escort.
 - v. Vehicular Restriction
 - 1) As directed, Security Officers shall establish barriers at all vehicular entrances to hospital grounds and parking facilities.
 - 2) Officers shall attempt to expedite removal of vehicles from key areas to facilitate access for emergency equipment. Only the following vehicles shall be permitted onto grounds:
 - a) Law Enforcement
 - b) Fire Department
 - c) Emergency Medical Service
 - d) San Diego County Office of Emergency Services (OES)
 - e) Authorized Emergency Vehicles
 - f) Staff (with proper identification badge/card)
 - vi. Vehicle Removal
 - 1) Unattended vehicles will not be permitted in restricted areas. Such vehicles will be towed as needed.
 - 2) Press vehicles will be directed to the Media Staging Area.
- 11. Hazardous Materials & Waste Management during EOP Activation
 - a. In the absence of functioning processes for management of sewage, bio-hazardous waste, and/or other hazardous materials during an emergency, the

- Environmental Services Supervisor or designee shall assume responsibility for waste management. Strategies may include (but are not limited to):
- i. Waste stream reduction strategies
 - ii. Use of alternate waste collection and disposal methods
 - iii. Use of improvised on-site storage facilities for securing toxic or hazardous materials until proper disposal methods can be re-established
- b. In the event of a disaster the hospital will follow hospital policies along with using their approved vendors for medical waste and hazardous waste.
- i. If identified vendors are unable to provide services for an extended amount of time, we would store/stock pile all waste in their pre-determined secured areas. Should a large radiological event occur, the radioactive material, (clothing, personal belongings, shrapnel, etc.) would be stored in a pre-designated area, down wind and away from the hospital.
 - ii. Items will be placed in a red bag, labeled with the patient's identification (if known) and kept there until advised what to do with the material by the County of San Diego Hazardous Materials (HAZMAT) Team.
 - iii. The hazardous material will be placed in a covered container and if need be larger containers will be obtained. ~~per hospital policy.~~
 - iv. A security officer or designee will be placed at the perimeter of this area, in proper PPE if indicated. If needed, the area may be secured per hospital policy.
- c. TCMC is equipped to manage decontamination with known chemical, biological, and radiological contaminants
- d. Disposing of Hazardous Waste
- i. See the Hazardous Waste policy
- e. Facility Contamination
- i. If the facility is contaminated, a contractor experienced in the isolation and decontamination process is notified by the IC or designee. Security will ensure containment and isolation of the affected area until it is declared safe by appropriate experts.
12. Staff and Family Support
- a. Housing
 - i. When conditions warrant the implementation of staffing augmentation plans and/or require boarding arrangements for staff members, the IC will delegate a leadership team member to coordinate such arrangements.
 - b. Staff Transportation
 - i. External conditions may create transportation difficulties for staff, inhibiting their ability to report for duty. When needed, the Transportation Unit shall coordinate transportation resources and arrangements through the Support Services Branch. If necessary, the hospital's utility vehicles, passenger vans, cars assigned to facility executives/leaders will be used.
 - c. Dependent Care
 - i. Dependent care areas may be established as needed. -At the discretion of the IC, when conditions warrant, the hospital will provide on-site child and elder dependent care for staff dependents, enabling the staff members to report for duty. These areas will be supervised by a designated the Dependent Care Unit Leader, and staffed by hospital volunteers, designated hospital staff and staff from the Labor Pool.
 - d. Staff Augmentation
 - i. It is the policy of TCMC to consider any employee on the premises during an EOP activation to be on duty. An employee may be called upon to support other duties ~~aid in duties~~ (within their scope of practice), ~~other than prescribed by his or her job~~, other work in departments or carry out

functions other than those normally assigned, and/or work hours in excess of (or different from) his or her normal schedule.

e. **Staffing Expansion Considerations**

i. Options for expansion of both clinical and nonclinical staff include the following:

- 1) Temporarily increase nurse-to-patient ratios on floors
- 2) Ask current staff to remain on overtime after shift
- 3) Modify or extend 8 and 12-hour shifts. Call back off-duty staff from earlier shift
- 4) Contract additional agency nurses
- 5) Cancel staff days off (first one per week, then both)
- 6) Cancel holidays and vacation leaves
- 7) Coordinate through the Corporate Command Center, who will work with the San Diego County Department of Health and San Diego County Medical Operations Center for staffing support from outside the hospital

f. **Staff Health Surveillance**

i. The employee Health Department will take measures to effectively anticipate, recognize, evaluate, control, and mitigate health threats encountered during response and recovery operations. Specific activities include:

- 1) Ensuring staff/workplace health surveillance requirements are identified
- 2) Directing and documenting health risk assessments
- 3) Determining required post-incident health surveillance activities based on known or potential health threats
- 4) Updating health risk assessments and medical countermeasures as new information becomes available
- 5) Enforcing the use of all required prophylactic medications, treatments, and personal protective equipment
- 6) Developing and implementing health risk communication plans
- 7) Submitting medical information related to infectious disease or environmental exposures to Infection Control, Risk Management, Safety and/or Human Resources.
- 8) Submitting health-related lessons learned after debrief to the ~~and after-action reports through the~~ Emergency Management Coordinator.

ii. Following demobilization, staff involved in event response and recovery operations shall be evaluated by a trained healthcare provider as indicated. The assessment will address actual/potential environmental exposures, injury or illness resulting from the event, and mental health or psychosocial issues. Appropriate medical referrals will be coordinated by the Employee Health Department. Required medical treatment and follow-up will be provided as directed by the Workers Compensation Program and related Human Resources policies. Referral providers will document staff member suitability for returning to work and any physical or other work restrictions and considerations. Essential data and records of staff work locations, medical evaluations, occupational/environmental health activities, patient/casualty encounters, and reportable medical events are collected and made available to appropriate entities for review as necessary.

13. **Disaster Privileging**

a. **Licensed Independent Practitioners (LIP)**

i. LIPs – See LIP policy.

- ii. Under the direction of the Chief of Staff, IC or designee, disaster privileges may be granted to licensed independent practitioners who volunteer to assist the facility. The privileges should be effective immediately and continue through the completion of the patient care needs or until the orderly transfer of patient care to an appropriately credentialed member of the medical staff can be accomplished.
 - iii. Following approval for emergency credentialing privileges the practitioner shall be provided and maintain on his or her person written verification of said privileges and identifies the practitioner's role in the emergency response and identifies by name the person to whom they report.
 - iv. The practitioner shall take direction from the Department Chairman, or designee, in their clinical specialty regarding patient care services. The practitioner's notations in the medical record shall reflect that the physician is working under "Disaster Privileges." Practitioners will complete Review the Temporary Disaster Privileges Application.
 - b. Medical Volunteer Credentialing and Identification
 - i. The Logistics Section Chief shall ensure that, as conditions warrant, appropriate identity and credentialing verification processes are followed. Review the Temporary Disaster Privileges Application.
- 14. Resource and Asset Management
 - a. Inventory Management
 - i. TCMC maintains a current inventory available to support the organization and patients during an emergency. Assets listed include volunteers, PPE, food and water, medical/surgical supplies, pharmaceuticals, linen, fuel for generators and vehicles, emergency lighting and communications equipment, evacuation chairs and slides, patient movement equipment, durable medical equipment, administrative supplies, and other items. The Resource Inventory is reviewed at least annually to ensure that adequate resource levels are maintained and supplier/vendor contact information is current.
- 15. Communication with Surveyors of Essential Supplies, Services, and Equipment
 - a. Contact information for around-the-clock (~~24x7x365~~) access to primary, secondary, and tertiary /alternate vendors for all critical supplies, services, and equipment are maintained:
 - i. By the leadership of the Supply Chain Department~~hospital department~~ that routinely orders and maintains the stock of the particular good or service.
 - ii. By the supply chain department, which assumes the role of the Procurement Unit during EOP activations
 - b. At the outset of an incident during which critical resources may be needed, the Procurement Unit Leader shall be notified by the Planning Section Chief of a projected resource shortfall, and vendor contact shall be initiated. As conditions warrant, the Procurement Unit Leader shall contact one or more vendors, including others not listed, until an acceptable source of supply is identified and arrangements are made to meet the need.
- 16. Resource Monitoring
 - a. During EOP activation, the Resource Unit (Planning Section) shall maintain current operational inventory status on all resources used for, or affected by, the incident. Such information shall be gathered and documented during the first eight hours of the incident, and every operational period thereafter. When pre-identified par level thresholds are met, the Resource Unit Leader~~Planning Section~~ shall follow up with Finance/Administration and Logistics Sections to ensure that necessary resource replenishment has been accomplished.
 - b. In the event resource replenishment cannot be accomplished, the Planning Section Chief shall develop alternative strategies for resource conservation and/or

HAZARD VULNERABILITY ANALYSIS PERFORMED BY THE MEDICAL CENTER.

1. The medical center has developed specific procedures in response to potential disasters and emergencies that may occur. Additionally, the medical center will create a Hazard Vulnerability Analysis (HVA) to identify areas of vulnerability and to undertake provisions to lessen the severity and/or impact of a disaster or emergency that could affect the services provided by the medical center.
2. The HVA is evaluated on an annual basis and input from the local fire department and community agencies and will be obtained to assure the medical center is aware of hazards in the community to which an emergency response may be required.
3. The medical center has developed a Utilities Disruption Matrix designed to provide available operational hours prior to departmental shut down or commencing of evacuation procedures. The Utilities Disruption Matrix is based on the medical center having the capabilities of operating self-sufficiently for up to 96 hours without the assistance of external agencies or resources.
4. For each emergency identified in the medical center's HVA as a high risk, the following shall be defined:
 - a. Mitigation activities that are designed to reduce the risk of potential damage due to an emergency situation.
 - b. Preparedness activities that organize and mobilize essential resources.
 - c. Response strategies and actions to be activated during an emergency situation.
 - d. Recovery strategies/actions that will help restore the systems that are critical to resuming normal operations of the medical center.
5. Will maintain a documented inventory of on-site assets and resources that will be needed during an emergency. At a minimum, this inventory should include:
 - a. Personal Protection Equipment (PPE)
 - b. Water
 - c. Fuel
 - d. Staffing
 - e. Linen
 - f. Cleaning Supplies
 - g. Food
 - h. Medical/Surgical Resources
 - i. Pharmaceutical Resources
6. The inventory of assets and resources shall be evaluated on an annual basis or as needed.
7. Methods shall be in place for the monitoring of the inventory of assets and resources during an emergency situation.

F. DEFINE AND INTEGRATE THE MEDICAL CENTERS ROLE WITH THE COMMUNITYWIDE EMERGENCY OPERATIONS EFFORTS TO PROMOTE INTER-OPERABILITY BETWEEN THE FACILITY AND THE COMMUNITY:

1. The Emergency Operations Plan shall be tested and exercises shall be developed based on the medical center's top scoring emergency situations within the Hazard Vulnerability Analysis. The exercise shall validate the effectiveness of the Emergency Operations Plan and will identify opportunities to improve.
2. The Emergency Operations Plan shall be tested and exercised a minimum of two (2) times per year, either in response to an actual emergency or in a planned exercise.
3. Only one (1) exercise per year shall include an influx of volunteer or simulated patients.
4. At least one (1) exercise per year shall be evaluated to see how effectively the hospital performs when the medical center cannot be supported by the local community for up to 96 hours. (Tabletop sessions are acceptable to meet the community portion of this exercise).
5. If applicable, the medical center will participate in at least one (1) communitywide exercise annually that is relevant to the priority of emergencies defined in the hazard vulnerability analysis. (Tabletop sessions are acceptable to meet the community portion of this exercise).
6. The Manager of Safety (Safety Officer) is identified as the designee whose sole responsibility

during emergency response exercises is to monitor performance and document opportunities for improvement.

7. The medical center cooperates with all local, county and state emergency management exercises. The Safety Officer is a member of the countywide emergency management system and coordinates with other agencies on any large scale exercises. San Diego Department of Public Health and Human Services Agency/EMS and Statewide Disaster planning efforts, coordinate with local police, fire and ambulance services in conjunction with acute care facilities.

G. COMMAND STRUCTURE:

1. The command structure utilized by the medical center in coordination with the communitywide structure will be the Hospital Incident Command System (HICS).

H. INITIATING THE PLAN, INCLUDING DESCRIPTION OF PLAN ACTIVATION:

1. The Emergency Operations Plan will be activated when it has been determined that a disaster or emergency situation has occurred or has the potential of occurring.
2. The Joint Commission's definition of an emergency:
 - a. *"a natural or man-made event that significantly disrupts the environment of care; that significantly disrupts care and treatment; or that results in sudden, significantly changed or increased demands for the organizations services. Some emergencies are called 'disasters' or 'potential injury creating events'."*
3. When the facility is notified of an emergency situation, the person receiving notification will immediately notify the Chief Executive Officer or his/her designee of the situation whether it be an external or internal emergency. The Nursing Administrative Supervisor will respond to the site of an internal emergency and report back to the Chief Executive Officer or his/her designee, the status of the situation.
4. The Chief Executive Officer or his/her designee will evaluate the emergency situation to determine whether the Emergency Operations Plan will be activated. If the Emergency Operations Plan is to be activated, the Chief Executive Officer or his/her designee will notify the Switchboard Operator to announce Code Orange External/Internal overhead.
5. The Chief Executive Officer or appointed designee will assume responsibility of the Hospital Incident Command center and activate the appropriate positions noted on the Incident Management Team Chart as deemed necessary for the occurrence:
 - a. Until the Incident Command System is in place, the Chief Executive Officer or his/her designee will determine if the Labor Pool will be opened depending on the size of the emergency situation. If the Labor Pool is not opened, the Nursing Administrative Supervisor may assign additional assistance to the Emergency Area as needed. Additional personnel will be called in as needed via the staff call back system.
 - b. The Nursing Administrative Supervisor will notify additional outside agencies that may need to assist the medical center in the event of an internal emergency (*i.e. fire department, police department or other agencies*).
6. The recovery phase will be initiated after the emergency situation is over and the medical center has been evaluated. The recovery phase of the plan is to be initiated by the Chief Executive Officer or his/her designee.

I. COMMUNICATION:

1. Notification of External Authorities:
 - a. The medical center shall have a communications system in place, including two-way radio equipment and operators who are familiar with the equipment's operation.
 - b. The medical center will provide for alternate communication methods in the event of a failure. Two-way radio equipment and cell phones shall be available in the event of an emergency. In the event that cell phones are not working, microwave communications, satellite phones, ham radios or portable 800 MHZ radios may be used.
2. The Safety Officer will approve media access to the facility, with only the Public Information

service reduction. This shall be done in coordination with the appropriate department managers of IS, Supply Chain Management, Pharmacy, and Facilities Management. In the event that resource shortfalls are projected, the following actions may be implemented at the direction of the IC:

- i. Procurement from alternate or nontraditional vendors
- ii. Procurement from communities outside the affected region
- iii. Resource substitution
- iv. Resource sharing arrangements with mutual aid partners
- v. Request for external stockpile support from the County Department of Health logistics cache
- vi. Request for external stockpile support from the State Department of Health Medical Emergency Response Cache (MERC), or the Strategic National Stockpile (SNS) (these requests go through the San Diego County Office of Emergency Services (OES)).

17. Resource Sharing

- a. In the event of a large-scale emergency or regional crisis, there may be a need for sharing resources and assets with our mutual aid partners, other healthcare organizations in the community or contiguous geographic area, or organizations across a larger region of the country. Resources and assets that may be shared include but are not limited to beds, transportation resources, linen, fuel, PPE, medical equipment, and supplies.
- b. Communication and coordination regarding the need for resources and assets shall be communicated initially through the Liaison Officer, to or from the mutual aid partner or local entity requesting or providing support.
- c. If resources are needed beyond the scope of our mutual aid partners or local entities, the Logistics Section Chief shall direct the Liaison Officer to establish contact with the County Office of Emergency Management Emergency Support Function (ESF) #8—Public Health Preparedness & Response desk. County Office of Emergency Management (OEM) will serve as the coordinating point for managing resources and asset deployment both within and outside the county during a large-scale incident.

18. Mutual Aid

- a. TCMC participates in local/regional preparedness and response initiatives and is prepared to share resources and assets both within its local jurisdiction, operational area, and within its region.

19. Volunteer Management

- a. The Logistics Section Chief shall ensure that, as conditions warrant, appropriate identification and access authorization processes are followed. Hospital identification indicating "Volunteer" and the individual's name shall be provided and displayed conspicuously at all times while the volunteer is engaged in the response.

20. Donation Management

- a. Three donation scenarios may arise when affected by a major emergency in the community. These donation scenarios include offers of miscellaneous goods and services from members of the public, blood donations from individuals, and donations of medical supplies and/or equipment, including pharmaceuticals, from an identified supplier/vendor.
- b. The following processes will be used to ensure the most efficient and effective utilization of donated goods received by the hospital during an incident. It is likely the receipt of goods and services will not coincide with the needs of the hospital or the healthcare needs of the community. Therefore, goods and services must be coordinated to realistically assess what is available versus what is needed.

21. Miscellaneous Goods and Services—General Policy

- a. Except in extraordinary circumstances, unsolicited offers of donated goods or services should be referred to the County Emergency Operations Center through the Corporate Emergency Operations Center operated by the Corporate Disaster Preparedness Department. Depending on the scope of the incident, the county, or a designated Voluntary Organization Active in Disaster (VOAD), may establish a Donations Coordination Center (DCC) under the direction of a Donations Specialist. The DCC will be the responsible entity for receipt, cataloguing, warehousing, and integration/distribution of donated goods into and through the county's overall disaster supply system.
 - b. Press releases and other forms of public information will be used to encourage and guide public donations. Donors will be discouraged from sending unsolicited goods directly to the hospital. Donors should be encouraged to make cash donations to locally sponsored funds or to established local charitable organizations.
 - c. As needed, the Logistics Section Chief shall be responsible for assessing unmet needs and coordinating with the DCC regarding availability of donated goods and services to meet these needs from the available donations and volunteers responding. The Logistics Chief shall also arrange for the transport of goods and materials to or from the hospital as conditions warrant.
- 22. Responsibility
 - a. The Support Branch Director~~Logistics Section Chief~~ shall be responsible for leading the donations management process (goods other than blood). If necessary, a Donations Specialist shall be assigned to the Logistics Section. The Logistics Section shall:
 - i. Establish a process for receiving and securing donated goods
 - ii. Establish a database and maintain tracking of all donated goods and services, including a record of the source and date received
 - iii. Warehouse and safeguard donated goods until they can be distributed
 - iv. Be alert for perishable items (e.g., food), hazardous or unidentified items (which may pose a threat), or items requiring special handling (e.g., medications requiring refrigeration)
 - v. Maintain a listing of goods and services offered or available from any source
 - vi. Coordinate with recognized local support agencies to determine available resources and needs, and to arrange for distribution of donated goods to the community as available
- 23. Blood Donations
 - a. Often, during a traumatic event, people present themselves at community hospitals to donate blood. The need for this is often promoted by the media, typically without a request from the hospital. In fact, any blood donated during a disaster must be screened by multiple tests to maximize the safety of transfused blood and components. These tests may be performed at the hospital laboratory or at the American Red Cross Southern California Blood Services Region, and will take about 48 hours to complete. However, to reinforce initial blood stores that may be rapidly depleted during a crisis, the hospital will establish an emergency blood donation program if the need arises. The following steps will be taken:
 - i. The Blood Donor Services Unit (Operations Section, Medical Care Branch, Clinical Support Services Group) shall be activated. The Unit Leader shall be responsible for carrying out all blood donation-related activities.
 - ii. A blood donor waiting area shall be established
 - iii. Signage shall be posted directing prospective blood donors to the waiting area

- iv. As needed, other pre-identified areas may be converted to an overflow blood drawing facility
 - v. A Security Officer shall be assigned to monitor the waiting area and assist donors on arrival. All security procedures in effect (e.g., access control; 100 percent identification check) shall be enforced for arriving blood donors.
 - vi. The Blood Donor Services Unit Leader shall coordinate with the Support Branch Director to arrange for needed staff, supplies, and transportation, including additional blood storage space if necessary.
- 24. Donations from an Identified Supplier/Vendor
 - a. In the event that an unsolicited apparent donation of supplies or equipment arrives at the hospital, the shipment shall not be accepted without the express authorization of the Finance Section Chief. The identity of the purveyor shall be established, and the Supply Unit Leader, in consultation with supply chain, shall determine whether the goods have been ordered or are needed. If no valid order can be verified, only the Finance Section Chief or designee is authorized to accept the delivery. ~~This policy exists to protect the hospital from taking delivery of unneeded "donations" that are subsequently billed to the hospital after the crisis.~~
- 25. Utility Management
 - a. TCMC has identified alternative means of providing critical utility services including but not limited to:
 - i. Electricity
 - ii. Water needed for consumption and essential care activities
 - iii. Water needed for equipment and sanitary purposes
 - iv. Fuel required for building operations, generators and essential transport services
 - v. Medical gas/vacuum systems
 - vi. Elevator
 - vii. Heating, ventilation and air conditioning (HVAC)
 - viii. Steam for sterilization
- 26. Loss of Community Support
 - a. There may be incidents or times when the local community is unable to support the hospital in six critical areas: communications; resources and assets; safety and security; staff responsibilities; utilities management; and patient clinical and support activities. Significant degradation or loss of local community support for any of the six critical areas may result in the suspension of specific services, alterations to the standards of care, temporarily or partial facility closure, or facility-wide evacuation.
 - b. Redundant communication systems are utilized to mitigate the impact on the facility and sustain operations for 96 hours. Multiple forms of communication have been identified within the facility.
 - c. Resources and assets are inventoried and maintained by the responsible department. These departments include but are not exclusive to Supply Chain Management, Dietary, Respiratory Therapy, Laboratory Services, and Engineering. Each of these departments maintains independent inventories of their supplies and estimate approximate usage timelines. These departments assist as advisors to the ICC to make difficult decisions to reduce or eliminate usage of certain supplies. When supplies and assets to support certain service lines are gone, the service lines are prioritized based on acuity and life-sustaining variables and are evacuated accordingly at the direction of the ICC.
 - d. In the All-Hazards approach, safety and security will be assessed through individuals deemed responsible for safety and security during an event. These individuals may include the following: Emergency Management Coordinator, Safety Officer, Plant Operations Director, or Infection Control. Each event may

take on different characteristics as time progresses, which may require operational changes to be considered. Individuals deemed responsible for Safety and Security will continue to assess situations throughout the events. ~~for 96 hours or until evacuated.~~

- e. Staff responsibilities are provided to each department with communication through the HICS organizational structure and DEAPs. During an event, departments and activities may be considered nonessential. Departments and individuals that are regarded as nonessential will be designated to the Labor Pool for reassignment to essential/business sustaining service lines at the request of the ICC. Department emergency call lists will be used to contact additional staff off campus. Volunteers will be credentialed and assigned tasks at the direction of the Labor Pool. Personal situations will be considered and resolved for staff members to sustain staffing for additional periods of time. ~~The staffing plan is designed to exceed 96 hours. However, resources required for different magnitudes of an event will significantly impact the staffing plan. If additional resources are unavailable, contract services, or through MOUs, the facility would be evacuated to an alternate care site.~~
 - f. Utilities are managed by the Engineering Department. The department has policies and procedures to respond to utility failures. An inventory of critical supplies on site, such as water and diesel, is maintained. Plant Operations provides direction to the ICC on the remaining resources during the event to estimate when utility resources may end.
 - g. Patient clinical and support activities would be available based on the supply, staff, and utility contingency plans. Clinical and support activities are altered to treat an influx of patients in the ED. An ED emergency operational plan includes predetermined locations for patients triaged. ~~Difficult decisions in regard to continuing or eliminating certain patient activities would be determined by the IC.~~ The Senior Medical and Administrative Staff, Operations Chief, as well as Medical Technical Specialists would serve as advisors when necessary. When patient clinical and support services cannot be provided, patients are evacuated to the nearest available facility.
27. Surge Support
- a. Bed Capacity/Expansion (Internal)
 - i. When the IC determines that normal bed vacancies cannot accommodate the admission requirements of casualties, the following steps shall be taken.
 - 1) The Incident Commander shall:
 - a) Identify capacity level needed and duration
 - b) Determine which surge spaces will be activated, in what order
 - c) Initiate transfer activities as needed to clear the ED of all pending admissions and holds, and maximize available ED and pre-admission holding space as rapidly as possible
 - d) Refrain from initiating in-patient discharge activities until valid confirmation of need is received from competent authority
 - e) Ensure notifications are made and waivers requested
 - 2) The Planning and Operations Section Chiefs /Director Throughput/Designee shall:
 - i) Initiate actions to maximize ED and holding capacity
 - ii) Begin canvassing to identify available rooms or space, patients ready for discharge, and prioritization of patients for discharge
 - iii) Initiate measures to staff surge spaces as directed

- iv) The Logistics Section Chief shall initiate measures to open, acclimatize, clean, equip, and supply surge spaces as directed.
 - v) The Finance/Administration Section Chief shall initiate cost tracking for all associated expenses, and shall prepare projections of daily impact based on anticipated surge level.
 - ii. As many patients as possible normally scheduled for discharge the following day will be discharged immediately; available house staff physicians shall be prepared to discharge these patients upon notification.
 - iii. Patients admitted for elective surgery will be discharged and re-admitted at a later date.
 - iv. Additional beds can be made available by doubling and tripling bed capacity in existing patient rooms, or using classrooms and waiting rooms as patient rooms.
 - v. Patients selected for evacuation, either discharged to home or to another facility, will be sent to the hospital lobby. Nursing will supply staff to oversee these areas with the help of house staff and other physicians. Patients who are discharged to home will be directed to leave immediately and directed to the hospital lobby.
- 28. **Alternate Care Site Operations (ACS) External**
 - a. 1135 Waiver
 - b. These waivers under section 1135 of the Social Security Act typically end no later than the termination of the emergency period, or 60 days from the date the waiver or modification is first published unless the Secretary of Health and Human Services (HHS) extends the waiver by notice for additional periods of up to 60 days, up to the end of the emergency period.
- 29. **Alternate Care Site Operations (ACS) External**
 - a. There are several circumstances under which establishment of an alternate care site may become necessary. These include:
 - i. The need to evacuate all or part of the hospital due to an internal or external event threatening the facility or its occupants
 - ii. An external incident producing a patient load that exceeds the facility's in-patient capacity for care
 - iii. An event where special circumstances, such as a communicable disease threat, require separation of some patients from the general hospital population
 - iv. An event where the facility is tasked with establishing a screening facility or point of distribution for medication or vaccination during a community-wide crisis.
 - 1) Under such circumstances, the IC may elect to activate one or more preplanned alternate care facilities.
- 30. **Incident Demobilization**
 - a. Demobilization is the orderly, efficient disengagement and release of resources from the incident response and the hospital's return to normal operations. Planning for demobilization should actually begin from the outset of the response.
 - b. The criteria to begin demobilization will vary incident by incident, but fundamental considerations are based on a reduction of impact of the event on the hospital. Impact assessment should include the following:
 - i. The number of incoming patients is declining to a level manageable using normal staffing patterns and resources.
 - ii. There is no secondary rise in patient volume expected.
 - iii. Other responders are beginning their demobilization.
 - iv. Other critical community infrastructure returns to normal operations.

- c. For large-scale and/or community-involved incidents, the IC shall consult not only with Command and General Staff but also with external decision makers, such as other hospitals, public health/ public safety agencies, and the local EOC, before making a final decision to begin demobilization. Depending on the situation, not all areas of the hospital may be able to begin demobilization at the same time. Thus, planning will need to address not only when the demobilization process is to begin but also how it will be implemented.

31. Finance/Administration

- a. The IC maintains overall responsibility for tracking and managing incident-related costs and expenditures. Incident financial activities involve developing financial monitoring strategies and outlining costs, expenses, funding sources, and contracting arrangements to accomplish the incident goals as determined by the IC. Finance/administration functions include tracking of personnel time and related costs, ordering items and initiating contracts, arranging for personnel-related payments and Workers' Compensation, tracking of response and recovery costs, and payment of invoices.
- b. To optimize the tracking process, incident-related costs shall be accounted for from the outset of the response. The primary costs to be closely tracked should include any expense that may be considered either directly or indirectly incident-related. Costs that would be incurred on a routine basis (such as routine facility operations, or staff that would have been working their regular shifts anyway) are not generally reimbursable, so their tracking is not essential.
- c. Costs to be monitored closely include:
 - i. Personnel (especially overtime and fee-for-service staff)
 - ii. Event-related patient care and clinical support activities
 - iii. Incident-related resources
 - iv. Equipment repair and replacement
 - v. Costs for event-related facility operations
 - vi. Vendor expenses
 - vii. Mutual aid financial remuneration
 - viii. Personnel illness, injury, or property damage claims
 - ix. Loss of revenue-generating activities
 - x. Cleanup, repair, replacement, and/or rebuild expenses

L. RECOVERY:

- 1. Recovery and Resumption of Normal Activities
 - a. Recovery activities are designed to return the organization to its pre-event state by restoring systems critical to the provision of care, treatment, and services. Recovery actions include compiling event documentation, conducting a critique, preparing an after-action report, performing critical incident stress debriefing, replenishing stock, repairing or replacing equipment, addressing physical plant issues, reviewing and revising the emergency operations plan and/or procedures, and training or retraining personnel, as necessary.
- 2. Facility Repair and Inspection
 - a. As the hospital enters the recovery phase, there are several facility issues to consider. The first, general housekeeping and cleanup is likely to be indicated following almost any response. The combination of response-related activity, coupled with the possible suspension of nonessential routine housekeeping services to free up staffing for other assignments, suggests that early attention is needed in this area. The Infrastructure Branch shall take the lead in inspecting the facility and in planning, prioritizing, and organizing the cleanup personnel and assignments to accomplish the work expeditiously.
 - b. The second issue—damage assessment and mitigation—is indicated if the facility was involved in the problem (e.g., fire, flood, and earthquake) or has been unable

Officer (PIO) interacting with the media.

3. A medical record system will be used to meet the minimum requirements of emergency management operations.

J. **PERSONNEL RESPONSIBILITIES:**

1. Notification of Personnel When Emergency Operations Plan is initiated:
 - a. In an emergency situation which is so wide spread to be considered an emergency and/or involving mass casualties, all medical center personnel, regardless of position, are expected to report to the medical center as soon as it is feasible to travel. Each department director maintains a current callback list of all personnel assigned to their department. Once the Emergency Operations Plan has been activated, the department director in cooperation with Human Resources will assign a staff member to initiate the call back list.
 - b. In the event there are excess personnel, the Hospital Command Center will communicate with department directors regarding rescheduling of personnel future needs. The medical staff will report to the Chief of Medical Staff or Medical Specialist Officer for their assignments.
2. Alternate Roles and Responsibilities of Personnel during Emergencies:
 - a. Personnel may not be assigned to their regular duties. Personnel will be asked to perform various jobs which will be considered vital to the effective operation of the hospital during the emergency situation. Personnel will be assigned duties based on the needs of the medical center. If personnel are not needed in their perspective units/departments, they will be sent to the Labor Pool for assignment.
3. Identification of Personnel in Emergencies:
 - a. Personnel on duty during activation of the Emergency Operations Plan will be identified by their picture identification name badge, which is mandated to be worn at all times while on duty.
 - b. Only persons wearing proper identification or possess valid credentials shall be allowed entrance into the medical center during an emergency situation.
4. Personnel Activities and Support:
 - a. The medical center has made provisions for staff support that can be implemented in the event of a communitywide emergency. Such provisions may include but not limited to:
 - i. Temporary housing/lodging needs.
 - ii. Transportation needs.
 - iii. Family support needs, as necessary (including short term child care)
 - iv. Incident stress debriefing and counseling.
5. Orientation and Training:
 - a. Personnel will attend orientation upon hire and annually thereafter, reviewing their specific roles and responsibilities during an emergency/disaster situation.
 - b. In-service education will be given to the specific staff on the backup communication system and obtaining supplies/equipment in the event of an emergency/disaster situation.
 - c. The Safety Officer or designee is responsible for in-servicing personnel to the Emergency Operations Plan.
 - d. The department directors are responsible for in-servicing their department personnel on the department specific responsibilities during an emergency/disaster situation.

K. **EMERGENCY CREDENTIALING OF CAREGIVERS:**

1. To provide a mechanism for emergency credentialing and granting privileges to volunteer/non-staff licensed independent practitioners in the event of a disaster.
2. The Chief Executive Officer or Chief of Staff or their designee(s), may grant emergency privileges upon presentation of a valid picture ID (issued by a state, federal or regulatory agency) e.g., driver's license or passport and at least one of the following:

- a. A current license to practice or primary source of verification of the license.
 - b. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT)
 - c. Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state or municipal entity.
 - d. Presentation by current facility or medical staff member with personal knowledge regarding practitioner's identity.
3. Verification of Information:
- a. Verification of the required information shall be done by the Medical Staff Office or designee as soon as feasible. A record of this information will be retained in the Medical Staff Office.
4. Conditions of Emergency Privileges:
- a. The emergency designee must practice under the direction and supervision of an existing member of the Tri City Hospital District.

L. RESOURCES AND ASSETS:

1. The medical center keeps a documented inventory of assets it has on site that would be needed in the event of an emergency or disaster situation. At a minimum, the inventory should include:
 - a. Linen
 - b. Cleaning Supplies
 - c. Personal Protective Equipment (PPE)
 - d. Water
 - e. Food
 - f. Fuel
 - g. Staffing
 - h. Medical Resources and Assets
 - i. Surgical Resources and Assets
 - j. Pharmaceutical Resources and Assets
2. Methods are established to monitor quantities of assets and resources during an emergency or disaster situation.
3. Arrange for emergency/disaster supporting services to be performed by local businesses, utility companies, government agencies and individuals. Emergency/ disaster supporting services may include:
 - a. Transportation
 - b. Communications
 - c. Traffic Control
 - d. Food Supplies
 - e. Utility Maintenance
 - f. Medical Supplies
4. These arrangements must be coordinated with the assistance of the Safety Officer, San Diego Department of Public Health or the local Office of Emergency Services (OES) whenever possible.
5. The medical center shall estimate its emergency needs for each kind of support and when feasible arrange to have supporting supplies, equipment and manpower pre-designated for medical center use.
6. Essential supplies, pharmaceuticals, medical supplies, equipment, food, water, linen, cleaning supplies and utilities shall be provided to meet shelter requirements for up to 96 hours when the medical center cannot be supported by the community. Procedures are in place for the procurement of additional supplies in an emergency.
7. In the event that the medical center cannot be supported by the local community for at least 96 hours, the Chief Executive Officer/Incident Commander, Incident Command Staff and in consultation with community leaders, will evaluate the following options and implement those

options that best serve the medical center and community:

- a. — Conservation of Resources
- b. — Curtailment of Services
- c. — Supplementing of resources from outside of the local community
- d. — Staged Evacuation
- e. — Total Evacuation

M. — SAFETY AND SECURITY:

- 1. — Efficient traffic flow must be established:
 - a. — Prepare floor plans which designate areas for specific patient care functions and ensure that personnel are familiar with these plans.
 - b. — Prepare and have available traffic control tools to show external and internal routing of casualties and other traffic.
 - c. — Assign and train volunteers to perform traffic control and security functions.
- 2. — At the time the Emergency Operations Plan is activated, the Security Department personnel will be responsible for locking all exits and entrances with the exception of the ambulance entrance which will be manned. The Security Staff shall maintain control of entry and egress from the facility. Personnel of the medical center are required to wear badges identifying them as personnel. Only persons with proper identification shall be admitted to the medical center during an emergency situation.
- 3. — Radioactive or Chemical Isolation and Decontamination:
 - a. — There is a designated decontamination room with separate ventilation system or ventilation shut off available for radioactive or chemical isolation and decontamination. Staff is trained in the response to radiological, biological, chemical or hazardous material contamination.
 - b. — Arrange with a local or State Emergency Management Agency Director (if applicable) for the training of staff who would perform the radiological monitoring of casualties and hospital areas and the acquisition of necessary radiological monitoring equipment. This equipment shall be stored in the medical center as part of its essential emergency supply equipment.

N. — UTILITIES MANAGEMENT:

- 1. — The medical center will provide for alternative sources of essential utilities, including:
 - a. — An emergency source of electrical power capable of operating all essential electrical equipment and plan for failure of back-up generators
 - b. — An alternate source for medical gas and vacuum delivery
 - c. — An alternate means of waste disposal in the event of sewage system failure
 - d. — Sufficient fuel to last for at least 96 hours of expanded operation

O. — PATIENT CLINICAL AND SUPPORT ACTIVITIES:

- 1. — Management of Patients during Emergencies (i.e. Scheduling, Modification or Discontinuation of Services, Control of Patient Information and Patient Transportation)
 - a. — Upon activation of the Emergency Operations Plan, normal admission requirements will be modified. Initially, admissions to the medical center will be limited to those whose survival depends upon services obtainable only through medical care.
 - b. — Outpatient care will be restricted to those whose lives may be ultimately depending upon the present expenditure of medical supplies and health manpower time.
- 2. — All elective admissions and procedures will be canceled, including elective surgery, no emergent outpatient and transferring patients who are stable to be discharged.
 - a. — Patients may be transferred to other facilities so those emergency victims may be accommodated.
 - b. — Individuals may be redirected or relocated for a Medical Screening Exam in the event that the Emergency Operations Plan has been activated. (Section 1135(b) of the Social

- to maintain an environment of care. In such cases, the Buildings/Grounds Unit, working within the Infrastructure Branch and the Safety Officer, shall be activated. One or more damage assessment teams shall be sent out to mitigate immediate threats, assess general safety and habitability, and survey and document damage. The Infrastructure Branch Director shall develop a plan of action for facility restoration and begin to carry out the plan as approved by the IC.
- c. Longer-term recovery is the third issue. Depending on the extent of the damage, repairs and restoration may take days to months to carry out. To expedite the necessary activities, the hospital may use outside vendors or contractors to perform some or all of the work. The Building/Grounds Unit, supported by the Infrastructure Branch, shall initiate the planning process, transitioning the information into the IAP process when possible. TCMC will reconstruct the facility using federal, state, and local authorities (California Occupational Safety and Health Administration (Cal/OSHA), National Electric Code (NEC), Uniform Building Code (UBC), Universal Product Code (UPC), and National Fire Protection Agency (NFPA) life safety code guide lines.
3. Accreditation and Licensure
 - a. The Joint Commission (TJC) provides specific re-accreditation requirements for organizations that have been closed or out of service as the result of a disaster and/or the organization's decision to cease operations. TJC will also work with responsible state and federal agencies to assist in re-establishing operations as well as its qualification for accreditation. This will be accomplished through State Department of Health Services architecture review and licensing department review.
 4. Resumption of Clinical Services
 - a. Once an environment of care is restored, the restoration of on-campus clinical service can begin. The Medical Care Branch Director shall investigate and report on the status of clinical services—specifically, what can be resumed (and in what timeframe), and what must continue to remain out of commission pending further activity or developments. If significant, the resumption and restoration process shall be prioritized and incorporated into the IAP for each operational period until completed.
 5. Repatriation of Patients and Staff
 - a. Repatriation is the process of returning patients and staff from relocation outside their normal service areas to their original hospital placement. Key elements of any repatriation planning include establishing communications between the facility and the returning individuals and leadership consideration of the evacuees' difficulties when returning to the facility.
 6. Resumption of Pre-Incident Staff Scheduling
 - a. As circumstances allow, personnel should be released from emergency duties to resume normal duties, attend to personal or family needs, be sent home, or to attend critical incident stress debriefing sessions, memorial services, or religious services. A staffing schedule should be quickly established, with early efforts targeted at releasing mutual aid personnel from other facilities, as well as volunteer licensed and non-independent licensed practitioners. Alternately, if the mutual aid and volunteer staffing will be used to provide relief for hospital staff, then one-for-one relief scheduling should be arranged, and a relief schedule posted. Other staff members may be released based on personal necessity. Personnel from other departments that were temporarily reassigned should be returned to their own departments for assignment. Personnel schedules may need to be adjusted to allow for rest periods and resumption of normal scheduling.
 7. Resource Inventory and Accountability
 - a. Department managers/ supervisors shall initiate an inventory of all supplies and equipment, and should request repair, replacement, or replenishment as needed

~~Security Act §489.24(a)(2)).~~

- ~~e. In the event the Emergency Operations Plan is activated, persons may be transferred prior to being stabilized, if, based upon the circumstances of the emergency the medical center is unable to provide proper care or treatment of services. (Section 1135(b) of the Social Security Act §489.24(a)(2)).~~

P. EVACUATION OF THE FACILITY:

- ~~1. When an emergency situation arises requiring evacuation of patients from threatened or affected areas, the safety of lives at Tri City Hospital District is the primary concern. Authority to order an evacuation is vested only with the Chief Executive Officer, his/her designees, or the Safety Officer. Patients shall be evacuated to an area of safety by whatever means are available. Formal agreements are in place with ambulance services and alternate care sites to transfer patients as necessary.~~
- ~~2. All personnel have been trained in evacuation procedures. Evacuation routes are posted throughout the medical center.~~
- ~~3. Relocation to alternate health facility or place of safety (i.e., churches, schools)~~
 - ~~a. Prepare maps of routes to relocation site~~
 - ~~b. Confirm periodically the availability of the relocation site~~
 - ~~c. Establish lists of supplies and equipment, by priority, to be relocated~~
 - ~~d. Arrange adequate transportation for evacuation and relocation~~
- ~~4. Establishing an Alternate Care Site When the Environment Cannot Support Adequate Patient Care~~
- ~~5. Formal agreements should be in place so that patients may be transferred to a facility that can provide adequate patient care. The Liaison Officer will be responsible for the inter-facility communication between the medical center and the designated alternative care site, and for retaining records of which patients were transferred to and/or from an alternative care site. The patient care unit transferring the patient is responsible for obtaining copies of the patient's medical records, gathering personal belongings and ensuring the patient's medications are continued throughout the transfer. If medical equipment is transferred with the patient, the patient care unit is responsible for documenting what equipment was transferred with the patient so that equipment may be retrieved during the recovery phase post emergency. The following agreements are in place:~~
 - ~~a. Ambulance contract agreements for transfer of patients between facilities~~
 - ~~b. Transfer agreements will be made between neighboring facilities~~
 - ~~c. Emergency acquisitions of medical supplies, pharmaceuticals, food, equipment, water, linen, emergency repair services, etc.~~

Q. CONTINUING AND/OR RE-ESTABLISHING OPERATIONS FOLLOWING AN EMERGENCY:

- ~~1. The medical center has mechanisms in place to restore the operational capabilities of the facility to pre-emergency levels. Once the emergency is over, the Engineering Department, including the Director of Facilities, Safety Officer, Risk Manager and other administration representatives, will begin assessing the damage to the facility and the environmental concerns to determine whether the medical center can safely provide medical care to the community and provide a safe environment for patients, personnel and visitors.~~
 - ~~a. Picture and/or videos will be taken of all damages to the facility's buildings, grounds, equipment, etc., including all off campus facilities.~~
 - ~~b. Architects, building inspectors and structural engineers may be called in to determine if the buildings are safe for occupancy.~~
 - ~~c. All potential environmental concerns will be evaluated for proper function, i.e., hazardous waste, fuel tanks, to ensure there is no leakage into the local sewer or water system or any other impact on other environmental concerns.~~
 - ~~d. Ensure personnel support programs have been instituted, i.e., crisis counseling, flexible work hours, cash advances, day care, particularly if your personnel and the medical center have been directly impacted by the emergency.~~

from the Logistics Section and/or from appropriate departments. This should be done by on-duty personnel immediately after the incident has ended and should not be postponed until the next shift or ordering day. Department managers/supervisors shall ensure that their areas are returned to a state of full operational readiness as quickly as possible.

8. **Critical Incident Stress Management (CISM)**
 - a. Following a crisis, it is essential that all participating staff come together within 24 hours for a debriefing that will focus on the prevention and alleviation of incident-related emotional trauma. The debriefing will be held with members of the Employee Assistance Program (EAP) Team, which is a crisis intervention support service.
 - b. The goal of the EAP Team is to provide assistance to help staff manage their reactions to the crisis so that they may return to their normal daily routine. The team offers confidential, nonjudgmental, emotional support and may suggest coping strategies that can assist in preventing delayed reactions to critical incident stress.
9. **Staff Health Surveillance**
 - a. The Employee Health Department will take measures to effectively anticipate, recognize, evaluate, control, and mitigate health threats encountered during response and recovery operations. Specific activities include:
 - i. Ensuring staff/workplace health surveillance requirements are identified
 - ii. Directing and documenting health risk assessments
 - iii. Determining required post-incident health surveillance activities based on known or potential health threats
 - iv. Updating health risk assessments and medical countermeasures as new information becomes available
 - v. Enforcing the use of all required prophylactic medications, treatments, and personal protective equipment
 - vi. Developing and implementing health risk communication plans
 - vii. Submitting medical information related to infectious disease or environmental exposures to Infection Prevention, Risk Management, Safety and/or Human Resources.
 - viii. Submitting health-related lessons learned and after-action reports through the Emergency Management Coordinator.
10. Following demobilization, staff involved in event response and recovery operations shall be evaluated by a trained healthcare provider (e.g., physician, LIP, EAP) as indicated. The assessment will address actual/potential environmental exposures, injury or illness resulting from the event, and mental health or psychosocial issues. Appropriate medical referrals will be coordinated by Employee Health.

M. REFERENCES:

1. County of San Diego Emergency Operations Plan, 2018; https://www.sandiegocounty.gov/content/sdc/oes/emergency_management/oes_jl_oparea.html
2. The Joint Commission Emergency Management Standards
3. The Centers for Medicare & Medicaid Services (CMS) Emergency Preparedness Requirements
4. Section 319 of the Public Health Service Act
 - a. [Hospital Incident Command System Incident Response Guides 2014 | EMSA \(ca.gov\)](https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Imz/Pages/hospitalincidentcommandsystemincidentresponseguides2014.aspx)

A. SCOPE OF SERVICES:

1. The scope of Tri-City Hospital District (TCHD) Emergency Operations Plan (EOP) is to provide a

- e. ~~Clear debris and secure unsafe buildings as necessary.~~
- f. ~~Restore internal and external communication devices~~
- g. ~~Inventory equipment and supplies for damage and determine if additional supplies need to be obtained from suppliers. Picture/videos will be taken of all damaged supplies and equipment for insurance purposes. Damaged supplies and equipment will be retained until approval is received from insurance providers for disposal.~~
- 2. ~~Notify the community through local media services regarding the services the medical center will be providing and the location they will be provided in the event that services are moved off-campus.~~
 - a. ~~Notify the medical center's insurance provider and contact third-party expert to prepare the claim.~~
 - b. ~~Ensure records and data have been protected and restore information as necessary from backup tapes.~~
 - c. ~~Keep detailed records.~~
- 3. ~~A proactive process shall be developed and implemented to seek other federal funding to support preparedness that takes advantage of developing interoperability training with local and regional multi-disciplinary partners.~~

R. PERFORMANCE STANDARDS:

- 1. ~~There is a planned, systematic, interdisciplinary approach to process design and performance measurement analysis and improvement related to organization wide safety. The Environmental Health and Safety Committee will develop and establish performance measures and related outcomes in a collaborative fashion, based on those priority issues known to be associated with the healthcare environment. Performance measures and outcomes will be prioritized based upon high risk; high volume, problem prone situations and potential or actual sentinel event related occurrences. Criteria for performance improvement measurement and outcome indicator selection will be based on the following:~~
 - a. ~~The measure can identify the events it was intended to identify~~
 - b. ~~The measurement has a documented numerator and denominator statement or description of the population to which the measure is applicable.~~
 - c. ~~The measure has defined data elements and allowable values~~
 - d. ~~The measure can detect changes in performance over time~~
 - e. ~~The measure allows for comparison over time within the organization or between the organization and other entities.~~
 - f. ~~The data intended for collection is available.~~
 - g. ~~Results can be reported in a way that is useful to the organization and other interested stakeholders.~~

S. NIMS PREPAREDNESS FUNDING:

- 1. ~~Tri City Hospital District shall establish a working relationship with State and San Diego County Department of Health and Human Services Agency/EMS and state associations to identify activities to obtain and appropriately allocate preparedness funding.~~
- 2. ~~The Environmental Health and Safety Committee on an on-going basis monitors performance regarding actual or potential risk related to one or more of the following:~~
 - a. ~~Personnel knowledge and skills~~
 - b. ~~Level of personnel participation~~
 - c. ~~Monitoring and inspection activities~~
 - d. ~~Emergency and incident reporting~~
 - e. ~~Inspection, preventative maintenance and testing of safety equipment~~
 - f. ~~Other performance measures and outcomes will be established by the Environmental Health and Safety Committee based on the criterion listed above. Data sources, frequency of data collection, individual(s) responsible for data collection, aggregation and reporting will be determined by the Environmental Health and Safety Committee.~~
- 3. ~~To identify opportunities for improvement/corrective action, the Environmental Health and Safety~~

program that ensures effective mitigation, preparation, response and recovery to disasters or emergencies affecting the environment of care. The medical center has developed an "all hazards" approach that supports a level of preparedness sufficient to address a wide range of emergencies regardless of cause. The Emergency Operations Plan and associated Emergency Management Program extends to all inpatient and outpatient line programs, ancillary services, support services and facilities including patient care, business occupancies and temporary alternate care sites of Tri City Medical Center. The plan also affects all staff, volunteers, contract staff, medical staff and associates including contracted services of Tri City Hospital District.

B. OBJECTIVE:

1. The objective of the Emergency Operations Plan is to effectively prepare for, manage an emergency situation and restore the facility to the same operational capabilities as pre-emergency levels.
2. Six (6) critical areas of emergency response shall be managed in order to assess the medical center's needs and prepare personnel to respond to incidents. The six critical areas are:
 - a. Communication
 - b. Resources and Assets
 - c. Safety and Security
 - d. Personnel Responsibilities
 - e. Utilities Management
 - f. Patient Clinical and Support Activities

C. OBJECTIVES:

1. The objectives of the Emergency Operations Plan will include the following:
 - a. Identifying procedures to prepare and respond to potential disasters or emergencies.
 - b. Provide education to personnel on the elements of the Emergency Operations Plan.
 - c. Establish and implement procedures in response to an assortment of disaster and emergency situations.
 - d. Identify alternate sources for supplies and services in the event of a disaster or emergency through establishing mutual aid agreements with neighboring hospitals and/or healthcare systems; public health departments; hazardous materials response teams; local fire department; local police department; area pharmacies; medical supply vendors.
 - e. Identify recovery strategies and actions to be activated in the event of a disaster or emergency situation.

D. RESPONSIBILITY:

1. The Safety Officer, in conjunction with the Environmental Health and Safety Committee is responsible for developing, implementing and monitoring all aspects of the Emergency Operations Plan, including the hazard vulnerability analysis, mitigation, preparedness, response and recovery.
 - a. The Safety Officer shall also track National Incident Management System (NIMS) implementation.
 - b. The Safety Officer will have a working knowledge of emergency management, the medical centers operations (daily/emergency) and the Hospital Incident Command Center operations.
 - c. It will be the responsibility of the medical centers leaders, as well as, medical personnel to actively participate in the organizations Emergency Operations Plan.
 - d. The Emergency Operations Plan shall be developed in coordination with local community agencies. The medical center shall communicate its needs and vulnerabilities to community emergency response agencies and identify the capabilities of the community in meeting the needs of the medical center.

E. SPECIFIC PROCEDURES IN RESPONSE TO A VARIETY OF EMERGENCIES BASED ON A

- Committee will follow the organization's improvement methodology. The basic steps to this model will consistently be followed and include planning, designing, measuring, analyzing/assessing, improving and evaluating effectiveness. Should the Environmental Health and Safety Committee feel a team approach is necessary for performance and process improvement to occur, the Environmental Health and Safety Committee will follow the organization's performance improvement guidelines for improvement team member selection.
4. Determination of team necessity will be based on those priority issues listed (high-risk, volume and problem prone situations and sentinel event occurrence). The Environmental Health and Safety Committee will review the necessity of team development, requesting primarily, team participation only in those instances where it is felt the Environmental Health and Safety Committee's contributions toward improvement would be limited (due to specialty, limited scope and/or knowledge of the subject matter). Should team development be deemed necessary, team members will be selected on the basis of their knowledge of the subject identified for improvement and those individuals who are "closest" to the subject identified. The team will be interdisciplinary, as appropriate to the subject to be improved.
 5. Performance Improvement monitoring and outcome activities will be presented to the Environmental Health and Safety Committee by the Safety Officer at least on a quarterly basis, with a report of performance outcome to the Quality Assurance Performance Improvement (QAPI) Committee.

T. ANNUAL EVALUATION OF THE EMERGENCY OPERATIONS PLAN OBJECTIVES, SCOPE, PERFORMANCE AND EFFECTIVENESS:

1. The annual evaluation of the Emergency Operations Plan will include a review of the scope according to Joint Commission standards and NIMS requirements to evaluate the degree in which the program meets accreditation standards, NIMS requirements and the current risk assessment of the medical center.
 - a. A comparison of the expectations and actual results of the program will be evaluated to determine if the goals and objectives of the program were met.
 - b. The overall performance of the program will be reviewed by evaluating the results of performance improvement outcomes. The overall effectiveness of the program will be evaluated by determining the degree that expectations were met.
 - c. The Emergency Operations Plan shall be revised and updated based on the annual evaluation of the Emergency Operations Program, including the Hazard Vulnerability Analysis.
2. The performance and effectiveness of the Emergency Operations Plan shall be reviewed by the Environmental Health and Safety Committee, the QAPI Committee, Administration and reported to the Board of Directors as well.

Emergency Operations Procedure Manual
Response and Assignment of Personnel

ISSUE DATE: 06/15

SUBJECT: Medical Staff Assignments

REVIEW DATE:
REVISION DATE:

Department Approval-Date(s):	05/1503/22
Environmental Health and Safety Committee Approval-Dates(s):	06/1503/22
Medical Executive Committee Approval-Dates(s):	n/a
Administration Approval:	03/22
Professional Affairs Committee Approval-Date(s):	06/15 n/a
Board of Directors Approval-Date(s):	06/15

A. POLICY:

1. Several teams of physicians will be needed to assist in the provision of definitive treatment and sorting. Assignments will be made after consideration of the physician's area of expertise.

B. PROCEDURE:

1. Initial responsibility for Triage and Treatment will be the responsibility of the Emergency Department (ED) Physician. As the disaster response expands, Medical Control responsibilities will be assumed by the Chief of Staff or his/her designee.
2. Upon initiation and notification of the disaster response, all available physicians in the facility will report to the Emergency Department.
3. The designated Medical Staff Unit Leader and the Chief of Staff or designee will implement a physician call-in from the Medical Staff Office after receiving a briefing on the status of the disaster situation and determining actual or potential medical care needs.
4. The designated Medical Staff Director will organize, prioritize, and assign physicians to areas where medical care is being delivered.
5. Team assignments which will be needed include:
 - a. Physician coverage for Immediate, Delayed, and Minimal Treatment areas.
 - a.b. Orthopedic Surgeons should report to the ED - ED Physician will designate assignments as necessary to cover all areas where care is delivered.
 - b.c. Operating Room – Anesthesiologist, Surgeons - evaluate and prioritize surgical candidates and perform surgical procedures as required.
 - e.d. Radiology – for interpretation of X-rays and other diagnostics.
 - d.e. Intensive Care and Med/Surg units- (provide medical care to patients on units if the attending physician isn't available. Assist with and provide care for disaster patients admitted to the units.
 - e.f. Utilization Review – make rounds with the Nursing Unit Leader and review for discharge or potential transfer.
 - f.g. Pathology – to assist with laboratory diagnostics, forensic issues, and pathological tissue diagnosis.

C. REFERENCES:

1. Title 22: Section 70741, 70743, 70745, 70746
2. The Joint Commission EM.02.02.07, EM.02.02.07, EP 8

EMERGENCY OPERATIONS PROCEDURE MANUAL

ISSUE DATE: NEW

SUBJECT: Radiology Emergency Management
(Disaster) Plan

REVISION DATE:

Department Approval: 02/22
Environmental Health and Safety Committee Approval: 03/22
Medical Executive Committee Approval: n/a
Administration Approval: 03/22
Professional Affairs Committee Approval: n/a
Board of Directors Approval:

A. PURPOSE:

1. To insure efficient radiology services and diagnostic reporting processes.
2. Maintain adequate availability of personnel, equipment and imaging infrastructure in the event of a disaster.

B. POLICY:

1. Due to the varying types and magnitudes of emergency event, Tri-City Medical Center (TCMC) has adopted the command structure of the Hospital Incident Command system (HICS). Once the decision has been made to activate the disaster plan, the HEICS becomes the standard operating procedure. The complete plan is located in the TCMC Emergency Operations Procedure (Disaster) Manual located in the main radiology x-ray department.
2. The radiology department will be notified of the Disaster Plan Activation from the PBX operator announcing "Code Orange" using the overhead paging system.
3. Radiology X-Ray Technologist In-Charge Responsibilities:
 - a. The Radiology X-ray Technologist in charge will immediately review the disaster manual and review procedures.
 - b. The radiology technologist will read the Radiology Unit Leader Job Description found in the Radiology Disaster Packet in the main radiology x-ray department.
 - i. Radiology Unit Leader duties will transfer to the Operations Manager or designee upon arrival
 - c. The radiology technologist in charge will:
 - i. Contact all areas in the radiology department to access the number of staff and modalities available for the disaster.
 - ii. Complete the Personnel Inventory Form and report to the Incident Command Center (French Rooms 1 and 2).
 - iii. Recall radiology staff from breaks and routine duties to radiology and standby for instructions.
 - 1) Personnel Inventory forms are located in the disaster packet located in the x-ray department.
 - 2) If the Incident Command Center is not setup, contact the Administrative Supervisor.

C. PROCEDURE:

1. Technologist In-Charge Responsibilities
 - a. When the Incident Commander (IC) has determined that the disaster callback procedure for the department is to be initiated, the Operations Manager / designee will be notified

- by the IC and advised of the circumstances. The Operations Manager/designee will initiate the department callback list.
- b. Each required radiology staff position needed to support services during the disaster will be called using the disaster callback list and advise of the disaster.
 - c. If unable to reach a workforce member on the list, continue down the list and contact the next workforce member.
 - d. The caller will pass the message from the incident commander as it was delivered to them.
 - e. Each workforce member will report to TCMC or remain on standby to return if needed.
 - f. All workforce members are required to show their employee identification badge. p to gain entry on the campus and into the hospital.
 - g. All workforce members are must keep their TCMC ID badge with them at all times.

B. **FORM(S):**

1. Personnel Inventory Form



Emergency Operations Procedure
General Information

SUBJECT: Scalable Event

ISSUE DATE: 06/15

REVIEW DATE(S):

REVISION DATE(S):

Department Approval Date(s):	05/1503/22
Environmental Health and Safety Committee Approval Dates(s):	06/1503/22
Medical Executive Committee Approval Dates(s):	n/a
Administration Approval:	03/22
Professional Affairs Committee Approval Date(s):	06/15 n/a
Board of Directors Approval Date(s):	06/15

A. PURPOSE:

1. To monitor, track, and report internal and external emergency code activations, to prepare Tri-City Medical Center (TCMC) for scalable events.

B. POLICY:

1. The National Incident Management Systems (NIMS) and the Hospital Incident Command System (HICS) established the need for organizations to use the Incident Command System to manage all incidents, emergencies and disasters.
2. The Director of Safety (Safety Officer) will track the activation of the Tri-City Healthcare District's emergency codes to determine if a code scales to an incident, emergency, or disaster. In addition, external events will be tracked, monitored, and reported.

C. DEFINITIONS:

1. Level 1 – An incident is localized and can be handled at the scene.
2. Level 2 – An emergency may affect a larger area and require off-site emergency responders.
3. Level 3 – A disaster affects the entire site or region and requires a full-scale response.
4. Communications:
 - a. The Operators will receive calls from the Director of Safety (Safety Officer) regarding any emergency code activation. Announcements will be made overhead three (3) times by the Private Branch Exchange (PBX) Operator, "Code Orange" e.i. **disaster code**.
 - b. Codes that are not cleared in 20 minutes are viewed as incidents that may have the potential to scale and require a larger response effort.
5. Reports:
 - a. The Director of the Safety (Safety Officer) will generate a quarterly report identifying all approved code activations. All reports will be forwarded to the Emergency Management Committee, Environmental Health and Safety Committee for review, and through all review and approval processes.

D. REFERENCES:

1. The Joint Commission EM.02.01.01EP6

**ENGINEERING
OPERATIONS**

ISSUE DATE: 03/19

SUBJECT: Emergency Generator Test
& Failures

REVIEW DATE(S):

REVISION DATE(S): 03/19

Department Approval:	08/18/21
Environmental Health & Safety Committee Approval:	11/18/22
Administration Approval:	03/19/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/19

A. PURPOSE:

1. To establish and maintain a method of performing generator testing.

B. POLICY:

1. Tri-City Healthcare District performs generator tests at the following intervals.

C. PROCEDURE:

1. MONTHLY – each electrical generator providing emergency power to the life safety and critical power elements will be tested:
 - a. 30 continuous minutes under hospital load
2. ANNUAL – each electrical generator providing emergency power to the life safety and critical power elements will be load bank tested for a total of 1 ½ continuous hours.
 - a. 30 minutes at 25% of the load on the name plate
 - b. 30 minutes at 50% of the load on the name plate
 - c. 1 hour at 75% of the load on the name plate
3. TRIENNIAL – each electrical generator providing power to the life safety and critical power elements will be tested:
 - a. For a duration of 4 continuous hours
 - b. At least every 36 months (+/- 45 days)
 - c. With a dynamic or static load of at least 30% of nameplate rating of the generator.
4. If the emergency generator fails a required test, interim measures are implemented to protect patient, visitors, and staff until necessary repairs or corrective action is completed.
5. A complete retest will be conducted after necessary repairs or corrective action is completed.
6. The date and data of the tests for each emergency generator will be maintained by the Engineering Department.

**ENGINEERING
EMERGENCY PREPAREDNESS**

ISSUE DATE: 11/94

SUBJECT: Failure of Fire Alarm System

REVIEW DATE(S):

REVISION DATE(S): 03/97, 05/00, 05/03, 05/06, 05/09,
06/12

Department Approval:	09/1812/21
Environmental Health & Safety Committee Approval:	11/1803/22
Administration Approval:	03/1903/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/19

A. POLICY:

1. In the event of fire alarm failure the following procedure will be followed.

B. PROCEDURE:

1. In the event that the fire alarm fails call the preferred fire alarm vendor that is most familiar with our system. Request that they come out immediately.
2. Call the Oceanside Fire Department Inform them that our fire alarm has failed.
3. Send out a hospital wide page to notify all staff. Inform them that our fire alarm system has failed and they are to dial "66" in case of a fire.
4. Call the Director of Engineering or Facilities Manager. ~~He will~~ to make arrangements with Security to implement a fire watch
5. After fire alarm system is repaired, notify all hospital departments and the Fire Department.
6. The duty engineer will generate the report and submit to the Director of Engineering. After the report is reviewed and signed off, the Director of Engineering will submit the report to the Environmental Health & Safety Committee.



**ENGINEERING
EMERGENCY PREPAREDNESS**

SUBJECT: Guidelines for Procedure for Failure of Essential Equipment or Utility

ISSUE DATE: 09/94

REVIEW DATE(S):

REVISION DATE(S): 02/97, 05/00, 05/03, 05/06, 05/09, 06/12

Department Approval:	09/1812/21
Environmental Health & Safety Committee Approval:	11/1803/22
Administration Approval:	03/1903/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/19

A. POLICY:

1. ~~The Director of Engineering is responsible for the proper and safe functioning of all equipment and utilities under Engineering's responsibility. It is therefore, the Director of Engineering's responsibility to maintain awareness of the equipment and utility services status, reliability and preventive maintenance.~~

B. PROCEDURE:

1. ~~Director of Engineering or his/her designee develop and manage procedures that specify the action to be taken during the failure of essential equipment and utility services. These procedures shall include a call system for summoning essential personnel and outside assistance when required.~~
2. ~~The following essential equipment and services shall be included:~~
 - a. ~~Major air conditioning equipment~~
 - b. ~~Air handling systems (ventilation, filtration, quantitative exchanges, pressures, humidity)~~
 - c. ~~Boilers~~
 - d. ~~Electrical power services~~
 - e. ~~Fire alarm and extinguishing systems~~
 - f. ~~Water supply~~
 - g. ~~All waste disposal systems~~
 - h. ~~Medical gas and vacuum systems~~
 - i. ~~Any other equipment/utilities essential to operations~~
3. ~~Qualified engineering consultative advice shall be available as needed.~~
4. ~~The Director of Engineering, Administration, Administrative Supervisor and Department(s) affected should be notified immediately during a failure.~~
5. ~~In the event that the in-house personnel cannot correct the problem and restore the operation of the equipment, the Director of Engineering or his/her designee shall call in an outside resource to correct the situation.~~



Tri-City Medical Center
Oceanside, California

ENGINEERING
EMERGENCY PREPAREDNESS

DELETE – follow Environment of
Care Policy: Life Safety and
Engineering Utility Management
Plan

SUBJECT: System Record Drawings

ISSUE DATE: 09/94

REVIEW DATE(S): 06/12

REVISION DATE(S): 02/97, 05/00, 05/03, 05/06, 05/09, 06/12

Department Approval: 09/1812/21

Environmental Health & Safety Committee Approval: 11/1803/22

Administration Approval: 03/1903/22

Professional Affairs Committee Approval: n/a

Board of Directors Approval: 03/19

A. POLICY:

1. It is the policy of Tri-City Medical Center, Engineering Department to maintain current operational plans for major utility systems including, but not limited to, HVAC, plumbing, normal power, emergency power, medical gas & vacuum, boiler & steam, natural gas, elevators, tube system and communication systems.
2. The plans (or as built drawings) of key utilities equipment location and controls are located in the Plan Room or on the cloud.
3. All construction projects utilize AIA (American Institute of Architects) certified Architects that specialize in Healthcare design. All plans are reviewed, approved and building permits are issued by Office of Statewide Health, Planning and Development (OSHPD). This ensures all projects comply with current Life Safety Codes, Building Codes, and Americans with Disabilities Act (ADA) requirements. All phases of construction are inspected by an Inspector of Record, OSHPD Compliance Officer, OSHPD Fire Marshal, and OSHPD District Structural Engineer before occupancy is granted.

**ENGINEERING
EQUIPMENT**

ISSUE DATE: 09/94 **SUBJECT:** Utility Management Plan

REVIEW DATE(S): 08/15

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

Department Approval: 44/1804/22
Environmental Health & Safety Committee Approval: 44/1803/22
Administration Approval: 03/1903/22
Professional Affairs Committee Approval: n/a
Board of Directors Approval: 03/19

A. EXECUTIVE SUMMARY:

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

B. PRINCIPLES:

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

C. OBJECTIVES:

1. Design, operate and maintain utility systems serving the buildings that house the healthcare services of TCHD to provide a safe, comfortable, appropriate environment that supports patient care and business operations.
2. Perform recommended maintenance to maximize system service life and reliability.
3. Manage the Utility Systems Management program to assure compliance with The Joint

Commission requirements.

D. **PROGRAM MANAGEMENT STRUCTURE:**

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

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

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

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

documentation of the distribution of all utility systems. The documents include as-built and record drawings, one line drawing's, valve charts, and similar documents. The documents include original construction documentation and documentation of renovations, alterations, additions, and modernizations. Hard copies of the documentation are maintained in the Plant Operations department. Documents that are available in electronic format are maintained on the Engineering Shared Drive.

9. Labeling of Controls for System Shutdown and Recovery
 - a. The Director of Engineering or Designee is responsible for assuring that current documents showing the layout of utility systems and the locations of controls that must be activated to implement a partial or complete shut-down of each utility system are available at all times.
 - b. The documents must include the original layout of the systems and all modifications, additions, and renovations that affect the process for implementing a partial or complete shutdown of a system. The documents must include information that can be used to identify specific controls. The controls must be identified by a label, numbered tag or other device that corresponds to the information on the documents.
10. Emergency Procedures
 - a. The Director of Engineering or Designee and appropriate clinical caregivers collaborate to identify life-critical medical equipment supported by the utility systems. Life-critical equipment is defined as equipment, the failure or malfunction of which would cause immediate death or irreversible harm to the patient dependent on the function of the equipment.
 - b. The Director of Engineering or Designee and the caregivers are responsible for developing appropriate resources to manage the response to the disruption of the function of the identified life-critical equipment. The resources are designed to minimize the probability of an adverse outcome of care.
 - c. The resources must include but are not limited to information about the availability of spare or alternate equipment, procedures for communication with staff responsible for repair of the equipment, and specific emergency clinical procedures and the conditions under which they are to be implemented.
 - d. Copies of applicable emergency procedures are included in the emergency operations manual of each clinical department. Training addressing the medical equipment emergency procedures is included in the department or job related orientation process. All utility systems emergency procedures are reviewed annually.
11. Inspection, Testing, and Maintenance of Emergency Power Systems
 - a. The Director of Engineering or Designee is responsible for identifying all emergency power sources and for developing procedures and controls for inspection, maintenance, and testing to assure maximum service life and reliability. TCHD uses battery-powered lights, engine driven generators, and large UPS stored energy systems to provide power for emergency lighting, operation of critical systems, and operation of information systems equipment.
 - b. Each required battery powered emergency lighting device is tested for 30 seconds each month and for 90 minutes annually.
 - c. The Emergency Power Supply Systems (EPSS) supply power for emergency exits, patient ventilation, fire and life safety equipment, public safety, communications, data and processes that if disrupted would have serious life safety or health consequences. Each required EPSS system is tested in accordance with the code requirements for the class of device.
 - d. The Director of Engineering or Designee is responsible for assuring that appropriate inspection, maintenance, and testing of the essential electrical system is done. Each motor/generator set serving the emergency power system is tested under connected load conditions 12 times a year. All automatic transfer switches are tested as part of each scheduled generator load test.
 - e. Testing parameters are recorded and evaluated by the Plant Operations staff. All

- deficiencies are rectified immediately or a temporary secondary source of essential electrical service is put in place to serve the needs to critical departments or services until the primary system can be restored to full service.
- f. If a failure during a planned test occurs, a full retest will be performed after appropriate repairs are made and essential electrical system is functional again.
 - g. Each diesel engine powered motor/generator not loaded to 30% or more of its nameplate capacity during connected load tests undergoes further evaluation to determine if the exhaust gas temperature reaches or exceeds the manufacturer's recommended temperature to prevent wet stacking. Each diesel engine failing to meet the temperature recommendation will be exercised annually by connecting it to a dynamic load bank and performing the three step test process specified by NFPA 99 and NFPA 110.
 - h. Batteries, fuel stored on site, controls, and other auxiliary emergency power equipment is inspected, maintained, and tested as required. The Director of Engineering or Designee Engineering staff and contracted service providers are responsible for assuring the reliability of each component part of the emergency power systems by performing all required calibration, inspection, maintenance, and testing in a timely manner.
12. Utility Systems Inventory and Initial Testing
- a. The Director of Engineering or Designee establishes and maintains a current, accurate, and separate inventory of all utility systems equipment included in a program of planned inspection or maintenance. The inventory includes equipment owned by TCHD and leased or rented equipment.
 - b. The Director of Engineering or Designee is responsible for implementation of the program of planned inspection and maintenance. All utility systems equipment is tested for performance and safety prior to use.
13. Testing of Life Support Equipment
- a. The Director of Engineering or Designee assures that scheduled testing of all utility systems that play a role in life support is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EHSC each quarter. If the quarterly rate of completion falls below 95%, the Director of Engineering or Designee will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.
14. Testing of Infection Control Support Equipment
- a. The Director of Engineering or Designee assures that scheduled testing of utility systems equipment that supports critical infection control processes is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EHSC each quarter. If the quarterly rate of completion falls below 95%, the Director of Engineering or Designee will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.
15. Testing of Non-Life Support Equipment
- a. The Director of Engineering or Designee assures that scheduled testing of all non-life support equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EHSC each quarter. If the quarterly rate of completion falls below 95%, the Facilities will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.
16. Medical Gas System Testing
- a. All medical gas systems are maintained and periodically tested to assure system performance. All testing and inspection is done in accordance with the requirements of the current edition of NFPA 99.
17. Modifying / Repairing Medical Gas Systems
- a. When a new medical gas system is installed or an existing system is breached for any reason, the Director of Engineering or Designee coordinates certification of the system

by a qualified service provider. The certification testing is done in accordance with the requirements of the current edition of NFPA 99. The Director of Engineering or Designee maintains a permanent record of all certification testing.

18. Labeling & Accessibility of Medical Gas Controls

- a. The Director of Engineering or Designee is responsible for assuring that all medical gas system control valves and monitoring stations are identified appropriately.
- b. In addition, the Director of Engineering or Designee is responsible for assuring that each monitoring station and valve is accessible. Accessibility is evaluated during scheduled tours.

F. **AFFECTED PERSONNEL/AREAS:**

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

G. **REFERENCE(S):**

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

ENVIRONMENT OF CARE MANUAL
Safety Management Plan

ISSUE DATE: 11/87

SUBJECT: -Safety Management Plan

REVISION DATE: 05/96, 06/97, 07/00, 06/08, 03/11, 06/12,
06/15, 12/17, 03/19

Department Approval:	11/2402/22
Environmental Health & Safety Committee Approval:	11/2403/22
Administration Approval:	11/2403/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/21

A. **EXECUTIVE SUMMARY:**

1. **This is a high-level Management Plan that helps us to better manage risks in the environment.** Each environment of care poses unique risks to the patients served, the workforce (WFM) and medical, **employees**, staff who use and manage it, and to others who enter the environment, **and visitors**. The Environment of Care (EC) Safety (EC) Program is designed to identify and manage the risks of the environments of care operated and owned **that could negatively affect patients, staff, visitors, and the physical buildings and equipment owned and operated** by Tri-City Healthcare District (TCHD).
An environmental safety program based on applicable laws, regulations, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by TCHD. The specific risks of each environment are identified by conducting and maintaining a proactive risk assessment.
2. **The Management Plan for Environmental Safety describes the risk, safety, and daily management activities that TCHD has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, WFM, and other individuals, coming to the organization's facilities. This Plan applies**
3. The management plan and the environmental safety program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.
4. The program is applied to the Medical Center and all affiliated **offsite** clinics and care sites owned and operated by TCHD. **The Plan also applies**
- 5.2. The Management Plan for Environmental Safety and associated policies extend to all **staff members, regular or temporary, patients**, inpatient and/or outpatient service line programs, ancillary services, support services and all facilities including patient care and business occupancies of TCHD, **contractors, vendors, and visitors**.
The plan also affects all WFM, volunteers, medical staff and associates including contracted services of TCHD.
3. **Proactive risk assessments are conducted for each building that provides healthcare services and is reviewed annually. All risk assessments conducted are based on current accreditation standards (The Joint Commission) and all applicable laws, and regulations.**
4. **This Management Plan is evaluated annually to determine the effectiveness of the plan and the activities related to mitigation efforts and managing adverse events related to illness, injury, risk identification, near misses, and injuries that occur in the environment.**

B. PRINCIPLES:-

1. The identification of specific risks faced by patients and WFM, and others in the **environment** is essential for ~~designing~~**ensuring a safe work areas and work practices environment for all who enter and must occur in an ongoing manner.** The identified risks and proven risk management practices are used to design procedures and controls to reduce the threats of adverse outcomes. In addition, the identified risks and the procedures and controls are used to educate WFMs to effectively use work environments and safe work practices to minimize the potential for adverse impact on WFMs, patients, and other individuals coming into the environment.
2. **Identified risks and risk assessments will be used to educate staff so that they can assist with maintaining a safe environment for all.**
3. **Safety is everyone's responsibility.**
- 2-4. Ongoing monitoring and evaluation of performance, assessment of accidents and incidents, and regular environmental rounds are essential management tools for ~~improving the safety of the~~**maintaining a safe** environment. The knowledge developed using these management tools is used to make changes in the physical environment, work practices, and increase ~~WFM staff~~**staff** knowledge.

C. GOALS/OBJECTIVES FOR FY 21

1. Complete ~~Perform an initial proactive risk assessment of the buildings, grounds, equipment, staff activities, and the care and work environment for patients and WFMs to evaluate the potential adverse impact on all persons coming to the facilities of TCHD.~~
~~Perform additional~~ **Safety** risk assessments when changes involving these issues occur.
~~Analyze accidents, incidents, and occurrences to identify root cause elements of those incidents.~~
~~Make changes in the procedures and controls to address identified root causes of incidents.~~
~~Conduct EOC rounds in all areas of the hospital and affiliated medical practices. Staff making rounds evaluate the physical environment, equipment, and work practices. Rounds are conducted in all support areas at least annually and all patient care areas at least semi-annually.~~
~~Present quarterly reports of EOC management activities to the Environmental Health & Safety Committee. The reports from each EOC area manager will identify key issues of performance and regulatory compliance, present recommendations for improvement, and provide information about ongoing activities to resolve previously identified EOC issues. The Safety Officer/designee coordinates the documentation and presentation of this information.~~
 - 4.a. **Assure that all for all departments have current organization-wide and department-specific procedures and controls designed to manage identified risks throughout the medical center and off-site locations.**
 - b. **Review the risks-Continue educating and raising awareness on COVID-19 safety protocols regularly.**

D. RESPONSIBILITIES:

1. The **Chief Executive Officer (CEO)** is responsible to assign leaders to the **Environmental Safety Leadership Team (ESLT).**
2. The ~~related procedures~~**ESLT is responsible for ensuring the safety program is implemented, managed, and evaluated to ensure improvements are made.**
3. The ~~controls at least once every three years~~**EOC Specialist, or designee, is responsible for the day-to-day management of the safety program.**
- 2-4. **The Board of Directors (BOD) and the CEO collaborate with senior leadership to assure that the EOC programs are current budget and staffing resources are available to support the safety program and maintain a safe environment for all.**

~~Assign qualified individuals to manage the EOC programs and to respond to immediate threats to life and health.~~

~~Perform an annual evaluation of the management plan and the scope, objectives performance and effectiveness of the Environmental Safety Program.~~

~~Design and present environmental safety education and training to all new and current WFMs, volunteers, members of the medical staff and others as appropriate.~~

5. **The Human Resources Department with assistance from the Education Department and other leadership staff is responsible for the development and presentation of appropriate safety and infection control materials for New Hire Orientation training, department training, and task-specific training.**
6. **Department leaders are responsible for assuring that all staff members actively participate in the environmental safety program and that they work safely with established procedures and conduct work-related activities in a manner consistent with their training.**
7. **Department leaders are responsible for reporting and assisting with incident investigation activities as well as participating in monitoring, evaluating, and improving the safety of their specific areas of responsibility.**
8. **Individual staff members are responsible for working safely, reporting risks in the environment, knowing the inherent risks of their jobs and job environments, and knowing how to report unidentified risks, near misses, illnesses and injuries. All incidents shall be reported immediately or as soon as possible to the staff member's supervisor.**

E. PROGRAM MANAGEMENT STRUCTURE:

1. ~~Hospital leaders from the following departments security, f~~(EC.01.01.01 EP1) **The Environmental Safety Leadership Team (ESLT) is an interdisciplinary team, appointed by the CEO, that is responsible for the effectiveness of the Safety Program. This team collaborates with other leaders in the organization to update, improve or make changes to the program to increase its effectiveness. Members of the team include the following positions:**
 - a. **Manager of Safety (EOC Specialist)**
 - b. **Manager of Risk Management, /Quality Improvement,**
 - c. **Manager of Regulatory Compliance,**
 - d. **Infection Prevention, a Control**
 - 3.e. **Director of Facilities Engineering andd Environmental Services will work as the Environmental Safety Leadership Team (ESLT) to develop the environmental safety program.**
- a.2. ~~The ESLT will: Collaborate with leaders throughout the organization to conduct appropriate risk assessments, develop risk related procedures and controls, develop staff education and training materials, and manage day-to-day activities of the environmental safety program. Collaboratecollaborates with the Patient Safety Committee to integrate environment of careEOC safety concerns into the Patient Safety program.~~
Coordinate
3. **The ESLT coordinates the development of reports to the Environmental Health and Safety (EH&S) Committee. The reports summarize the organizational experience, performance management, and improvement activities, and other environmental safety issues.**
- b.4. **The ESLT maintains current knowledge of environmental safety laws, regulations, and standards of safety, assesses the need to make changes to procedures, controls, training, and other activities to assure that the environmental safety issuesmanagement program reflects the current risks present in the environment.**
- 2.5. ~~The Environmental Health and SafetyEH&S Committee Monitorsmonitors and evaluates the~~

- processes used to manage the environment of care. Members of the Environmental Health and Safety Committee are appointed by the Committee Chair.
6. The ~~EH~~**EH&S Committee** meets a minimum of four (4) times per year.
 7. During each meeting ~~one~~, **the following topics are presented:**
 - a. ~~One or more ECEOC performance management and improvement reports is presented. In addition, reports of the findings of environmental rounds, incident analysis, regulatory~~
 - b. **EOC rounds reports**
 - c. **Incidents analyses**
 - ~~e.d.~~ **Regulatory changes and other issues are presented as appropriate.**
 - e. **Other relevant issues**
 - ~~3-8.~~ The ~~EH&S Committee~~**Acts** acts on recommendations for improvement, changes in procedures and controls, orientation and education, and program changes ~~related~~**that may be necessary due to regulatory changes in regulations.**
 9. The ~~Assigns~~**EH&S Committee assigns** individuals or groups responsibilities for developing solutions to identified ~~Assigns individuals or groups responsibilities~~**the responsibility** for developing solutions to identified issues. **These assignments are documented and the individual or group is held accountable for completing their assignments.**
 10. **The EH&S Committee maintains a tracking log to ensure that risks are identified, changes are made, and the effectiveness of the changes are analyzed.**
 - ~~d-11.~~ Membership of the ~~EH&S~~ **Committee** includes ~~representation from~~**the following representatives:**
 - a. **Senior Administration**
 - ~~i.b.~~ Nursing Administration,
 - ~~ii.c.~~ Facilities Management,
 - d. **Security**
 - ~~iii.e.~~ Risk Management,
 - ~~iv.f.~~ Quality Improvement,
 - ~~a.g.~~ Human Resources,
 - ~~v.h.~~ Bio-Medical Services,
 - ~~vi.i.~~ Education,
 - ~~vii.j.~~ Medical Staff, Physician representation,
 - ~~viii.k.~~ Infection Prevention**Control**
 - ~~ix.l.~~ Others as deemed appropriate.
 12. The Board of Directors of ~~TCHD~~**(BOD)** receives regular reports of the activities of the ~~Environmental Safety Program~~**environmental safety program** from the ~~Environmental Health and Safety~~**EH&S** Committee. The Board reviews the reports and, as appropriate, communicates concerns about identified issues back to the **EOC Specialist or representative.**
 - ~~e-13.~~ The CEO or ~~Safety Officer~~/designee. The Board collaborates with the Chief Executive Officer (CEO) and other senior leadership to assure budget and staffing resources are available to support the environmental safety program. The CEO or designee of TCHD receives regular reports of the activities of the Environmental Safety Program. The CEO or designee collaborates with the ESLT and other appropriate staff to address environmental safety issues and concerns.

F. ELEMENTS OF THE PLAN:

1. The ~~Emergency~~hospital has a library of information regarding inspection, testing, and maintenance of its equipment and systems. (EC.01.01.01 EP3)
 - a. Each department responsible for inspection, testing and maintenance, keeps logs and records as well as manuals, manufacturer's procedures, technical bulletins,

- and other information in their respective departments. For example:
- i. **Biomedical Engineering is responsible for maintaining all medical equipment maintenance records and they keep all records in an electronic database**
 - ii. **Facilities Management Program contains provisions for management staff on-duty to take immediate, appropriate action keeps all utility equipment inventory and maintenance records in the Computerized Maintenance Management System (CMMS)**
2. **The hospital has a written plan for managing the following: The environmental safety of patients and everyone else who enters the hospital's facilities. (EC.01.01.01 EP4)**
- a. **The Illness and Injury Prevention Program (IIPP) outlines the overall safety program for the hospital's facilities.**
 - i. **The IIPP outlines the following:**
 - 1) **Responsibility**
 - 2) **Compliance** event of a situation that poses an immediate threat
 - 3) **Communication**
 - 4) **Hazard Assessment**
 - 5) **Accident/Exposure Investigation**
 - 6) **Hazard Correction**
 - 7) **Training and Instruction**
 - 8) **Recordkeeping**
 - ii. **Staff members are trained to report all incidents, potential hazards, injuries, patient events and near misses immediately to life, health their supervisors, the EOC Specialist, or property anonymously to the Health Care Values compliance hotline at 844-521-7862**
- 4.1. ~~The Human Resources Department with the assistance from the Education Department and other leadership staff are responsible for the development and presentation of appropriate materials for orienting new staff members to the organization, the department to which they are assigned, and task specific~~ **hospital implements its process to identify safety and infection control procedures. The orientation and ongoing education and training emphasize patient safety.** **security risks associated with the environment of care**
- Department leaders are responsible for assuring that all staff actively participates in the environmental safety program by observing established procedures and conducting work related activities in a manner consistent with their training. Department leaders also participate in the reporting and investigation of incidents occurring in their departments and in the monitoring, evaluation, and improvement of the effectiveness of the environmental safety program in their areas of responsibility. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job related procedures and controls required to minimize the potential for adverse outcomes of care and workplace accidents.

ELEMENTS OF THE ENVIRONMENTAL SAFETY MANAGEMENT PROGRAM:

5. **Appointment of Environmental Safety Leadership) could affect**
The CEO or designee appoints a team of qualified individuals to assume responsibility for the development, implementation and monitoring of the environmental safety management program. The ESL includes the Safety Officer/ or designee, Manager of Risk, Quality Improvement Leader, Manager of Regulatory Compliance and Infection Prevention, and the Director of Engineering.
 - a. ~~The ESL coordinates the development and implementation of the environmental safety program and assures it is integrated with the patient safety, infection control, risk management, and other programs as appropriate.~~

The ESL maintains a current knowledge of environmental safety laws, regulations, and standards of safety, assesses the need to make changes to procedures, controls, training, and other activities to assure that the environmental safety management program reflects the current risks present in the environment of TCHD.

6. Designation of Persons to Intervene When Immediate Threats to Life, Health, or Property are Identified

a. The Emergency Management Program includes specific response plans for TCHD that address implementation of an appropriate intervention whenever conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings. The response plans follow the Hospital Incident Command System (HICS) all hazards response protocol. An appropriate event incident commander is appointed at the time any emergency response is implemented.

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

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

7. Environmental Safety Management Plan

a.b. The Environmental Safety Management Plan describes the procedures and controls in place to minimize the potential adverse impact of the environment on patients, staff, and other people coming to the **hospital's** facilities of TCHD. The Environmental Safety Management Program is described in this management plan. **(EC.02.01.01 EP1)**

8. The ESLThe hospital identifies safety risks associated with the environment of care

i. The ESL of TCHD performs proactive risk assessments to identify risks that create the potential for personal injury of WFMs or adverse outcomes of patient care. The purpose of the risk assessments is to gather information that can be in the environment. The information gathered is used to develop procedures and controls to minimize the potential of adverse events affecting these risks that could negatively affect staff, patients, contractors, and visitors

1) The ESLT coordinates the risk assessment process with the EOC Specialist, department directors, and others. The as appropriate.

ii. Information used to create the risk assessments use information from sources such as EOC rounds, the results of root cause analysisinclude, but are not limited to the following:

1) EOC Rounds

2) Root Cause Analyses (RCA), incident reports, and external)

3) Incident Reports

a.4) External reports such as The Joint Commission Sentinel Event Alerts, California Department of Health (CDPH) All Facilities Letters (AFLs), California Occupational Safety and Health Administration Cal/OSHA

standards, and Food and Drug Administration (FDA) product recall notices.

~~The ESL coordinates the risk assessment process with the Director of Engineering, department Directors and others as appropriate.~~

9.c. The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment (**EC.02.01.01 EP3**)

a.i. ~~The results of the risk~~**Risk** assessment process are ~~data, injury report data, and all reported incident data is~~ used to create new or revise existing procedures and controls. They are ~~improve the environment and minimize risk. This data is~~ also used to guide the modification of the environment or the procurement of ~~procure~~ equipment, **supplies, or other technology** that can eliminate or significantly reduce ~~minimize~~ identified risks. The procedures, controls, environmental design changes, and equipment are designed to effectively manage the level of environmental safety in a planned and systematic manner.

d. EOC rounds **are conducted throughout the year on a prepared schedule. Each patient care area is scheduled for EOC rounds.**

~~The Development and Management of Policies and Procedures~~

~~The Safety Officer or designee follows the administrative policy for the development of organization-wide and department specific policies, procedures, and controls designed to eliminate or minimize~~**EOC Specialist, or designee, coordinates** the identified risks

b.i. ~~The organization-wide policies and procedures and controls are available to all departments and services on the organizational intranet. Departmental procedures and controls are maintained by department directors. The department directors are accountable for ensuring that all staff are familiar~~**deficiencies** with organizational, departmental, ~~the ESLT and the~~ appropriate job related procedures and controls. Department directors are also accountable for monitoring appropriate implementation of the policies, procedures and controls in their area(s) of responsibility. Each staff member is accountable for implementing the policies, procedures and controls related to their work processes.**department director(s).**

ii. **EOC rounds are performed when construction or other activities create unusual risks that may require the design and implementation of a plan to manage Interim Life Safety Measures, Infection Control Risk Measures, Proactive Construction Risk Management Measures, or other temporary issues.**

~~The ESLT analyzes the results of the The policies, procedures and controls are reviewed when significant changes in services occur, when new technology or space is acquired, and at least every three years.~~

~~The Safety Officer assists with the reviews of policies and procedures with department heads and other appropriate staff.~~

iii. **EOC rounds to determine if deficiencies are corrected in a timely manner and to determine trends that require action to improve practices or environmental conditions.**

40.e. The hospital maintains all grounds and equipment (**EC.02.01.01 EP5**)

~~The Director of Engineering (Facilities Management) is responsible for:~~

i. ~~Managing~~**managing** the appearance and safety of the hospital grounds.
~~Assuring equipment used to maintain the campus is in proper operating condition~~
~~Grounds staff are trained to operate and maintain the equipment~~

ii.f. ~~Scheduling~~**The Director of Facilities is responsible for scheduling** the work

required to maintain the appearance and safety of hospital grounds.

11.i. The Engineering and facilities staff and Security Officers/designee will make regular rounds of the grounds to identify unsafe conditions.

12.ii. The Security Manager and Engineering staff reports/report all deficiencies to the Director of Engineering (Facilities Management) for appropriate action.

13.g. The hospital responds to product notices and recalls (**EC.02.01.01 EP11**)

a.i. The Risk Manager/EOC Specialist and the Director of Materials Management coordinate a product safety recall system. TCHD utilizes the National Recall Alert Center (NRAC) E-Class system that is designed to quickly assess safety recall notices; respond to recalls/those that affect TCHD, and to ensure/assure all active safety recalls are completed in a timely manner.

b.ii. A quarterly report of safety recall notices that require/require action to eliminate defective equipment or supplies from TCHD is presented to the Environmental Health & Safety/EH&S Committee by the EOC Specialist.

h. The hospital collects information to monitor conditions in the environment (**EC.04.01.01 EP1, EP3, EP4, EP5, EP6, EP8, EP9, EP10, EP11**)

The hospital prohibits smoking)

TCHD has developed a Smoke Free Environment policy. The policy prohibits smoking of any kind (i.e., cigarettes, cigars, pipe, chewing tobacco, e-cigarettes and vapor-producing devices) in any hospital building or campus by all WFM, visitors and patients.

i. TCHD has identified alternatives to tobacco products that are offered to all. TCHD has developed tobacco replacement product resources to assist the WFMs and patients with smoking cessation as desired. Staff may purchase tobacco replacement products via Employee Health at a discounted cost. hospital establishes a process for continually monitoring, internally reporting, and investigating the following:

- 1) Injuries to patients or others within the hospital's facilities
- 2) Occupational illnesses and staff injuries
- 3) Incidents of damage to its property or the property of others
- 4) Security incidents involving patients, staff, or others within the facilities

e. Hazardous

The hospital takes action to maintain compliance with its smoking policy-

d.5) The procedures for managing the use of smoking materials are followed and waste spills and enforced by all leadership and staff. exposures

The hospital monitors conditions in the environment-

- 6) Fire safety management problems, deficiencies, and failures
- 7) Medical or laboratory equipment management problems, failures, and use errors
- 8) Utility systems management problems, failures, or use errors

ii. The Manager of Risk Management coordinates the design and implementation of the incident reporting and analysis process.

e.iii. The Safety Officer/designee/EOC Specialist works with Risk Management to design appropriate processes to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.

f.i. Incident reports are completed per hospital policy for incidents reported by patients or visitors... Completed incident reports are forwarded to Risk Management.

Risk Management works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

- g.i. **In addition, the Manager of Risk Management and the EOC Specialist** collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment or staff behaviors that require action. The findings of such analysis are reported to the Environmental Health and Safety Committee and the Patient Safety Committee, as appropriate. The Safety Officer or designee provides summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.
 - 1) **The findings of such analysis are reported to the EH&S Committee and the Patient Safety Committee, as appropriate.**
 - 2) **The EOC Specialist provides summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.**
- h.ii. ~~The The Safety Officer or designee~~ **EOC Specialist** coordinates the collection of information about environmental safety, patient safety deficiencies including identification of opportunities for improvement from all areas of TCHD.
 - i.1) ~~The Environmental Health and Safety~~ **The EH&S Committee and the Patient Safety Committee** are responsible for identifying opportunities for improving environmental safety **the environment**, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.
- iii. The Chairperson of the ~~Environmental Health & Safety~~ **EH&S Committee** prepares quarterly reports to the leadership of TCHD.
 - 1) The quarterly reports summarize key issues reported to the ~~EH&S Committee and PSC~~ **EH&S Committee** with their recommendations. Quarterly reports are
 - j.2) **The quarterly report is also** used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to hospital leaders **assure Hospital leaders that management responsibilities have been carried out.** Annual reports are provided to the Board of Directors related to EC, or more often if warranted.

Annual reports are provided to the Board of Directors related to EC, or more often if warranted. ~~Environmental tours are conducted annually in patient care areas-~~

~~EOC rounds at TCHD are conducted throughout the year on a schedule prepared by the ESLT. Each patient care area is scheduled for an environmental tour every twelve months. The Safety Officer or designee with the ESLT coordinates correction of identified deficiencies with the appropriate department director(s).~~

- 3) ~~EOC tours are performed when construction or other activities create unusual risks that may require design and implementation of a plan to manage Interim Life Safety Measures, Infection Control Risk Measures, Proactive Construction Risk Management Measures, or other temporary issues.~~
- j. **Development and Management of Policies and Procedures (LD.04.01.07 EP1)**
 - i. **The EOC Specialist follows the administrative policy for the development of organization-wide and department-specific policies, procedures, and**

- controls designed to eliminate or minimize identified risks.
- ii. The EOC Specialist assists department leaders with the development of department or job-specific environmental safety procedures and controls.
- iii. The organization-wide policies, procedures, and controls are available to all staff members on the organizational intranet.
- iv. Department specific procedures and controls are maintained by department directors.
 - 1) The department directors are responsible for ensuring that all staff is familiar with organizational, departmental, and appropriate job-related policies, procedures, and controls.
 - 2) Department directors are also responsible for ensuring implementation of these policies, procedures, and controls
 - 3) Individual staff members are held accountable for implementing the policies, procedures, and controls related to their specific work duties and tasks
- v. The policies, procedures, and controls are reviewed when significant changes occur when new technology or space is acquired, and at least every three years.
- vi. The EOC Specialist assists with the reviews of policies and procedures with department directors and other appropriate staff.
- k. Every twelve months the

The ESLT analyzes the results of the environmental tours to determine if deficiencies are corrected in a timely manner and to determine if there are patterns or trends that require action to improve practices or environmental conditions.

14. Environmental tours are conducted annually in non-patient care areas. EOC rounds at TCHD are conducted throughout the year on a schedule prepared by the ESLT. Each non-patient care area is scheduled for an environmental tour annually. The Safety Officer or designee with the ESLT coordinates correction of identified deficiencies with the appropriate department director(s).

EOC tours are performed when construction or other activities create unusual risks that may require design and implementation of a plan to manage Interim Life Safety Measures, Infection-Control Risk Measures, Proactive Construction Risk Management Measures, or other temporary issues.

- 15. The hospital uses its tours to identify deficiencies, hazards, and unsafe practices.
 - a. The ESLT manages a process of EOC rounds designed to evaluate staff knowledge and skills, observe current environmental and patient safety practices, and to evaluate environmental conditions. Findings of the environmental rounds are used as a resource for improving environmental and patient safety procedures and controls, updating orientation education and education programs, and improving staff performance.
- The ESLT analyzes the results of the environmental tours to determine if deficiencies are corrected in a timely manner and to determine if there are patterns or trends that require action to improve practices or environmental conditions.
- k. The hospital evaluates each environment of care management plan annually using multiple sources such as analysis including a review of the plan's objectives, scope, performance, and effectiveness. (EC.04.01.01 EP15)

The EOC Specialist coordinates the annual evaluation of the Environment of environmental rounds, incident reports, findings of external reviews, benchmarking programs or assessments by regulators, accrediting bodies, insurers, and consultants, minutes from appropriate committees.

- b.i. The Care management plans are reviewed.
- i.ii. The annual evaluation examines the management plans to determine if the

- plans they accurately represent the management of environmental and patient safety risks.
- iii. ~~to evaluate~~
 - ~~ii-1)~~ **The review also evaluates** the operational results of each Environment of Care program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. ~~The~~
 - 2) The annual evaluation uses a variety of information sources. ~~Findings~~ **The sources include aggregate analysis of EOC rounds and incident reports, findings of external reviews, benchmarking programs or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of the EH&S Committee meetings, and analytical summaries of other activities.**
 - 3) **The findings** of the annual review are presented to the ~~EHSC~~ **EH&S Committee by the end of the first quarter of the fiscal year.**
 - 4) Each report presents a balanced summary of an ~~Environment of Care~~ **EOC** program for the preceding fiscal year.
 - 5) Each report includes an action plan to address identified ~~weaknesses~~ **gaps**. ~~Deficiencies~~
 - ~~e-iv.~~ **The annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review (PPR). Any deficiencies identified on an annual basis will be** immediately addressed by a plan for improvement.
 - ~~d-v.~~ Effective development and implementation of the plans for improvement will be monitored by the ~~Safety Officer/designee~~ **EOC Specialist.**
 - ~~e-vi.~~ The results of the annual evaluation are presented to the ~~EHSC for review~~ **EH&S Committee. The Committee reviews and if required, approves the reports. Actions and recommendations of the Committee are documented in the minutes.**
 - vii. The annual evaluation is distributed to the CEO, ~~Board of Directors~~ **BOD**, organizational leaders, the ~~PSC~~ **Patient Safety Committee**, the Quality Assurance Performance Improvement Committee, and others as appropriate.
 - ~~f-viii.~~ The manager of each ~~Environment of Care program~~ **EOC Management Plan** is responsible for implementing the recommendations in the report as part of the performance improvement process.
 - a-i. The hospital ~~Analysis and actions regarding~~ **analyzes** identified environmental-
 environment of care issues-. (EC.04.01.03)
 - i. **Identified EOC issues are communicated through the EH&S Committee and the ESLT to senior leadership, the BOD and the CEO for analysis.**
 - ii. **The hospital uses the results of data to identify opportunities to resolve environmental safety issues (EC.04.01.03 EP2)**
 - 1) ~~Once the data has been presented to leadership of the hospital, regulatory compliance, quality improvement, or patient safety concurs with the EHSC recommendations for improvements to the environment of care management programs, a team of~~ **and appropriate staff committees, a team** is appointed to manage the improvement project.
 - ~~g-2)~~ **The EHSC** ~~EH&S Committee~~ **works with the team to identify the goals for improvement, the, establish a timeline for the project, the steps in the project, a budget, if needed, priorities, and to establish objective**

- measures/measurements of improvement.
- 3) The ~~EHSC establishes~~ **EH&S Committee also established** a schedule for the team to report progress and results.
- ~~h.4)~~ All final improvement reports are summarized as part of the annual review of the **overall** program and presented to hospital ~~– leadership,~~ **the performance improvement team,** and patient safety leadership.
- 16-m. Orientation and Ongoing Education and Training – **(HR.01.04.01 EP1 & 3, & EC 01.05.03, EC.03.01.01 EP1 – EP3)**
- i. Orientation and training addressing the ~~environment of care~~ **EOC programs** is provided to each ~~employee, contract staff member,~~ **contractor,** and volunteer.
- a.ii. All Licensed Independent Practitioners (LIP) receive ~~an~~ orientation to the Environment of Care in accordance with the Medical Staff policies and bylaws.
- b.iii. Annual EOC training is provided and documented via NetLearning.
- e.iv. The Human Resources ~~(HR)~~ Department with participation from the Education Department coordinates the general New Employee Orientation ~~per HR policies.~~ **((NEO) program.**
- 1) ~~GOALS/OBJECTIVES 2021-2022:~~ **New staff members are required to attend the NEO program within 30 days of their date of employment.**
- 2) **The Human Resources Department with participation from the Education Department maintains attendance records for each new staff member completing the general orientation program.**
- v. **New staff members are also required to participate in orientation to the department where they are assigned to work.**
- 1) **The departmental orientation addresses job related patient safety and environmental risks and the policies, procedures, and processes to minimize or eliminate them during routine daily operations.**
- vi. **The EOC Specialist collaborates with the department managers, the Manager of Risk Management/Quality, the Manager of Regulatory Compliance and Infection Control, the Patient Safety Officer, and others as appropriate to develop content materials for general and job-related orientation and continuing education programs.**
- vii. **The EOC Specialist gathers data during EOC rounds and other activities to determine the level of competency of staff and licensed independent practitioners related to their ability to describe or demonstrate how job-related physical risks are to be managed or eliminated.**
- viii. **The EOC Specialist evaluates the level of competency of staff and LIPs related to understanding and demonstrating the actions to be taken when environmental incidents occur and how to report environmental hazards or incidents.**
- ix. **Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating EOC risks are reported to the EH&S Committee.**
- x. **When deficiencies are identified, action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.**

D.

Complete safety risk assessments for all departments, services throughout TCHD.
Redesign the EOC touring process and scheduling.
Continue to provide education to staff in identifying and reporting Work Place Violence.

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

1. **Code Adam (Infant Abduction) Policy:** ~~Smoke Free Environment~~
5. ~~_____~~

6. **REFERENCE(S):**

7. ~~The Joint Commission (TJC). 2021. The Joint Commission E-Edition: Emergency Management Chapter.~~
2. ~~The Joint Commission (TJC). 2021. The Joint Commission E-Edition: Code Blue/Pink (Adult/Infant Arrest) Policy~~
3. **Code Caleb Policy**
4. **Code Dr. Strong (Violent Person) Policy**
5. **Code Gray (Hostage Situation) Policy**
6. **Code Green (02 Emergency) Policy**
7. **Code Orange (Disaster) Policy**
8. **Code Red (Fire) Policy**
9. **Code Silver (Active Shooter) Policy**
10. **Code Yellow (Radiation Disaster) Policy**
11. ~~Environment of Care Chapter:~~ **(EOC) Audit Tool – Clinical Rounds**
12. **Environmental Health and Safety Committee Charter**
13. **EOC Audit Tool – Non-clinical Rounds**
14. **EOC Security Management Plan**
15. **EOC Waste Management Plan**
16. **Hazardous Materials and Waste Management Plan**
17. **Illness and Injury Prevention Program (IIPP)**
18. **Security Management Plan**

H. **REFERENCES:**

1. **The Joint Commission for Health Care Organizations Standards**
2. **Cal/OSHA, Title 8**

INFECTION CONTROL

ISSUE DATE: 03/16

SUBJECT: Management of Patients with Multi-
Drug Resistant Organism (MDRO)
and/or C. Difficile Infection

REVISION DATE(S): 12/18

Infection Control Department Approval:	09/1808/21
Infection Control Committee Approval:	10/1811/21
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	10/1802/22
Administration Approval:	12/1803/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/18

A. DEFINITIONS:

1. Multi-drug resistant Organism (MDROs) and Clostridium Difficile are organisms of epidemiological significance in the health care setting. MDROs are defined as microorganisms that are resistant to one or more classes of antimicrobial agents. The clinical manifestations are often similar to infections caused by susceptible pathogens; however the options for treatment are limited. MDROs and C. Difficile infection increase the length of stay, costs and mortality of patients. The MDROs of significance are:
 - a. Vancomycin Resistant Enterococci (VRE)
 - b. Methicillin Resistant Staphylococcus aureus (MRSA)
 - c. Resistant Acinetobacter baumannii
 - d. Carbapenem- resistant Enterobacteriaceae (CRE)
 - i. Klebsiella pneumonia
 - ii. Escherichia coli
 - e. Extended Spectrum beta Lactamase Producers (ESBL)
 - i. Klebsiella pneumonia
 - ii. Escherichia coli
 - f. Other MDROs as identified by Laboratory identification and/or Physician
2. The risk factors for obtaining an MDRO (Infection or colonization) include those with severe disease, ICU stay, compromised host defenses, recent surgery or indwelling medical devices.
3. The risk factors for obtaining C.difficile infection are: antimicrobial exposure, acquisition of C.difficile, advanced age, underlying illness, immunosuppression, tube feeds and gastric acid suppression. The purpose of this policy is to prevent the transmission of MDROs and C.Difficile Infection.
4. C.Difficile Infection: This policy applies to patients who have active C.difficile Infection as defined by those with a recent positive test for C.diff during current admission or recent positive test and still has active diarrhea.
5. Cohorting is the placement of patients with the same microorganism in the same room. Usually done when private rooms are not available.
6. Recommendations for MRSA active surveillance culturing are focused on high-risk populations and the delay inherent in identifying MRSA in clinical cultures makes it impossible to know the MRSA status of every patient when they are admitted. The use of Standard Precautions and most importantly hand hygiene will reduce the risk of cross transmission from unknown cases. Please note: Routine screening for other types of MDROs is not recommended.

B. POLICY

1. Transmission:
 - a. Transmission may occur through direct contact with a MDRO carrier and ineffectively disinfected equipment. The use of Standard and Contact Precautions to break the chain of transmission is recommended in the acute care hospital.
2. Strategies To Reduce Risk Of Cross Transmission:
 - a. Because of the difficulty in treating MDRO infections, it is imperative that health care workers prevent the transmission of MDRO from colonized or infected patient to other patients or personnel.
 - b. Compliance with Standard Precautions and Contact Precautions will reduce the risk of transmission between patients.
 - c. Place patients in Contact Precautions in the following cases :
 - i. Active MRSA, ESBL, VRE, CRE/other MDRO infections. Active infections include positive cultures from blood, urine, respiratory or wound. These will be noted in the patients Problem List in Cerner.
 - ii. Patients with a history of ESBL or CRE. The history can be found in the patients Problem List in Cerner.
 - iii. Patients with active C.difficile infection.
 - d. Perform hand hygiene before and after gloving. Hands of health care workers can become transiently colonized which is the most common mode of transmission of healthcare associated MDROs.
 - i. Wear gloves for contact with membranes, damaged skin, or with any moist body substance (i.e., oral secretions, sputum, blood, urine, feces, and vomitus).
 - ii. Change gloves between patients and on the same patient when an episode of care has multiple components such as care at different anatomical sites involving moist body substances or mucous membranes.
 - 1) Wearing gloves does not take the place of hand washing. Perform hand hygiene after removing gloves.
 - iii. Wear a new pair of gloves with each patient. Failure to change gloves between patient contacts is an infection control hazard.
 - iv. Wear a plastic apron or a gown if it is likely that clothing will be soiled. Change aprons/gowns between patients.
 - e. Remove gloves and gown before leaving the patient's room. Ensure that after glove and gown removal hand hygiene is performed. Ensure that clothing and hands do not come in contact with environmental surfaces (doorknobs and curtains).
 - f. Follow Standard Precautions and wear face protection if it is likely that eyes, nose or mouth will be splashed with moist body substances or secretions (e.g. during wound care or suctioning an intubated patient).
 - g. Environmental cleaning is an important measure to reduce risk of transmission.
 - h. Use of dedicated non-critical patient care equipment is recommended. Reusable equipment must be disinfected before being used on another patient.
 - i. Patients with C.difficile infection, perform the following in addition to above:
 - i. Wash hands with soap and water after removing gloves.
 - ii. Ensure purple "D" sign is posted along with the contact precautions sign outside patient room
 - iii. Room is cleaned with bleach product by EVS staff
 - iv. Reusable equipment is cleaned after patient use by bleach product (if product tolerates bleach product otherwise utilize hospital approved disinfectant)
3. Cohorting:
 - a. Single patient room preferred **but if not available then separate patient beds by minimum of 6 feet-**
 - b. **Create a visual barrier to define the isolation space(s). A privacy curtain or a portable wipeable screen may be used. The isolated space must be treated as though they are a separate room.**

- c. **Request Environmental Services to do a terminal clean of the isolated area once a patient has been transferred to a single room or discharged.**
 - d. **Dedicate patient care items and equipment to each isolated patient if possible.**
 - a. ~~See Guideline for Cohorting Patients on Additional Precautions for specific MDRO or organism in Related Documents.~~
 - b-e. **See Guideline for Cohorting Patients on Additional Precautions for specific MDRO or organism in Related Documents.** Cohorting (patients with same MDROs sharing a room) is permitted for the following:
 - i. ~~MRSA: Cohort patients with current MRSA infection~~
 - ii. ~~VRE: Cohort patient with current VRE infections~~
 - iii. ~~ESBL, CRE, or C. Difficile: Do not cohort patients without consulting Infection control for the following organisms (past or current history).~~
 - e-f. When a private room is not available and cohorting is not achievable, consider the epidemiology of the microorganism and the patient population when determining patient placement. First try to select someone with no invasive lines (IV, central line, foley, trach, etc.) or open wound. If this is not possible, then select someone with an invasive line that carries a low risk of infection, such as a peripheral IV or NG tube. Consult with infection control staff when there are questions about patient placement. Also consider the conditions of the individual patients and the ability to transmit the infection in giving them priority for single room placement, for example stool incontinence and/or uncontained drainage.
4. **Discharge, Transfer, And Transport Of Patient:**
- a. Isolation Signs communicate isolation status to visitors and healthcare workers when entering the room. A "D" Sign is placed on the outside of a patient room to communicate to healthcare workers if a patient has C.difficile infection.
 - i. C.difficile infection is not placed on the problem list since past history does not define isolation in future admissions.
 - b. Hand off communication includes isolation information to receiving unit and transporters.
 - c. Patient Transfer: try to cover or contain potentially infectious body fluids prior to transport. The transporter should discard contaminated PPE before transport. Perform good hand hygiene. Don clean PPE at destination to handle the patient.
 - d. When arranging transfer, communicate information to nursing home, home health agency or other hospital receiving patient
 - e. Infection Control communicates final lab results to receiving facilities if they are not available until after discharge in the following situations:
 - i. Positive MDRO culture known after the patient was discharged to another healthcare facility and the patient had no history of the same MDRO
 - ii. Positive C.difficile tests known after the patient was discharged to another healthcare facility.
5. **Discontinuation of Contact Precautions:**
- 5-a. **Consult Infection Prevention when a decision to discontinue isolation is made**
 - b. ~~Active-MRSA~~
 - i. **Colonization (positive MRSA PCR nares: No contact precautions.**
 - ii. **Active infection:**~~infection-~~ remain in Contact Precautions for duration of stay
 - iii. **History of active infection**
 - 1) If greater than 1 year ago place patient in contact precautions upon admission and collect 2 MRSA PCR nares at least 5 days apart and patient must be off antibiotic for at least 48 hours. If both tests are negative isolation can be discontinued.
 - a-2) If less than 1 year ago contact precautions is required until discharge.
 - c. ~~Active-ESBL~~
 - i. **Active infection: remain in Contact Precautions for duration of stay**
 - ii. **History of active infection**
 - 1) If history is greater than 1 year ago place patient in contact

- c.
 - d.
 - b. & CRE: remain in Contact Precautions for duration of stay
 - Active VRE
 - i. Active infection: remain in Contact Precautions for duration of stay
 - ii. History of active infection
 - 1) If history is greater than 1 year ago place patient in contact precautions upon admission and obtain three consecutive negative stool, rectal, or peri-rectal cultures at least one week apart. Patient must be off antibiotics effective against VRE for at least 48 hours. If tests are negative isolation can be discontinued.
 - 2) If history is less than 1 year ago contact precautions is required until discharge.
 - e. CRE and Other MDRO's
 - e.i. Contact precautions required at all times. No discontinuation of isolation precautions allowed. Infection: Isolation may be discontinued after obtaining three consecutive negative stool, rectal or peri-rectal cultures one or more weeks apart.
 - f. Active C.Difficile infection: remain in Contact Precautions for duration of stay.
6. Patient Education:
- a. Patients discovered to have MRSA, VRE or ESBL colonization or infection, or C.difficile infection is given pre-printed educational handouts provided through Micromedex.
- Micromedex: CareNotes Procedure

C. RELATED DOCUMENT(S)

1. **Guideline for Cohorting Patients on Additional Precautions**
2. **Guideline for Discontinuing Isolation Precautions**
- 4.3. Infection Control Policy: Standard and Transmission Based Precautions.
- 2.4. Patient Care Services Standardized Procedure: Methicillin Resistant Staphylococcus Aureas (MRSA) Screening Procedure
- 3-5. Type and Duration of Precautions – Disease Specific (FKA Short Sheet)

D. REFERENCE(S):

1. APIC Guide. (2010) Guide to the Elimination of Methicillin Resistant Staphylococcus aureus (MRSA) transmission in Hospital Settings, 2nd edition.
2. APIC Text of Infection Control and Epidemiology Fourth edition 2014.
3. Centers for Disease Control and Prevention. Guidance for Control of Carbapenem-resistant Enterobacteriaceae 2012. Available at <http://www.cdc.gov/hai/pdfs/cre/CRE-guidance-508.pdf>
4. Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007 <http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf>
5. Management of Multidrug-Resistant Organisms In Healthcare Settings, Healthcare Infection Control Practices Advisory Committee (HICPAC) 2006 Jane D. Siegel, MD; Emily Rhinehart, RN MPH CIC; Marguerite Jackson, PhD; Linda Chiarello, RN MS; the Healthcare Infection Control Practices Advisory Committee

GUIDELINE FOR COHORTING PATIENTS ON ADDITIONAL PRECAUTIONS

Patient Cohorting (the placement of patients exposed to or infected with the same laboratory-confirmed pathogen in the same inpatient room/geographic area) is a strategy which can be used when patient requirements for private rooms exceed capacity. Infection Prevention does not *routinely* recommend cohorting of patients on additional precautions.

Patients on **Airborne Precautions** (tuberculosis, chicken pox, disseminated herpes zoster and measles) *always* require placement in a single-patient room with dedicated bathroom, negative pressure, and with the door closed at all times.

When used, priority for cohorting should go to patients who do **not** have symptoms and/or risk factors suggestive of communicable diseases such as coughing, diarrhea/vomiting, and/or uncontained drainage.

Please inform Infection Prevention when a decision to cohort is made.

Patient Eligibility

Does patient have more than one transmissible disease/organism?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does patient require airborne or airborne/contact precautions? (e.g., suspected or confirmed TB, chicken pox or disseminated shingles, measles, undiagnosed fever with a rash).	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is patient an admitted resident of a congregate living site with active outbreak(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "yes" to any questions, patients are not candidates for cohorting.	

Personal Protective Equipment (PPE)

- Adhere to hand hygiene, appropriate use of personal protective equipment, and appropriate environmental cleaning guidelines.
- Change PPE between each patient interaction and treat each patient space as a private room.
- Remove PPE and perform hand hygiene when leaving one isolated bedspace or before providing care to the other patients in the room.

Patient Space Considerations

- Separate patient beds by minimum of 6 feet.
- Create a visual barrier to define the isolation space(s). A privacy curtain or a portable wipeable screen may be used.
- The isolated space must be treated as though they are a separate room.
- Place dedicated isolation cart at entrance of room. Place the linen hamper and garbage receptacle in close proximity.
- Dedicate the bathroom to one patient.
- Request Environmental Services to do a terminal clean of the isolated area once a patient has been transferred to a single room or discharged.

Patient Care Items

- Dedicate patient care items and equipment to each isolated patient if possible. Otherwise, clean and disinfect items before use on any other patient. Shared items that cannot be cleaned/disinfected should be discarded.

GUIDELINE FOR COHORTING PATIENTS ON ADDITIONAL PRECAUTIONS

Table 1: Considerations for cohorting when single room accommodation is not available.

Please consult IP if you have questions on these guidelines, note increased numbers of symptomatic patients, or require assistance on placement of patients with suspect or confirmed communicable diseases

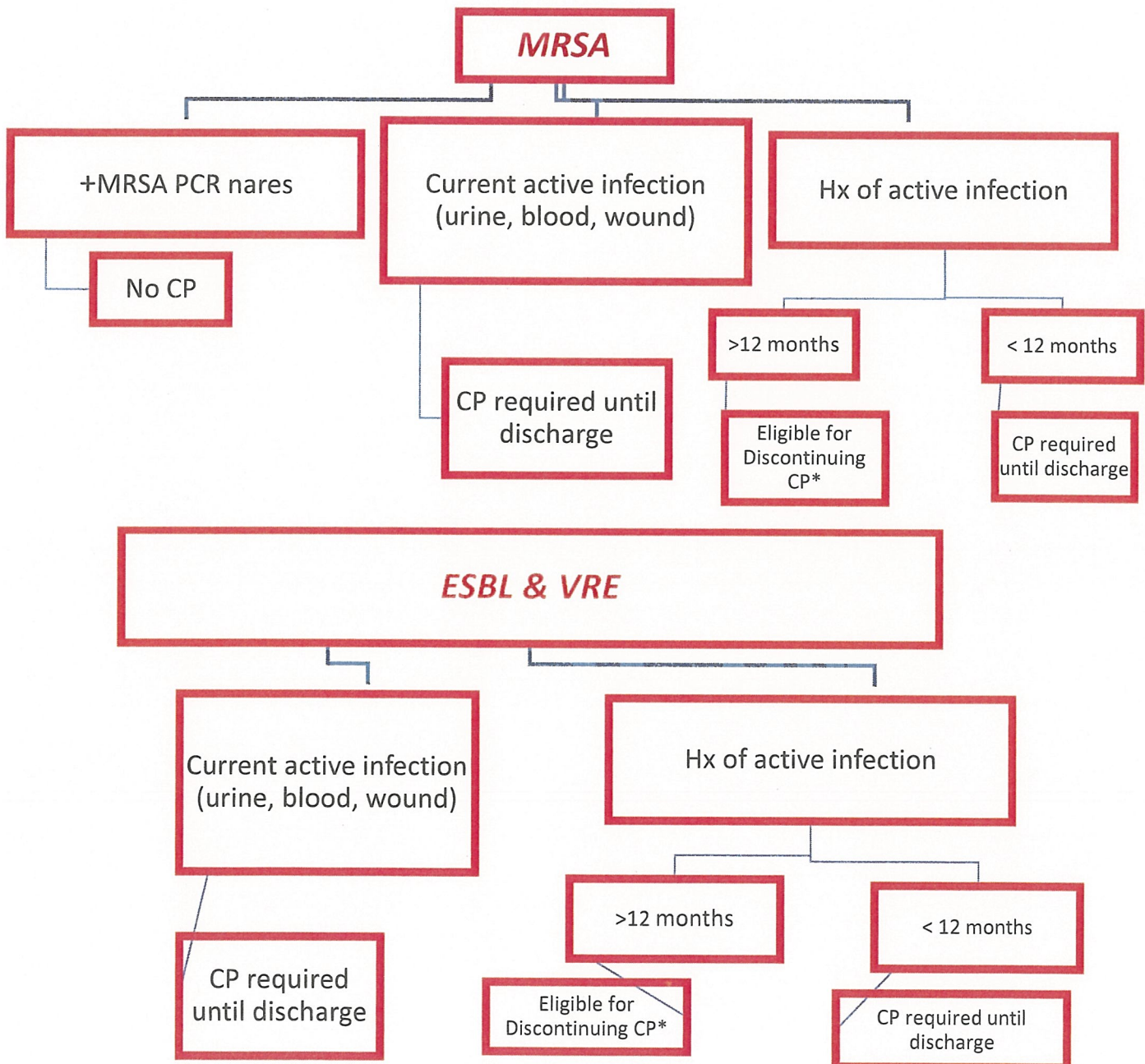
Color Code	MDRO or organism	Type of Isolation	Cohorting Guidelines
	ESBL	Contact	Cohort with another patient with lab-confirmed ESBL. Treat each bedspace like a private room.
	MRSA (history, nares screen)	Standard	Cohort with other patients not on additional precautions
	MRSA (active infection)	Contact	Cohort with another patient with lab-confirmed MRSA. Treat each bedspace like a private room.
	VRE (history, nares screen)	Standard	Cohort with other patients not on additional precautions
	VRE (active infection)	Contact	Cohort with another patient with lab-confirmed VRE. Treat each bedspace like a private room.
	COVID-19	Contact and Droplet	Cohort with other patients not on additional precautions Cohort with another patient with lab-confirmed COVID-19. Treat each bedspace like a private room.
	<i>Clostridioides difficile</i>	Contact with sporicidal cleaning	Private room recommended. If unavailable, cohort with another patient with lab-confirmed <i>C. difficile</i> . Treat each bedspace like a private room. Bathroom cannot be shared
	Norovirus	Contact or Contact & Droplet	Private room recommended. If unavailable, cohort with another patient with lab-confirmed norovirus. Add Droplet precautions if patient is vomiting. Treat each bedspace like a private room. Bathroom cannot be shared
	Influenza or lab confirmed viral illness	Contact & Droplet	Private room recommended. If unavailable, cohort patients with lab confirmation of the same viral organism. Treat each bedspace like a private room.
	Gastrointestinal (GI) symptomatic patient	Contact or Contact & Droplet	Private room recommended. If lab confirmation unavailable, bedside isolation is required until lab confirmation or private room is available. Add Droplet precautions if patient is vomiting. Treat each bedspace like a private room. Bathroom cannot be shared
	Acute Respiratory Illness (e.g., Influenza-like-illness (ILI), pneumonia) with unknown respiratory virus	Contact & Droplet	Private room recommended. If lab confirmation unavailable and all other options have been exhausted , cohort with another patient having ILI symptoms until private room is available. Treat each bedspace like a private room.
	Acute Respiratory Illness with travel history	Contact & Droplet	These patients should not be cohorted.
	Other MDROs (Carbapenemase producing organisms)	Contact	These patients should not be cohorted.

GUIDELINE & CLEARANCE CRITERIA FOR DISCONTINUING ISOLATION PRECAUTIONS

This guideline provides a protocol for discontinuation of contact precautions (CP) for the following organisms: methicillin-resistant *Staphylococcus aureus* (MRSA), vancomycin-resistant enterococci (VRE), and extended-spectrum *B*-lactamase (ESBL) -producing organisms. This does not apply to other MDROs such as CRE, Carbapenem resistant pseudomonas or Acinetobacter.

Please consult Infection Prevention when a decision to discontinue isolation is made.

Patient Eligibility



GUIDELINE & CLEARANCE CRITERIA FOR DISCONTINUING ISOLATION PRECAUTIONS

Clearance Criteria for Discontinuing Contact Precaution for the following Organisms:

MRSA – Off antibiotics effective against MRSA for at least 48 hours prior to 2 negative nares PCR screening 5 days apart.

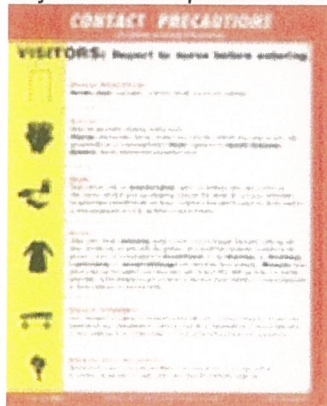
VRE – Off antibiotics effective against VRE for at least 48 hours prior to 3 negative stool, rectal, or peri-rectal cultures at least 5 days apart.

ESBL – Off antibiotics effective against ESBL for at least 48 hours prior to 1 negative urine culture.

Type and Duration of Precautions - Disease Specific (FKA-~~AKA~~ Short Sheet)

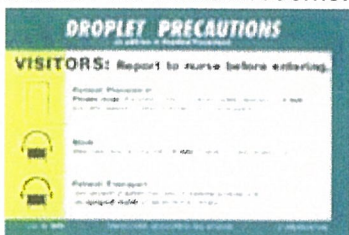
A. CONTACT PRECAUTIONS:

1. For illnesses easily passed by direct contact with the patient or equipment. Private room if available. Cohort with others with same organisms. Do not place with fresh post-op or patients with invasive tubes. HCW wear gloves in the room and add a gown if clothes might touch objects or the patient. Use a mask to protect your face from sprays or splashes.



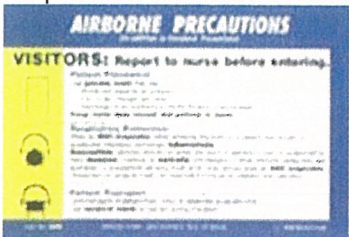
B. DROPLET PRECAUTIONS:

1. For illnesses passed in large droplets (wet drop to wet mucus membrane contact). Private room if available. Cohort with others with same organisms. HCW wear a mask when closer than 3 ft. to the patient. Surgical masks for visitors going closer than 3 ft. to the patient and for patients outside the isolation rooms.



C. AIRBORNE PRECAUTIONS:

1. For illnesses passed in the air. Place in a negative pressure room (C26, 143, 243, 443, 287, 387, 487, 200, 201, 301, 312 & 326) Keep the door closed at all times. HCW wear N95 respirators in the patient's room. Surgical masks for visitors going into the isolation room and for patients outside the isolation rooms.



Type and Duration of Precautions - Disease Specific (FKA AKA Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Abscess Draining, major	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	No dressing or containment of drainage; until drainage stops or can be contained by dressing
Abscess Draining, minor or limited	Standard		Dressing covers and contains drainage
Acquired human immunodeficiency syndrome (HIV)	Standard		Post-exposure chemoprophylaxis for some blood exposures [866].
Actinomycosis	Standard		Not transmitted from person to person
Adenovirus infection (see agent-specific guidance under gastroenteritis, conjunctivitis, pneumonia)			
Amebiasis	Standard		Person to person transmission is rare. Transmission in settings for the mentally challenged and in a family group has been reported [1045]. Use care when handling diapered infants and mentally challenged persons [1046].
Anthrax	Standard		Infected patients do not generally pose a transmission risk.
Anthrax Cutaneous	Standard		Transmission through non-intact skin contact with draining lesions possible, therefore use Contact Precautions if large amount of uncontained drainage. Handwashing with soap and water preferable to use of waterless alcohol based antiseptics since alcohol does not have sporicidal activity [983].
Anthrax Pulmonary	Standard		Not transmitted from person to person
Anthrax Environmental: aerosolizable spore-containing powder or other substance		Until environment completely decontaminated	<p>Until decontamination of environment complete [203]. Wear respirator (N95 mask or PAPRs), protective clothing; decontaminate persons with powder on them (<u>Occupational Health Guidelines for Remediation Workers at Bacillus anthracis-Contaminated Sites --- United States, 2001--2002</u> (https://www.cdc.gov/mmwr/preview/mmwrhtml/mm513_5a3.htm))</p> <p>Hand hygiene: Handwashing for 30-60 seconds with soap and water or 2% chlorhexidine gluconate after spore contact (alcohol handrubs inactive against spores [983].</p> <p>Post-exposure prophylaxis following environmental exposure: 60 days of antimicrobials (either doxycycline, ciprofloxacin, or levofloxacin) and post-exposure vaccine under IND</p>
Antibiotic-associated colitis (see <i>Clostridium difficile</i>)			
Arthropod-borne • viral encephalitides (eastern, western, Venezuelan equine encephalomyelitis; St Louis, California encephalitis; West Nile Virus) and	Standard		Not transmitted from person to person except rarely by transfusion, and for West Nile virus by organ transplant, breastmilk or transplacentally [530, 1047]. Install screens in windows and doors in endemic areas. Use DEET-containing mosquito repellants and

Type and Duration of Precautions - Disease Specific (FKA-AKA Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
viral fevers (dengue, yellow fever, Colorado tick fever)			clothing to cover extremities.
Ascariasis	Standard		Not transmitted from person to person
Aspergillosis	Standard		Contact Precautions and Airborne if massive soft tissue infection with copious drainage and repeated irrigations required [154].
Avian influenza (see influenza, avian below)			
Babesiosis	Standard		Not transmitted from person to person except rarely by transfusion.
Blastomycosis, North American, cutaneous or pulmonary	Standard		Not transmitted from person to person
Botulism	Standard		Not transmitted from person to person
Bronchiolitis (see respiratory infections in infants and young children)	Contact + Standard	Duration of illness	Use mask according to Standard Precautions.
Brucellosis (undulant, Malta, Mediterranean fever)	Standard		Not transmitted from person to person except rarely via banked spermatozoa and sexual contact [1048, 1049]. Provide antimicrobial prophylaxis following laboratory exposure [1050].
<i>Campylobacter</i> gastroenteritis (see gastroenteritis)			
Candidiasis, all forms including mucocutaneous	Standard		
Cat-scratch fever (benign inoculation lymphoreticulosis)	Standard		Not transmitted from person to person
Cellulitis	Standard		
Chancroid (soft chancre) (<i>H. ducreyi</i>)	Standard		Transmitted sexually from person to person
Chickenpox (see >varicella)			
<i>Chlamydia trachomatis</i> Conjunctivitis	Standard		
<i>Chlamydia trachomatis</i> Genital (lymphogranuloma venereum)	Standard		
<i>Chlamydia trachomatis</i> Pneumonia (infants ≤3 mos. of age)	Standard		
<i>Chlamydia pneumoniae</i>	Standard		Outbreaks in institutionalized populations reported, rarely [1051, 1052].
Cholera (see gastroenteritis)			
Closed-cavity infection Open drain in place; limited or minor drainage	Standard		Contact Precautions if there is copious uncontained drainage
Closed-cavity infection No drain or closed drainage system in place	Standard		
<i>Clostridium botulinum</i>	Standard		Not transmitted from person to person
<i>Clostridium difficile</i> (see gastroenteritis, <i>C. difficile</i>)	Contact + Standard	Duration of illness	
<i>Clostridium perfringens</i> Food poisoning	Standard		Not transmitted from person to person
<i>Clostridium perfringens</i> Gas gangrene	Standard		Transmission from person to person rare; one outbreak in a surgical setting reported [1053]. Use

Type and Duration of Precautions - Disease Specific (FKA-AKA Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
			Contact Precautions if wound drainage is extensive.
Coccidioidomycosis (valley fever) Draining lesions	Standard		Not transmitted from person to person except under extraordinary circumstances because the infectious arthroconidial form of <i>Coccidioides immitis</i> is not produced in humans [1054].
Coccidioidomycosis (valley fever) Pneumonia	Standard		Not transmitted from person to person except under extraordinary circumstances, (e.g., inhalation of aerosolized tissue phase endospores during necropsy, transplantation of infected lung) because the infectious arthroconidial form of <i>Coccidioides immitis</i> is not produced in humans [1054, 1055].
Colorado tick fever	Standard		Not transmitted from person to person
Congenital rubella	Contact + Standard	Until 1 yr of age	Standard Precautions if nasopharyngeal and urine cultures repeatedly neg. after 3 mos. of age
Conjunctivitis Acute bacterial	Standard		
Conjunctivitis Acute bacterial <i>Chlamydia</i>	Standard		
Conjunctivitis Acute bacterial Gonococcal	Standard		
Conjunctivitis Acute viral (acute hemorrhagic)	Contact + Standard	Duration of illness	Adenovirus most common; enterovirus 70 [1056], Coxsackie virus A24 [1057] also associated with community outbreaks. Highly contagious; outbreaks in eye clinics, pediatric and neonatal settings, institutional settings reported. Eye clinics should follow Standard Precautions when handling patients with conjunctivitis. Routine use of infection control measures in the handling of instruments and equipment will prevent the occurrence of outbreaks in this and other settings. [460, 814, 1058, 1059 461, 1060].
Corona virus associated with SARS (SARS-CoV) (see severe acute respiratory syndrome)			
Coxsackie virus disease (see enteroviral infection)			
Creutzfeldt-Jakob disease (CJD, vCJD)	Standard		Use disposable instruments or special sterilization/disinfection for surfaces, objects contaminated with neural tissue if CJD or vCJD suspected and has not been R/O; No special burial procedures [1061]
Croup (see respiratory infections in infants and young children)			
Crimean-Congo Fever (see Viral Hemorrhagic Fever)	Standard		
Cryptococcosis	Standard		Not transmitted from person to person, except rarely via tissue and corneal transplant [1062, 1063]
Cryptosporidiosis (see gastroenteritis)			
Cysticercosis	Standard		Not transmitted from person to person
Cytomegalovirus infection, including in neonates and immunosuppressed patients	Standard		No additional precautions for pregnant HCWs

Type and Duration of Precautions - Disease Specific (EKA-AKA Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Decubitus ulcer (see Pressure ulcer)			
Dengue fever	Standard		Not transmitted from person to person
Diarrhea, acute-infective etiology suspected (see gastroenteritis)			
Diphtheria Cutaneous	Contact + Standard	Until off antimicrobial treatment and culture-negative	Until 2 cultures taken 24 hours apart negative
Diphtheria Pharyngeal	Droplet + Standard	Until off antimicrobial treatment and culture-negative	Until 2 cultures taken 24 hours apart negative
Ebola virus (see viral hemorrhagic fevers)			⚠ Ebola Virus Disease for Healthcare Workers [2014]: Update: Updated recommendations for healthcare workers can be found at Ebola: U.S. Healthcare Workers and Settings (https://www.cdc.gov/vhf/ebola/healthcare-us/).
Echinococcosis (hydatidosis)	Standard		Not transmitted from person to person
Echovirus (see enteroviral infection)			
Encephalitis or encephalomyelitis (see specific etiologic agents)			
Endometritis (endomyometritis)	Standard		
Enterobiasis (pinworm disease, oxyuriasis)	Standard		
<i>Enterococcus</i> species (see multidrug-resistant organisms if epidemiologically significant or vancomycin resistant)			
Enterocolitis, <i>C. difficile</i> (see <i>C. difficile</i> , gastroenteritis)			
Enteroviral infections (i.e., Group A and B Coxsackie viruses and Echo viruses) (excludes polio virus)	Standard		Use Contact Precautions for diapered or incontinent children for duration of illness and to control institutional outbreaks
Epiglottitis, due to <i>Haemophilus influenzae</i> type b	Droplet + Standard	Until 24 hours after initiation of effective therapy	See specific disease agents for epiglottitis due to other etiologies)
Epstein-Barr virus infection, including infectious mononucleosis	Standard		
Erythema infectiosum (also see Parvovirus B19)			
<i>Escherichia coli</i> gastroenteritis (see gastroenteritis)			
Food poisoning Botulism	Standard		Not transmitted from person to person
Food poisoning <i>C. perfringens</i> or <i>welchii</i>	Standard		Not transmitted from person to person
Food poisoning Staphylococcal	Standard		Not transmitted from person to person
Furunculosis, staphylococcal	Standard		Contact if drainage not controlled. Follow

Type and Duration of Precautions - Disease Specific (FKA-AKA Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
			institutional policies if MRSA
Furunculosis, staphylococcal Infants and young children	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	
Gangrene (gas gangrene)	Standard		Not transmitted from person to person
Gastroenteritis	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks for gastroenteritis caused by all of the agents below
Gastroenteritis Adenovirus	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis <i>Campylobacter</i> species	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis Cholera (<i>Vibrio cholerae</i>)	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis <i>C. difficile</i>	Contact + Standard	Duration of illness	Discontinue antibiotics if appropriate. Do not share electronic thermometers [853], 854; ensure consistent environmental cleaning and disinfection. Hypochlorite solutions may be required for cleaning if transmission continues [847]. Handwashing with soap and water preferred because of the absence of sporicidal activity of alcohol in waterless antiseptic handrubs [983].
Gastroenteritis <i>Cryptosporidium</i> species	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis <i>E. coli</i> Enteropathogenic O157:H7 and other shiga toxin- producing strains	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis <i>E. coli</i> Other species	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis <i>Giardia lamblia</i>	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis Noroviruses	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks. Persons who clean areas heavily contaminated with feces or vomitus may benefit from wearing masks since virus can be aerosolized from these body substances [142, 147 148]; ensure consistent environmental cleaning and disinfection with focus on restrooms even when apparently unsoiled [273, 1064]). Hypochlorite solutions may be required when there is continued transmission [290-292]. Alcohol is less active, but there is no evidence that alcohol antiseptic handrubs are not effective for hand decontamination [294]. Cohorting of affected patients to separate airspaces

Type and Duration of Precautions - Disease Specific (FKA-AKA Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
			and toilet facilities may help interrupt transmission during outbreaks.
Gastroenteritis Rotavirus	Contact + Standard	Duration of illness	Ensure consistent environmental cleaning and disinfection and frequent removal of soiled diapers. Prolonged shedding may occur in both immunocompetent and immunocompromised children and the elderly [932, 933].
Gastroenteritis <i>Salmonella</i> species (including <i>S. typhi</i>)	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis <i>Shigella</i> species (Bacillary dysentery)	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis <i>Vibrio parahaemolyticus</i>	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis Viral (if not covered elsewhere)	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis <i>Yersinia enterocolitica</i>	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
German measles (see rubella; see congenital rubella)			
Giardiasis (see gastroenteritis)			
Gonococcal ophthalmia neonatorum (gonorrheal ophthalmia, acute conjunctivitis of newborn)	Standard		
Gonorrhea	Standard		
Granuloma inguinale (Donovanosis, granuloma venereum)	Standard		
Guillain-Barre' syndrome	Standard		Not an infectious condition
<i>Haemophilus influenzae</i> (see disease-specific recommendations)			
Hand, foot, and mouth disease (see enteroviral infection)			
Hansen's Disease (see Leprosy)			
Hantavirus pulmonary syndrome	Standard		Not transmitted from person to person
<i>Helicobacter pylori</i>	Standard		
Hepatitis, viral Type A	Standard		Provide hepatitis A vaccine post-exposure as recommended [1065]
Hepatitis, viral Type A-Diapered or incontinent patients	Contact + Standard		Maintain Contact Precautions in infants and children <3 years of age for duration of hospitalization; for children 3-14 yrs. of age for 2 weeks after onset of symptoms; >14 yrs. of age for 1 week after onset of symptoms [833, 1066, 1067].
Hepatitis, viral Type B-HBsAg positive; acute or chronic	Standard		See specific recommendations for care of patients in hemodialysis centers 778
Hepatitis, viral Type C and other unspecified non-A, non-B	Standard		See specific recommendations for care of patients in hemodialysis centers [778]
Hepatitis, viral	Standard		

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Infection Control Policy: Standard and Transmission-Based Precautions

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Type and Duration of Precautions - Disease Specific (FKA-AKA Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Type D (seen only with hepatitis B)			
Hepatitis, viral Type E	Standard		Use Contact Precautions for diapered or incontinent individuals for the duration of illness [1068]
Hepatitis, viral Type G	Standard		
Herpangina (see enteroviral infection)			
Hookworm	Standard		
Herpes simplex (<i>Herpesvirus hominis</i>) Encephalitis	Standard		
Herpes simplex (<i>Herpesvirus hominis</i>) Mucocutaneous, disseminated or primary, severe	Contact + Standard	Until lesions dry and crusted	
Herpes simplex (<i>Herpesvirus hominis</i>) Mucocutaneous, recurrent (skin, oral, genital)	Standard		
Herpes simplex (<i>Herpesvirus hominis</i>) Neonatal	Contact + Standard	Until lesions dry and crusted	Also, for asymptomatic, exposed infants delivered vaginally or by C-section and if mother has active infection and membranes have been ruptured for more than 4 to 6 hours until infant surface cultures obtained at 24-36 hours. of age negative after 48 hours incubation [1069, 1070]
Herpes zoster (varicella-zoster) (shingles) Disseminated disease in any patient Localized disease in immunocompromised patient until disseminated infection ruled out	Airborne + Contact + Standard	Duration of illness	Susceptible HCWs should not enter room if immune caregivers are available; no recommendation for protection of immune HCWs; no recommendation for type of protection, i.e. surgical mask or respirator; for susceptible HCWs.
Herpes zoster (varicella-zoster) (shingles) Localized in patient with intact immune system with lesions that can be contained/covered	Standard	Duration of illness (with wound lesions, until wounds stop draining)	Susceptible HCWs should not provide direct patient care when other immune caregivers are available.
Histoplasmosis	Standard		Not transmitted from person to person
Human immunodeficiency virus (HIV)	Standard		Post-exposure chemoprophylaxis for some blood exposures [866].
Human metapneumovirus	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	HAI reported [1071], but route of transmission not established [823]. Assumed to be Contact transmission as for RSV since the viruses are closely related and have similar clinical manifestations and epidemiology. Wear masks according to Standard Precautions.
Impetigo	Contact + Standard	Until 24 hours after initiation of effective therapy	
Infectious mononucleosis	Standard		
Influenza Human (seasonal Influenza)	-		See Prevention Strategies for Seasonal Influenza in Healthcare Settings (https://www.cdc.gov/flu/professionals/infectioncontrol/h_ealthcaresettings.htm) for current seasonal influenza guidance.

Type and Duration of Precautions - Disease Specific (FKA AKA Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Influenza Avian (e.g., H5N1, H7, H9 strains)	-		See [This link is no longer active: www.cdc.gov/flu/avian/professional/infect-control.htm . Similar information may be found at Interim Guidance for Infection Control Within Healthcare Settings When Caring for Confirmed Cases, Probable Cases, and Cases Under Investigation for Infection with Novel Influenza A Viruses Associated with Severe Disease (https://www.cdc.gov/flu/avianflu/novel-flu-infection-control.htm), accessed May 2016.] for current avian Influenza guidance.
Influenza Pandemic Influenza (also a human Influenza virus)	Droplet		See [This link is no longer active: http://www.pandemicflu.gov . Similar information may be found at Interim Guidance for Infection Control Within Healthcare Settings When Caring for Confirmed Cases, Probable Cases, and Cases Under Investigation for Infection with Novel Influenza A Viruses Associated with Severe Disease (https://www.cdc.gov/flu/avianflu/novel-flu-infection-control.htm), accessed May 2016.] for current pandemic Influenza guidance.
Kawasaki syndrome	Standard		Not an infectious condition
Lassa fever (see viral hemorrhagic fevers)	-		
Legionnaires' disease	Standard		Not transmitted from person to person
Leprosy	Standard		
Leptospirosis	Standard		Not transmitted from person to person
Lice Head (pediculosis)	Contact + Standard	Until 24 hours after initiation of effective therapy	See [This link is no longer active: http://www.cdc.gov/ncidod/dpd/parasites/lice/default.htm . Similar information may be found at CDC's Parasites - Lice (https://www.cdc.gov/parasites/lice/index.html), accessed May 2016.]
Lice Body	Standard		Transmitted person to person through infested clothing. Wear gown and gloves when removing clothing; bag and wash clothes according to CDC guidance [This link is no longer active: http://www.cdc.gov/ncidod/dpd/parasites/lice/default.htm . Similar information may be found at CDC's Parasites - Lice (https://www.cdc.gov/parasites/lice/index.html), accessed May 2016.]
Lice Pubic	Standard		Transmitted person to person through sexual contact. See CDC's [This link is no longer active: http://www.cdc.gov/ncidod/dpd/parasites/lice/default.htm . Similar information may be found at CDC's Parasites - Lice (https://www.cdc.gov/parasites/lice/index.html), accessed May 2016.]
Listeriosis (<i>listeria monocytogenes</i>)	Standard		Person-to-person transmission rare; cross-transmission in neonatal settings reported [1072, 1073 1074, 1075]
Lyme disease	Standard		Not transmitted from person to person
Lymphocytic choriomeningitis	Standard		Not transmitted from person to person

Type and Duration of Precautions - Disease Specific (FKA AKA Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Lymphogranuloma venereum	Standard		
Malaria	Standard		Not transmitted from person to person except through transfusion rarely and through a failure to follow Standard Precautions during patient care 1076-1079. Install screens in windows and doors in endemic areas. Use DEET-containing mosquito repellants and clothing to cover extremities.
Marburg virus disease (see viral hemorrhagic fevers)	-		
Measles (rubeola)	Airborne + Standard	4 days after onset of rash; duration of illness (with wound lesions, until wounds stop draining) in immune compromised	<p>⚠ Measles Update [November 2011]: Updated recommendations can be found at <u>Immunization of Healthcare Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP)</u> (https://www.cdc.gov/mmwr/pdf/rr/rr6007.pdf).</p> <p>Susceptible HCWs should not enter room if immune care providers are available; no recommendation for face protection for immune HCW; no recommendation for type of face protection for susceptible HCWs, i.e., mask or respirator [1027, 1028]. For exposed susceptibles, post-exposure vaccine within 72 hours or immune globulin within 6 days when available [17, 1032, 1034]. Place exposed susceptible patients on Airborne Precautions and exclude susceptible healthcare personnel.</p>
Melioidosis, all forms	Standard		Not transmitted from person to person.
Meningitis Aseptic (nonbacterial or viral; also see enteroviral infections)	Standard		Contact for infants and young children.
Meningitis Bacterial, gram-negative enteric, in neonates	Standard		
Meningitis Fungal	Standard		
Meningitis <i>Haemophilus Influenzae</i> , type b known or suspected	Droplet + Standard	Until 24 hours after initiation of effective therapy	
Meningitis <i>Listeria monocytogenes</i> (See Listeriosis)	Standard		
Meningitis <i>Neisseria meningitidis</i> (meningococcal) known or suspected	Droplet + Standard	Until 24 hours after initiation of effective therapy	See meningococcal disease below.
Meningitis <i>Streptococcus pneumoniae</i>	Standard		
Meningitis <i>M. tuberculosis</i>	Standard		Concurrent, active pulmonary disease or draining cutaneous lesions may necessitate addition of Contact and/or Airborne; For children, Airborne Precautions until active tuberculosis ruled out in visiting family members (see tuberculosis below) 42

Type and Duration of Precautions - Disease Specific (EKA-AKA Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Meningitis Other diagnosed bacterial	Standard		
Meningococcal disease: sepsis, pneumonia, Meningitis	Droplet + Standard	Until 24 hours after initiation of effective therapy	Postexposure chemoprophylaxis for household contacts, HCWs exposed to respiratory secretions; postexposure vaccine only to control outbreaks 15, 17.
<i>Molluscum contagiosum</i>	Standard		
Monkeypox	Airborne + Contact + Standard	Airborne-Until monkeypox confirmed and smallpox excluded Contact-Until lesions crusted	See CDC's Monkeypox website (https://www.cdc.gov/poxvirus/monkeypox/) [Current version of this document may differ from original.] for most current recommendations. Transmission in hospital settings unlikely [269]. Pre- and post-exposure smallpox vaccine recommended for exposed HCWs
Mucormycosis	Standard		
Multidrug-resistant organisms (MDROs), infection or colonization (e.g., MRSA, VRE, VISA/VRSA, ESBLs, resistant <i>S. pneumoniae</i>)	Contact + Standard		MDROs judged by the infection control program, based on local, state, regional, or national recommendations, to be of clinical and epidemiologic significance. Contact Precautions recommended in settings with evidence of ongoing transmission, acute care settings with increased risk for transmission or wounds that cannot be contained by dressings. See recommendations for management options in <u>Management of Multidrug-Resistant Organisms In Healthcare Settings, 2006</u> (https://www.cdc.gov/infectioncontrol/guidelines/mdro/) [870]. Contact state health department for guidance regarding new or emerging MDRO.
Mumps (infectious parotitis)	Droplet + Standard	Until 9 days	After onset of swelling; susceptible HCWs should not provide care if immune caregivers are available. Note: (Recent assessment of outbreaks in healthy 18- 24 year olds has indicated that salivary viral shedding occurred early in the course of illness and that 5 days of isolation after onset of parotitis may be appropriate in community settings; however the implications for healthcare personnel and high-risk patient populations remain to be clarified.)
Mycobacteria, nontuberculosis (atypical)			Not transmitted person-to-person
Mycobacteria, nontuberculosis (atypical) Pulmonary	Standard		
Mycobacteria, nontuberculosis (atypical) Wound	Standard		
<i>Mycoplasma pneumonia</i>	Droplet + Standard	Duration of Illness	
Necrotizing enterocolitis	Standard		Contact Precautions when cases clustered temporally [1080-1083].
Nocardiosis, draining lesions, or other presentations	Standard		Not transmitted person-to-person
Norovirus (see gastroenteritis)			
Norwalk agent Gastroenteritis (see gastroenteritis)			
Orf	Standard		

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Infection Control Policy: Standard and Transmission-Based Precautions

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Type and Duration of Precautions - Disease Specific (EKA-AKA Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Parainfluenza virus infection, respiratory in infants and young children	Contact + Standard	Duration of illness	Viral shedding may be prolonged in immunosuppressed patients [1009, 1010]. Reliability of antigen testing to determine when to remove patients with prolonged hospitalizations from Contact Precautions uncertain.
Parvovirus B19 (Erythema infectiosum)	Droplet + Standard		Maintain precautions for duration of hospitalization when chronic disease occurs in an immunocompromised patient. For patients with transient aplastic crisis or red-cell crisis, maintain precautions for 7 days. Duration of precautions for immunosuppressed patients with persistently positive PCR not defined, but transmission has occurred [929].
Pediculosis (Lice)	Contact + Standard	Until 24 hours after initiation of effective therapy after treatment	
Pertussis (whooping cough)	Droplet + Standard	Until 5 days	Single patient room preferred. Cohorting an option. Post-exposure chemoprophylaxis for household contacts and HCWs with prolonged exposure to respiratory secretions [863]. Recommendations for Tdap vaccine in adults under development.  Tdap Vaccine Recommendations [2011] Update: Current recommendations can be found at Tdap / Td ACIP Vaccine Recommendations (www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/tdap-td.html) .
Pinworm infection (Enterobiasis)	Standard		
Plague (<i>Yersinia pestis</i>) Bubonic	Standard		
Plague (<i>Yersinia pestis</i>) Pneumonic	Droplet + Standard	Until 48 hours	Antimicrobial prophylaxis for exposed HCW [207].
Pneumonia Adenovirus	Droplet + Contact + Standard	Duration of illness	Outbreaks in pediatric and institutional settings reported [376, 1084-1086]. In immunocompromised hosts, extend duration of Droplet and Contact Precautions due to prolonged shedding of virus [931]
Pneumonia Bacterial not listed elsewhere (including gram-negative bacterial)	Standard		
Pneumonia <i>B. cepacia</i> in patients with CF, including respiratory tract colonization	Contact + Standard	Unknown	Avoid exposure to other persons with CF; private room preferred. Criteria for D/C precautions not established. See CF Foundation guideline [20]
Pneumonia <i>B. cepacia</i> in patients without CF (see multidrug-resistant organisms)			
Pneumonia <i>Chlamydia</i>	Standard		
Pneumonia	Standard		

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Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Fungal			
Pneumonia <i>Haemophilus influenzae</i> , type b Adults	Standard		
Pneumonia <i>Haemophilus influenzae</i> , type b Infants and children	Droplet + Standard	Until 24 hours after initiation of effective therapy	
Pneumonia <i>Legionella spp.</i>	Standard		
Pneumonia Meningococcal	Droplet + Standard	Until 24 hours after initiation of effective therapy	See meningococcal disease above
Pneumonia Multidrug-resistant bacterial (see multidrug-resistant organisms)			
Pneumonia <i>Mycoplasma</i> (primary atypical Pneumonia)	Droplet	Duration of illness	
Pneumonia Pneumococcal pneumonia	Standard		Use Droplet Precautions if evidence of transmission within a patient care unit or facility [196-198, 1087]
Pneumonia <i>Pneumocystis jiroveci</i> (<i>Pneumocystis carinii</i>)	Standard		Avoid placement in the same room with an immunocompromised patient.
Pneumonia <i>Staphylococcus aureus</i>	Standard		For MRSA, see MDROs
Pneumonia Streptococcus, group A Adults	Droplet + Standard	Until 24 hours after initiation of effective therapy	See streptococcal disease (group A streptococcus) below Contact precautions if skin lesions present
Pneumonia Streptococcus, group A Infants and young children	Droplet + Standard	Until 24 hours after initiation of effective therapy	Contact Precautions if skin lesions present
Pneumonia Varicella-zoster (See Varicella- Zoster)			
Pneumonia Viral Adults	Standard		
Pneumonia Viral Infants and young children (see respiratory infectious disease, acute, or specific viral agent)			
Poliomyelitis	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	
Pressure ulcer (decubitus ulcer, pressure sore) infected	Contact + Standard	Duration of illness (with	If no dressing or containment of drainage; until drainage stops or can be contained by dressing

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Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Major		wound lesions, until wounds stop draining)	
Pressure ulcer (decubitus ulcer, pressure sore) infected Minor or limited	Standard		If dressing covers and contains drainage
Prion disease (See Creutzfeld-Jacob Disease)			
Psittacosis (ornithosis) (<i>Chlamydia psittaci</i>)	Standard		Not transmitted from person to person
Q fever	Standard		
Rabies	Standard		Person to person transmission rare; transmission via corneal, tissue and organ transplants has been reported [539, 1088]. If patient has bitten another individual or saliva has contaminated an open wound or mucous membrane, wash exposed area thoroughly and administer postexposure prophylaxis. [1089]
Rat-bite fever (<i>Streptobacillus moniliformis</i> disease, <i>Spirillum minus</i> disease)	Standard		Not transmitted from person to person
Relapsing fever	Standard		Not transmitted from person to person
Resistant bacterial infection or colonization (see multidrug-resistant organisms)			
Respiratory infectious disease, acute (if not covered elsewhere) Adults	Standard		
Respiratory infectious disease, acute (if not covered elsewhere) Infants and young children	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	Also see syndromes or conditions listed in Table 2
Respiratory syncytial virus infection, in infants, young children and immunocompromised adults	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	Wear mask according to Standard Precautions [24] CB [116, 117]. In immunocompromised patients, extend the duration of Contact Precautions due to prolonged shedding [928]. Reliability of antigen testing to determine when to remove patients with prolonged hospitalizations from Contact Precautions uncertain.
Reye's syndrome	Standard		Not an infectious condition
Rheumatic fever	Standard		Not an infectious condition
Rhinovirus	Droplet + Standard	Duration of illness (with wound lesions, until wounds stop draining)	Droplet most important route of transmission [104 1090]. Outbreaks have occurred in NICUs and LTCFs [413, 1091, 1092]. Add Contact Precautions if copious moist secretions and close contact likely to occur (e.g., young infants) [111, 833].
Rickettsial fevers, tickborne (Rocky Mountain spotted fever, tickborne Typhus fever)	Standard		Not transmitted from person to person except through transfusion, rarely
Rickettsialpox (vesicular rickettsiosis)	Standard		Not transmitted from person to person
Ringworm (dermatophytosis, dermatomycosis, tinea)	Standard		Rarely, outbreaks have occurred in healthcare settings, (e.g., NICU [1093], rehabilitation hospital [1094]. Use Contact Precautions for outbreak.
Ritter's disease staphylococcal scalded skin	Contact + Standard	Duration of illness (with	See staphylococcal disease, scalded skin syndrome below

Type and Duration of Precautions - Disease Specific (EKA-AKA Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
syndrome)		wound lesions, until wounds stop draining)	
Rocky Mountain spotted fever	Standard		Not transmitted from person to person except through transfusion, rarely
Roseola infantum (exanthem subitum; caused by HHV-6)	Standard		
Rotavirus infection (see gastroenteritis)			
Rubella (German measles) (also see congenital rubella)	Droplet + Standard	Until 7 days after onset of rash	Susceptible HCWs should not enter room if immune caregivers are available. No recommendation for wearing face protection (e.g., a surgical mask) if immune. Pregnant women who are not immune should not care for these patients [17, 33]. Administer vaccine within three days of exposure to non-pregnant susceptible individuals. Place exposed susceptible patients on Droplet Precautions; exclude susceptible healthcare personnel from duty from day 5 after first exposure to day 21 after last exposure, regardless of post-exposure vaccine.
Rubeola (see measles)			
Salmonellosis (see gastroenteritis)			
Scabies	Contact	Until 24	
Scalded skin syndrome, staphylococcal	Contact	Duration of illness (with wound lesions, until wounds stop draining)	See staphylococcal disease, scalded skin syndrome below)
Schistosomiasis (bilharziasis)	Standard		
Severe acute respiratory syndrome (SARS)	Airborne + Droplet + Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining) plus 10 days after resolution of fever, provided respiratory symptoms are absent or improving	Airborne preferred; D if AIR unavailable. N95 or higher respiratory protection; surgical mask if N95 unavailable; eye protection (goggles, face shield); aerosol- generating procedures and "supershedders" highest risk for transmission via small droplet nuclei and large droplets [93, 94, 96]. Vigilant environmental disinfection (see [This link is no longer active: www.cdc.gov/ncidod/sars . Similar information may be found at CDC Severe Acute Respiratory Syndrome (SARS) (https://www.cdc.gov/sars/index.html), accessed May 2016.])
Shigellosis (see gastroenteritis)			
Smallpox (variola; see Vaccinia for management of vaccinated persons)	Airborne + Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	Until all scabs have crusted and separated (3-4 weeks). Non-vaccinated HCWs should not provide care when immune HCWs are available; N95 or higher respiratory protection for susceptible and successfully vaccinated individuals; postexposure vaccine within 4 days of exposure protective [108, 129, 1038-1040].
Sporotrichosis	Standard		
<i>Spirillum minor</i> disease (rat-bite fever)	Standard		Not transmitted from person to person
Staphylococcal disease (<i>S aureus</i>) Skin, wound, or burn	Contact	Duration of illness (with wound lesions,	No dressing or dressing does not contain drainage adequately

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Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Major		until wounds stop draining)	
Staphylococcal disease (<i>S aureus</i>) Skin, wound, or burn Minor or limited	Standard		Dressing covers and contains drainage adequately
Staphylococcal disease (<i>S aureus</i>) Enterocolitis	Standard		Use Contact Precautions for diapered or incontinent children for duration of illness
Staphylococcal disease (<i>S aureus</i>) Multidrug-resistant (see multidrug-resistant organisms)			
Staphylococcal disease (<i>S aureus</i>) Pneumonia	Standard		
Staphylococcal disease (<i>S aureus</i>) Scalded skin syndrome	Contact	Duration of illness (with wound lesions, until wounds stop draining)	Consider healthcare personnel as potential source of nursery, NICU outbreak [1095].
Staphylococcal disease (<i>S aureus</i>) Toxic shock syndrome	Standard		
<i>Streptobacillus moniliformis</i> disease (rat-bite fever)	Standard		Not transmitted from person to person
Streptococcal disease (group A streptococcus) Skin, wound, or burn Major	Contact + Droplet + Standard	Until 24 hours after initiation of effective therapy	No dressing or dressing does not contain drainage adequately
Streptococcal disease (group A streptococcus) Skin, wound, or burn Minor or limited	Standard		Dressing covers and contains drainage adequately
Streptococcal disease (group A streptococcus) Endometritis (puerperal sepsis)	Standard		
Streptococcal disease (group A streptococcus) Pharyngitis in infants and young children	Droplet	Until 24 hours after initiation of effective therapy	
Streptococcal disease (group A streptococcus) Pneumonia	Droplet	Until 24 hours after initiation of effective therapy	
Streptococcal disease (group A streptococcus) Scarlet fever in infants and young children	Droplet	Until 24 hours after initiation of effective therapy	
Streptococcal disease (group A streptococcus) Serious invasive disease	Droplet	Until 24 hours after initiation of effective therapy	Outbreaks of serious invasive disease have occurred secondary to transmission among patients and healthcare personnel [162, 972, 1096-1098] Contact Precautions for draining wound as above; follow rec. for antimicrobial prophylaxis in selected conditions [160].
Streptococcal disease (group	Standard		

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Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
B streptococcus), neonatal			
Streptococcal disease (not group A or B) unless covered elsewhere Multidrug-resistant (see multidrug-resistant organisms)			
Strongyloidiasis	Standard		
Syphilis Latent (tertiary) and seropositivity without lesions	Standard		
Syphilis Skin and mucous membrane, including congenital, primary, secondary	Standard		
Tapeworm disease <i>Hymenolepis nana</i>	Standard		Not transmitted from person to person
Tapeworm disease <i>Taenia solium</i> (pork)	Standard		
Tapeworm disease Other	Standard		
Tetanus	Standard		Not transmitted from person to person
Tinea (e.g., dermatophytosis, dermatomycosis, ringworm)	Standard		Rare episodes of person-to-person transmission
Toxoplasmosis	Standard		Transmission from person to person is rare; vertical transmission from mother to child, transmission through organs and blood transfusion rare
Toxic shock syndrome (staphylococcal disease, streptococcal disease)	Standard		Droplet Precautions for the first 24 hours after implementation of antibiotic therapy if Group A streptococcus is a likely etiology
Trachoma, acute	Standard		
Transmissible spongiform encephalopathy (see Creutzfeldt-Jacob disease, CJD, vCJD)			
Trench mouth (Vincent's angina)	Standard		
Trichinosis	Standard		
Trichomoniasis	Standard		
Trichuriasis (whipworm disease)	Standard		
Tuberculosis (<i>M. tuberculosis</i>) Extrapulmonary, draining lesion	Airborne + Contact + Standard		Discontinue precautions only when patient is improving clinically, and drainage has ceased or there are three consecutive negative cultures of continued drainage [1025, 1026]. Examine for evidence of active pulmonary tuberculosis.
Tuberculosis (<i>M. tuberculosis</i>) Extrapulmonary, no draining lesion, Meningitis	Standard		Examine for evidence of pulmonary tuberculosis. For infants and children, use Airborne until active pulmonary tuberculosis in visiting family members ruled out [42]
Tuberculosis (<i>M. tuberculosis</i>) Pulmonary or laryngeal disease, confirmed	Airborne		Discontinue precautions only when patient on effective therapy is improving clinically and has three consecutive sputum smears negative for acid-fast bacilli collected on separate days (MMWR 2005; 54: RR-17 <u>Guidelines for Preventing the Transmission of <i>Mycobacterium tuberculosis</i> in Health-Care Settings, 2005</u> (https://www.cdc.gov/mmwr/preview/mmwrhtml/rr541

Type and Duration of Precautions - Disease Specific (FKA-AKA Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
			7a 1.htm?s_cid=rr5417a1_e)) [12].
Tuberculosis (<i>M. tuberculosis</i>) Pulmonary or laryngeal disease, suspected	Airborne		Discontinue precautions only when the likelihood of infectious TB disease is deemed negligible, and either 1. there is another diagnosis that explains the clinical syndrome or 2. the results of three sputum smears for AFB are negative. Each of the three sputum specimens should be collected 8-24 hours apart, and at least one should be an early morning specimen
Tuberculosis (<i>M. tuberculosis</i>) Skin-test positive with no evidence of current active disease	Standard		
Tularemia Draining lesion	Standard		Not transmitted from person to person
Tularemia Pulmonary	Standard		Not transmitted from person to person
Typhoid (<i>Salmonella typhi</i>) fever (see gastroenteritis)			
Typhus <i>Rickettsia prowazekii</i> (Epidemic or Louse-borne Typhus)	Standard		Transmitted from person to person through close personal or clothing contact
Typhus <i>Rickettsia typhi</i>	Standard		Not transmitted from person to person
Urinary tract infection (including pyelonephritis), with or without urinary catheter	Standard		
Vaccinia			Only vaccinated HCWs have contact with active vaccination sites and care for persons with adverse vaccinia events; if unvaccinated, only HCWs without contraindications to vaccine may provide care.
Vaccinia Vaccination site care (including autoinoculated areas)	Standard		Vaccination recommended for vaccinators; for newly vaccinated HCWs: semi-permeable dressing over gauze until scab separates, with dressing change as fluid accumulates, ~3-5 days; gloves, hand hygiene for dressing change; vaccinated HCW or HCW without contraindication to vaccine for dressing changes [205, 221, 225].
Vaccinia (adverse events following vaccination) Eczema vaccinatum	Contact	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material
Vaccinia (adverse events following vaccination) Fetal vaccinia	Contact	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material
Vaccinia (adverse events following vaccination) Generalized vaccinia	Contact	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material
Vaccinia (adverse events following vaccination)	Contact		For contact with virus-containing lesions and exudative material

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Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Progressive vaccinia			
Vaccinia (adverse events following vaccination) PostVaccinia encephalitis	Standard		
Vaccinia (adverse events following vaccination) Blepharitis or conjunctivitis	Contact + Standard		Use Contact Precautions if there is copious drainage
Vaccinia (adverse events following vaccination) Iritis or keratitis	Standard		
Vaccinia (adverse events following vaccination) Vaccinia-associated erythema multiforme (Stevens Johnson Syndrome)	Standard		Not an infectious condition
Vaccinia (adverse events following vaccination) Secondary bacterial infection (e.g., <i>S. aureus</i> , group A beta hemolytic streptococcus)	Standard + Contact		Follow organism-specific (strep, staph most frequent) recommendations and consider magnitude of drainage
Varicella Zoster	Airborne + Contact + Standard	Until lesions dry and crusted	Susceptible HCWs should not enter room if immune caregivers are available; no recommendation for face protection of immune HCWs; no recommendation for type of protection, i.e., surgical mask or respirator for susceptible HCWs. In immunocompromised host with varicella Pneumonia, prolong duration of precautions for duration of illness. Post-exposure prophylaxis: provide post-exposure vaccine ASAP but within 120 hours; for susceptible exposed persons for whom vaccine is contraindicated (immunocompromised persons, pregnant women, newborns whose mother's varicella onset is <5days before delivery or within 48 hours after delivery) provide VZIG, when available, within 96 hours; if unavailable, use IVIG, Use Airborne for exposed susceptible persons and exclude exposed susceptible healthcare workers beginning 8 days after first exposure until 21 days after last exposure or 28 if received VZIG, regardless of postexposure vaccination. [1036].
Variola (see smallpox)			
<i>Vibrio parahaemolyticus</i> (see gastroenteritis)			
Vincent's angina (trench mouth)	Standard		
Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses	Standard + Droplet + Contact	Duration of illness (with wound lesions, until wounds stop draining)	<p>⚠️ Ebola Virus Disease Update [2014]: Updated recommendations for healthcare workers can be found at Ebola: U.S. Healthcare Workers and Settings (https://www.cdc.gov/vhf/ebola/healthcare-us/).</p> <p>Single-patient room preferred. Emphasize:</p> <ol style="list-style-type: none"> 1. use of sharps safety devices and safe work practices,

Type and Duration of Precautions - Disease Specific (FKA-AKA Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
			<p>2. hand hygiene;</p> <p>3. barrier protection against blood and body fluids upon entry into room (single gloves and fluid-resistant or impermeable gown, face/eye protection with masks, goggles or face shields); and</p> <p>4. appropriate waste handling.</p> <p>Use N95 or higher respirators when performing aerosol-generating procedures. Largest viral load in final stages of illness when hemorrhage may occur; additional PPE, including double gloves, leg and shoe coverings may be used, especially in resource-limited settings where options for cleaning and laundry are limited. Notify public health officials immediately if Ebola is suspected [212, 314, 740, 772]. Also see Table 3 for Ebola as a bioterrorism agent.</p>
Viral respiratory diseases (not covered elsewhere) Adults	Standard		
Viral respiratory diseases (not covered elsewhere) Infants and young children (see respiratory infectious disease, acute)			
Whooping cough (see pertussis)			
Wound infections Major	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	No dressing or dressing does not contain drainage adequately
Wound infections Minor or limited	Standard		Dressing covers and contains drainage adequately
<i>Yersinia enterocolitica</i> Gastroenteritis (see gastroenteritis)			
Zoster (varicella-zoster) (see herpes zoster)			
Zygomycosis (phycomycosis, mucormycosis)	Standard		Not transmitted person-to-person

Type and Duration of Precautions - Disease Specific (FKA-AKA Short Sheet)

Clinical Syndromes or Conditions Warranting Empiric Transmission- Based Precautions in Addition to Standard Precautions

Disease	Clinical Syndrome or Condition†	Potential Pathogens‡	Empiric Precautions (Always Includes Standard Precautions)
Diarrhea	Acute diarrhea with a likely infectious cause in an incontinent or diapered patient	Enteric pathogens§	Contact Precautions (pediatrics and adult)
Meningitis	Meningitis	<i>Neisseria meningitidis</i>	Droplet Precautions for first 24 hours of antimicrobial therapy; mask and face protection for intubation
Meningitis	Meningitis	Enteroviruses	Contact Precautions for infants and children
Meningitis	Meningitis	<i>M. tuberculosis</i>	Airborne Precautions if pulmonary infiltrate Airborne Precautions plus Contact Precautions if potentially infectious draining body fluid present
Rash or Exanthems, Generalized, Etiology Unknown	Petechial/ecchymotic with fever (general)	<i>Neisseria meningitidis</i>	Droplet Precautions for first 24 hours of antimicrobial therapy
Rash or Exanthems, Generalized, Etiology Unknown	Petechial/ecchymotic with fever (general) - If positive history of travel to an area with an ongoing outbreak of VHF in the 10 days before onset of fever	Ebola, Lassa, Marburg viruses	Droplet Precautions plus Contact Precautions, with face/eye protection, emphasizing safety sharps and barrier precautions when blood exposure likely. Use N95 or higher respiratory protection when aerosol-generating procedure performed. ⚠ Ebola Virus Disease Update [2014]: Updated recommendations for healthcare workers can be found at Ebola: U.S. Healthcare Workers and Settings (https://www.cdc.gov/vhf/ebola/health-care-us/) .
Rash or Exanthems, Generalized, Etiology Unknown	Vesicular	Varicella-zoster, herpes simplex, variola (smallpox), vaccinia viruses	Airborne plus Contact Precautions; Contact Precautions only if Herpes simplex, localized zoster in an immunocompetent host or vaccinia viruses most likely
Rash or Exanthems, Generalized, Etiology Unknown	Maculopapular with cough, coryza and fever	Rubeola (measles) virus	Airborne Precautions
Respiratory Infections	Cough/fever/upper lobe pulmonary infiltrate in an HIV- negative patient or a patient at low risk for human immunodeficiency virus (HIV) infection	<i>M. tuberculosis</i> , Respiratory viruses, <i>S. pneumoniae</i> , <i>S. aureus</i> (MSSA or MRSA)	Airborne Precautions plus Contact precautions
Respiratory Infections	Cough/fever/pulmonary infiltrate in any lung location in an HIV- infected patient or a patient at high risk for HIV	<i>M. tuberculosis</i> , Respiratory viruses, <i>S. pneumoniae</i> , <i>S. aureus</i> (MSSA or	Airborne Precautions plus Contact Precautions Use eye/face protection if aerosol-generating procedure performed or contact with respiratory secretions

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Disease	Clinical Syndrome or Condition†	Potential Pathogens‡	Empiric Precautions (Always Includes Standard Precautions)
	infection	MRSA)	anticipated. If tuberculosis is unlikely and there are no AIIRs and/or respirators available, use Droplet Precautions instead of Airborne Precautions Tuberculosis more likely in HIV-infected individual than in HIV negative individual
Respiratory Infections	Cough/fever/pulmonary infiltrate in any lung location in a patient with a history of recent travel (10-21 days) to countries with active outbreaks of SARS, avian influenza	<i>M. tuberculosis</i> , severe acute respiratory syndrome virus (SARS- CoV), avian influenza	Airborne plus Contact Precautions plus eye protection. If SARS and tuberculosis unlikely, use Droplet Precautions instead of Airborne Precautions.
Respiratory Infections	Respiratory infections, particularly bronchiolitis and pneumonia, in infants and young children	Respiratory syncytial virus, parainfluenza virus, adenovirus, influenza virus, <i>Human metapneumovirus</i>	Contact plus Droplet Precautions; Droplet Precautions may be discontinued when adenovirus and influenza have been ruled out
Skin or Wound Infection	Abscess or draining wound that cannot be covered	<i>Staphylococcus aureus</i> (MSSA or MRSA), group A streptococcus	Contact Precautions Add Droplet Precautions for the first 24 hours of appropriate antimicrobial therapy if invasive Group A streptococcal disease is suspected

⚠ Format Change [February 2017]: The format of this section was changed to improve readability and accessibility. The content is unchanged.

* Infection control professionals should modify or adapt this table according to local conditions. To ensure that appropriate empiric precautions are implemented always, hospitals must have systems in place to evaluate patients routinely according to these criteria as part of their preadmission and admission care.

† Patients with the syndromes or conditions listed below may present with atypical signs or symptoms (e.g. neonates and adults with pertussis may not have paroxysmal or severe cough). The clinician's index of suspicion should be guided by the prevalence of specific conditions in the community, as well as clinical judgment.

‡ The organisms listed under the column "Potential Pathogens" are not intended to represent the complete, or even most likely, diagnoses, but rather possible etiologic agents that require additional precautions beyond Standard Precautions until they can be ruled out.

§ These pathogens include enterohemorrhagic *Escherichia coli* O157:H7, *Shigella spp*, hepatitis A virus, noroviruses, rotavirus, *C. difficile*.

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Infection Control Considerations for High-Priority (CDC Category A) Diseases that May Result from Bioterrorist Attacks or are Considered to be Bioterrorist Threats

Table 3A. Anthrax

Characteristics	Infection Control Considerations
Site(s) of Infection; Transmission Mode Cutaneous and inhalation disease have occurred in past bioterrorist incidents	Cutaneous (contact with spores); Respiratory Tract: (inhalation of spores); Gastrointestinal Tract (ingestion of spores - rare) Comment: Spores can be inhaled into the lower respiratory tract. The infectious dose of <i>B. anthracis</i> in humans by any route is not precisely known. In primates, the LD50 (i.e., the dose required to kill 50% of animals) for an aerosol challenge with <i>B. anthracis</i> is estimated to be 8,000–50,000 spores; the infectious dose may be as low as 1-3 spores
Incubation Period	Cutaneous: 1 to 12 days; Respiratory Tract: Usually 1 to 7 days but up to 43 days reported; Gastrointestinal Tract: 15-72 hours
Clinical Features	Cutaneous: Painless, reddish papule, which develops a central vesicle or bulla in 1-2 days; over next 3-7 days lesion becomes pustular, and then necrotic, with black eschar; extensive surrounding edema. Respiratory Tract: initial flu-like illness for 1-3 days with headache, fever, malaise, cough; by day 4 severe dyspnea and shock, and is usually fatal (85%- 90% if untreated; meningitis in 50% of Respiratory Tract cases. Gastrointestinal Tract: if intestinal form, necrotic, ulcerated edematous lesions develop in intestines with fever, nausea and vomiting, progression to hematemesis and bloody diarrhea; 25-60% fatal
Diagnosis	Cutaneous: Swabs of lesion (under eschar) for immunohistochemistry, polymerase chain reaction and culture; punch biopsy for immunohistochemistry, polymerase chain reaction and culture; vesicular fluid aspirate for Gram stain and culture; blood culture if systemic symptoms; acute and convalescent sera for ELISA serology Respiratory Tract: Chest X-ray or CT scan demonstrating wide mediastinal widening and/or pleural effusion, hilar abnormalities; blood for culture and polymerase chain reaction; pleural effusion for culture, polymerase chain reaction and immunohistochemistry; cerebrospinal fluid if meningeal signs present for immunohistochemistry, polymerase chain reaction and culture; acute and convalescent sera for ELISA serology; pleural and/or bronchial biopsies immunohistochemistry. Gastrointestinal Tract: blood and ascites fluid, stool samples, rectal swabs, and swabs of oropharyngeal lesions if present for culture, polymerase chain reaction and immunohistochemistry.
Infectivity	Cutaneous: Person-to-person transmission from contact with lesion of untreated patient possible, but extremely rare. Respiratory Tract and Gastrointestinal Tract: Person-to-person transmission does not occur. Aerosolized powder, environmental exposures: Highly infectious if aerosolized
Recommended Precautions	Cutaneous: Standard Precautions; Contact Precautions if uncontained copious drainage. Respiratory Tract and Gastrointestinal Tract: Standard Precautions. Aerosolized powder, environmental exposures: Respirator (N95 mask or Powered Air Purifying Respirators), protective clothing; decontamination of persons with powder on them (Occupational Health Guidelines for Remediation Workers at <i>Bacillus anthracis</i> -Contaminated Sites --- United States, 2001--2002 (https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5135a3.htm)). Hand hygiene: Handwashing for 30-60 seconds with soap and water or 2% chlorhexidine gluconate after spore contact (alcohol handrubs inactive against spores [Weber DJ JAMA 2003; 289:1274]). Post-exposure prophylaxis following environmental exposure: 60 days of antimicrobials (either doxycycline, ciprofloxacin, or levofloxacin) and post- exposure vaccine under IND

Table 3B. Botulism

Characteristics	Infection Control Considerations
Site(s) of Infection;	Gastrointestinal Tract: Ingestion of toxin-containing food,

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Characteristics	Infection Control Considerations
Transmission Mode	Respiratory Tract: Inhalation of toxin containing aerosol cause disease. Comment: Toxin ingested or potentially delivered by aerosol in bioterrorist incidents. LD50 (lethal dose for 50% of experimental animals) for type A is 0.001 µg/ml/kg.
Incubation Period	1-5 days.
Clinical Features	Ptosis, generalized weakness, dizziness, dry mouth and throat, blurred vision, diplopia, dysarthria, dysphonia, and dysphagia followed by symmetrical descending paralysis and respiratory failure.
Diagnosis	Clinical diagnosis; identification of toxin in stool, serology unless toxin-containing material available for toxin neutralization bioassays.
Infectivity	Not transmitted from person to person. Exposure to toxin necessary for disease.
Recommended Precautions	Standard Precautions.

Table 3C. Ebola Hemorrhagic Fever

Characteristics	Infection Control Considerations
Site(s) of Infection; Transmission Mode	As a rule infection develops after exposure of mucous membranes or respiratory tract, or through broken skin or percutaneous injury.
Incubation Period	2-19 days, usually 5-10 days
Clinical Features	Febrile illnesses with malaise, myalgias, headache, vomiting and diarrhea that are rapidly complicated by hypotension, shock, and hemorrhagic features. Massive hemorrhage in < 50% pts.
Diagnosis	Etiologic diagnosis can be made using respiratory tract-polymerase chain reaction, serologic detection of antibody and antigen, pathologic assessment with immunohistochemistry and viral culture with EM confirmation of morphology,
Infectivity	Person-to-person transmission primarily occurs through unprotected contact with blood and body fluids; percutaneous injuries (e.g., needlestick) associated with a high rate of transmission; transmission in healthcare settings has been reported but is prevented by use of barrier precautions.
Recommended Precautions	Hemorrhagic fever specific barrier precautions: If disease is believed to be related to intentional release of a bioweapon, epidemiology of transmission is unpredictable pending observation of disease transmission. Until the nature of the pathogen is understood and its transmission pattern confirmed, Standard, Contact and Airborne Precautions should be used. Once the pathogen is characterized, if the epidemiology of transmission is consistent with natural disease, Droplet Precautions can be substituted for Airborne Precautions. Emphasize: <ol style="list-style-type: none"> 1. use of sharps safety devices and safe work practices, 2. hand hygiene; 3. barrier protection against blood and body fluids upon entry into room (single gloves and fluid- resistant or impermeable gown, face/eye protection with masks, goggles or face shields); and 4. appropriate waste handling. Use N95 or higher respirators when performing aerosol-generating procedures. In settings where AIIRs are unavailable or the large numbers of patients cannot be accommodated by existing AIIRs, observe Droplet Precautions (plus Standard Precautions and Contact Precautions) and segregate patients from those not suspected of VHF infection. Limit blood draws to those essential to care. See text for discussion and Appendix A for recommendations for naturally occurring VHFs.

Plague

Pneumonic plague is not as contagious as is often thought. Historical accounts and contemporary evidence indicate that persons with plague usually transmit the infection only when the disease is in the end stage. These persons cough copious amounts of bloody sputum that contains many plague bacteria. Patients in the early stage of primary pneumonic plague (approximately the first 20–24 h) apparently pose little risk [1, 2]. Antibiotic medication rapidly clears the sputum of plague bacilli, so that a patient generally is not infective within hours after initiation of effective antibiotic treatment [3]. This means that in modern times many patients will never reach a stage where they pose a

Type and Duration of Precautions - Disease Specific (FKA AKA Short Sheet)

significant risk to others. Even in the end stage of disease, transmission only occurs after close contact. Simple protective measures, such as wearing masks, good hygiene, and avoiding close contact, have been effective to interrupt transmission during many pneumonic plague outbreaks [2]. In the United States, the last known cases of person to person transmission of pneumonic plague occurred in 1925 [2].

Table 3D. Plague

Characteristics	Infection Control Considerations
Site(s) of Infection; Transmission Mode	Respiratory Tract: Inhalation of respiratory droplets. Comment: Pneumonic plague most likely to occur if used as a biological weapon, but some cases of bubonic and primary septicemia may also occur. Infective dose 100 to 500 bacteria
Incubation Period	1 to 6, usually 2 to 3 days.
Clinical Features	Pneumonic: fever, chills, headache, cough, dyspnea, rapid progression of weakness, and in a later stage hemoptysis, circulatory collapse, and bleeding diathesis
Diagnosis	Presumptive diagnosis from Gram stain or Wayson stain of sputum, blood, or lymph node aspirate; definitive diagnosis from cultures of same material, or paired acute/convalescent serology.
Infectivity	Person-to-person transmission occurs via respiratory droplets risk of transmission is low during first 20-24 hours of illness and requires close contact. Respiratory secretions probably are not infectious within a few hours after initiation of appropriate therapy.
Recommended Precautions	Standard Precautions, Droplet Precautions until patients have received 48 hours of appropriate therapy. Chemoprophylaxis: Consider antibiotic prophylaxis for HCWs with close contact exposure.

1. Wu L-T. A treatise on pneumonic plague. Geneva: League of Nations, 1926. III. Health.
2. Kool JL. Risk of person to person transmission of pneumonic plague. Clinical Infectious Diseases, 2005; 40 (8): 1166-1172
3. Butler TC. Plague and other Yersinia infections. In: Greenough WB, ed. Current topics in infectious disease. New York: Plenum Medical Book Company, 1983.

Table 3E. Smallpox

Characteristics	Infection Control Considerations
Site(s) of Infection; Transmission Mode	Respiratory Tract Inhalation of droplet or, rarely, aerosols; and skin lesions (contact with virus). Comment: If used as a biological weapon, natural disease, which has not occurred since 1977, will likely result.
Incubation Period	7 to 19 days (mean 12 days)
Clinical Features	Fever, malaise, backache, headache, and often vomiting for 2-3 days; then generalized papular or maculopapular rash (more on face and extremities), which becomes vesicular (on day 4 or 5) and then pustular; lesions all in same stage.
Diagnosis	Electron microscopy of vesicular fluid or culture of vesicular fluid by WHO approved laboratory (CDC); detection by polymerase chain reaction available only in select LRN labs, CDC and USAMRID
Infectivity	Secondary attack rates up to 50% in unvaccinated persons; infected persons may transmit disease from time rash appears until all lesions have crusted over (about 3 weeks); greatest infectivity during first 10 days of rash.
Recommended Precautions	Combined use of Standard, Contact, and Airborne Precautions until all scabs have separated (3-4 weeks). Transmission by the airborne route is a rare event; Airborne Precautions is recommended when possible, but in the event of mass exposures, barrier precautions and containment within a designated area are most important. 204, 212 Only immune HCWs to care for pts; post-exposure vaccine within 4 days. Vaccinia: HCWs cover vaccination site with gauze and semi-permeable dressing until scab separates (≥ 21 days). Observe hand hygiene. Adverse events with virus-containing lesions: Standard plus Contact Precautions until all lesions crusted. Vaccinia adverse events with lesions containing infectious virus include inadvertent autoinoculation, ocular lesions (blepharitis, conjunctivitis), generalized vaccinia,

Type and Duration of Precautions - Disease Specific (~~FKA~~ ~~AKA~~ Short Sheet)

Characteristics	Infection Control Considerations
	progressive vaccinia, eczema vaccinatum; bacterial superinfection also requires addition of contact precautions if exudates cannot be contained. 216, 217

Table 3F. Tularemia

Characteristics	Infection Control Considerations
Site(s) of Infection; Transmission Mode	Respiratory Tract: Inhalation of aerosolized bacteria. Gastrointestinal Tract: Ingestion of food or drink contaminated with aerosolized bacteria. Comment: Pneumonic or typhoidal disease likely to occur after bioterrorist event using aerosol delivery. Infective dose 10-50 bacteria
Incubation Period	2 to 10 days, usually 3 to 5 days
Clinical Features	Pneumonic: malaise, cough, sputum production, dyspnea; Typhoidal: fever, prostration, weight loss and frequently an associated pneumonia.
Diagnosis	Diagnosis usually made with serology on acute and convalescent serum specimens; bacterium can be detected by polymerase chain reaction (LRN) or isolated from blood and other body fluids on cysteine-enriched media or mouse inoculation.
Infectivity	Person-to-person spread is rare. Laboratory workers who encounter/handle cultures of this organism are at high risk for disease if exposed.
Recommended Precautions	Standard Precautions

Type and Duration of Precautions - Disease Specific (FKA AKA Short Sheet)

Recommendations for Application of Standard Precautions for the Care of All Patients in All Healthcare Settings

Component	Recommendations
Hand hygiene	After touching blood, body fluids, secretions, excretions, contaminated items; immediately after removing gloves; between patient contacts.
Personal protective equipment (PPE) Gloves	For touching blood, body fluids, secretions, excretions, contaminated items; for touching mucous membranes and nonintact skin
Personal protective equipment (PPE) Gown	During procedures and patient-care activities when contact of clothing/exposed skin with blood/body fluids, secretions, and excretions is anticipated.
Personal protective equipment (PPE) Mask, eye protection (goggles), face shield	During procedures and patient-care activities likely to generate splashes or sprays of blood, body fluids, secretions, especially suctioning, endotracheal intubation. During aerosol-generating procedures on patients with suspected or proven infections transmitted by respiratory aerosols wear a fit-tested N95 or higher respirator in addition to gloves, gown and face/eye protection.
Soiled patient-care equipment	Handle in a manner that prevents transfer of microorganisms to others and to the environment; wear gloves if visibly contaminated; perform hand hygiene.
Environmental control	Develop procedures for routine care, cleaning, and disinfection of environmental surfaces, especially frequently touched surfaces in patient-care areas.
Textiles and laundry	Handle in a manner that prevents transfer of microorganisms to others and to the environment
Needles and other sharps	Do not recap, bend, break, or hand-manipulate used needles; if recapping is required, use a one-handed scoop technique only; use safety features when available; place used sharps in puncture-resistant container
Patient resuscitation	Use mouthpiece, resuscitation bag, other ventilation devices to prevent contact with mouth and oral secretions
Patient placement	Prioritize for single-patient room if patient is at increased risk of transmission, is likely to contaminate the environment, does not maintain appropriate hygiene, or is at increased risk of acquiring infection or developing adverse outcome following infection.
Respiratory hygiene/cough etiquette (source containment of infectious respiratory secretions in symptomatic patients, beginning at initial point of encounter e.g., triage and reception areas in emergency departments and physician offices)	Instruct symptomatic persons to cover mouth/nose when sneezing/coughing; use tissues and dispose in no-touch receptacle; observe hand hygiene after soiling of hands with respiratory secretions; wear surgical mask if tolerated or maintain spatial separation, >3 feet if possible.

(See Sections II.D.-II.J. and III.A.1)

INFECTION CONTROL

ISSUE DATE: 07/02

SUBJECT: ~~Philosophy~~ Infection Prevention
Program Plan

REVISION DATE(S): 04/09, 05/12, 09/15, 09/18

Infection Control Department Approval:	05/18 07/21
Infection Control Committee Approval:	07/18 11/21
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	08/18 02/22
Administration Approval:	09/18 03/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	09/18

A. PURPOSE

1. The purpose of the Infection Prevention (IP) Program Plan is to reduce or limit the risks of acquiring or transmitting healthcare-associated infections (HAIs) and/or epidemiologically significant microorganisms among patients, healthcare workers, physicians, volunteers, visitors, and other guests. In order to achieve this goal, well defined policies and surveillance methodologies are employed to limit organism transmission:
 - a. During patient care activities,
 - b. During the use of hospital medical equipment, devices and supplies,
 - c. From the hospital environment, and
 - d. The hands of healthcare personnel
2. Effective infection prevention and control requires collaboration with leadership, risk management, performance improvement, patient safety, and clinical staff.

B. OPERATIONAL OBJECTIVES

1. The scope of the infection prevention program addresses all pertinent services and sites of care in the organization. It includes surveillance, prevention and control of infections in patients, healthcare workers and visitors in the inpatient and ambulatory outpatient care settings.
2. Epidemiological principles and methodologies are employed to achieve the following objectives:
 - a. Design systematic methods for managing resources and information in order to satisfy documentation requirements and generate useful infection surveillance data
 - b. Develop policies and procedures which are evidence-based and validate criteria and standards which delineate approved infection prevention and control practices in compliance with regulatory statutes and accrediting agency standards
 - c. Define and describe the distribution and determinants of infectious disease and epidemiologically significant microorganisms within the healthcare environment
 - d. Identify causal relationships and risk factors associated with disease acquisition and transmission.
 - e. Establish an ongoing program of self-assessment and continuous quality improvement based on a system of identifying, documenting, and resolving

- infection prevention and control issues and problems through a process of monitoring, analyzing, and evaluating sole and aggregate infection surveillance data
- f. Design and implement effective infection control audits, tracer studies, corrective action plans, and outbreak management and intervention strategies which prevent or control the spread of infection, and promote a healthful environment
 - g. Develop an effective means of communicating infection control and prevention information and the infection surveillance status of the organization to the appropriate individuals, thereby creating a heightened awareness of infection control and prevention issues and engendering administrative action and resource support, when necessary
 - h. Promote an infection control program and plan design which is cost effective and in compliance with the Centers for Disease Control and Prevention (CDC) guidelines, applicable laws and regulations, accrediting agency standards, and recognized prudent infection control practices
 - i. Prepare for a mass influx of highly contagious patients, especially those requiring airborne precautions
 - j. Provide a system for evaluating the effectiveness of program performance and implementation

C. STATEMENT OF AUTHORITY:

- 1. Responsibility [TJC IC.01.01.01, CMS §482.42 (a), GACHRLS HSC §1288.95]
 - a. The Medical Executive Committee (MEC) by Authorization of the Board of Directors, delegates to the Infection Prevention Committee (IPC), through Tri-City Medical Center's Medical Director of Infection Prevention and the Infection Preventionist the responsibility and authority for ensuring that infectious disease precaution policies are adhered to and correct procedures are maintained by all departments and all levels of personnel. The program design is based on requirements and guidelines from governmental agencies such as the Centers for Disease Control and Prevention (CDC), The Joint Commission (TJC), the California Occupational Health and Safety Administration (CALOSHA), the California Administrative Code, the California Department of Public Health (CDPH).
 - b. Individuals responsible for the Infection Prevention Program.
 - i. The IP Program requires management by an individual with knowledge that is appropriate to the risks identified by the hospital, as well as knowledge of the analysis of infection risks, principles of infection prevention, and data analysis.
 - ii. The Medical Director of Infection Prevention is an infectious disease physician.
 - iii. Management responsibilities for the IP program at TCMC has been assigned to the Infection Preventionist.
 - iv. The IP Department has been given authority to develop, implement and enforce the IP Program policies, effectiveness of prevention and/or control activities and interventions.
 - v. The IP Department has the authority to order patient isolation or patient testing as requested by the local public health authorities.
 - vi. The Infection Preventionist will report to the Director of Clinical Quality Resources.
 - vii. Hours of operation are M-F 8:00-4:30, and on call after hours and weekends.
 - c. Maintenance of qualifications for Infection Prevention Leadership [TJC IC.01.01.01]
 - i. There will be no less than 1 certified Infection Preventionist, who will be

- certified (CIC) through the national certification board of Infection Control and Epidemiology (CBIC).
 - ii. The IP staff will maintain competency in all essential elements of the job through professional organizations and through educational offerings relevant to the position. These educational offerings may include webinars, self-learning modules, or hospital programs.
 - iii. The Infection Prevention Department Head will maintain membership in infection control associations (National APIC, San Diego County Chapter of APIC)
 - iv. The Infection Prevention Committee Chairperson designated hospital epidemiologist will participate in a continuing medical education (CME) training program offered by the CDC and Society for Healthcare Epidemiologists of America (SHEA), or other recognized professional organization. Documentation of attendance will be placed in the physician's credentialing file.
- d. Allocation of resources for the Infection Prevention Program
 - i. Hospital leaders will allocate needed resources for the Infection Prevention Program and provide systems to support infection prevention activities. In determining the number of Infection Preventionists and support staff, the organization considers patient census, characteristics of the patient population, and the complexity of the healthcare services to assure that resources are adequate to accomplish the task required for the infection prevention program.
 - ii. Hospital leadership will review, on an ongoing basis (but no less frequently than annually), the resources and the effectiveness of the hospital's infection prevention activities.
 - iii. Systems to access information will be provided to support infection prevention activities, such as CernerWorks.
 - iv. Laboratory support will be provided to support infection prevention activities. Reference laboratory services may be utilized for assistance in specialty areas such as strain typing.
 - v. Equipment, supplies, and resource materials will be provided to support infection prevention activities; the Infection Prevention department has the necessary computer hardware and software to support surveillance and analysis, a designated printer/copier, and confidential fax.
 - vi. Infection Prevention personnel will have appropriate access to medical or other relevant records and to staff members who can provide information on the adequacy of the institution's compliance with regard to regulations, standards, and guidelines.
 - vii. The support of the Information Technology Department will be provided to assist in compliance with required reporting of infection surveillance information to external organizations.
- e. Shared responsibilities for the Infection Prevention Program
 - i. The prevention of infections is a shared responsibility among all clinical and non-clinical staff in the hospital.
 - ii. Medical Staff Responsibilities: The Medical Directors and Medical Staff provide expertise from their respective areas and disciplines in conjunction with the members of the Infection Prevention Committee to assist with preventing infections.
 - iii. Department-Specific Responsibilities: The Managers/Directors or their designee are responsible for monitoring employees and assuring compliance with infection prevention policies and procedures. Responsibilities include, but are not limited to:
 - 1) Monitor cleanliness of their departments or units.

- 2) Monitor compliance with use and documentation related to high-level disinfection, as appropriate for their job functions.
 - 3) Assure that healthcare workers use safe and effective practices for all cleaning, disinfection, and sterilization, as appropriate for their job functions and in accordance with policy.
 - 4) Monitor compliance with hand hygiene policies.
 - 5) Coordinate with Infection Prevention to plan and implement educational or in-service programs on the prevention of infections.
 - 6) Orient existing and new staff on infection prevention issues and risks specific to their job duties, i.e. sharps safety, medical waste handling, infection prevention policies and National Patient Safety Goals.
 - 7) Ensure proper documentation for invasive devices (central lines, ventilators, and urinary catheters) and monitor use for medical necessity.
 - 8) Ensuring proper patient care practices and product safety are maintained in the unit.
 - 9) Revising and updating departmental policies relating to infection prevention in collaboration with the Infection Prevention personnel
- iv. Healthcare Worker Responsibilities: All healthcare workers of the organization have responsibilities in preventing the spread of infection and will:
- 1) Not report to work with signs and symptoms of illness e.g., diarrhea, conjunctivitis, or fever.
 - 2) Notify Infection Prevention Department of infection related issues.
 - 3) Comply with required immunizations.
 - 4) Participate fully in the Caregiver Health Program.
 - 5) Complete orientation and annual education review and test.
 - 6) Participate in the review of infection prevention data within own departments.
 - 7) Use safety sharps and safe handling of sharps to avoid blood borne pathogen exposure.
 - 8) Avoid food and drink in areas of patient care
 - 9) Adhere to Infection Prevention policies for prevention of healthcare associated infections (Infection Prevention Manual in Lucidoc)
 - 10) Adhere to hand hygiene guidelines

D. INFECTION PREVENTION COMMITTEE [TJC IC.01.05.01, GACHRLS HSC §70739:

1. The purpose of the Infection Prevention Committee is to provide a planned, systematic, system-wide approach to designing, measuring, assessing and improving performance related to the infection prevention program thereby providing a safe environment for patients, employees, physicians, visitors, and others.
2. Function
 - a. Review, analyze and evaluate patient infection rates and trends in employee exposures, injuries and resulting illnesses.
 - b. Define and approve the type and scope of surveillance, prevention and control activities annually.
 - c. Promote continuing education related to infection prevention and control for medical staff and hospital personnel.
 - d. Establish protocols for special studies or focused reviews.
 - e. Review and approve major changes made to any hospital-wide and/or individual department infection prevention and control policies and procedures. The Infection Prevention Department Head has the authority to approve minor changes and will conduct a review of the above mentioned policies/procedures

every three years or as needed per changes in practices, regulations and standards.

3. Reporting

- a. The Committee reports activities and surveillance data through the TCMC's Quality Assurance Performance Improvement (QAPI) Committee on a regularly scheduled basis with quarterly review of established scorecards. The Committee minutes are routed to the TCMC Medical Staff Executive Committee. Reports may be presented to other individuals/groups/departments that need to be aware of the information presented or problems identified so they may be involved in corrective actions, resolutions and evaluations. Copies of all reports are kept on file in the Infection Prevention department office.

4. Membership

- a. The Infection Prevention Committee is a medical staff committee chaired by the TCMC Chair of Infection Prevention with interdisciplinary representation of at least the following:
 - i. Medical staff which may include: hospitalist; surgeon; administration; quality improvement; risk management; microbiology; nursing; perioperative/surgical services; pharmacy; employee health.
- b. TCMC's Infection Prevention Department Head is an active member who oversees the agenda as it relates to infection prevention issues.
- c. Upon request from the IP medical director, other departments/service (e.g. environmental services, facilities, respiratory care, sterile processing, etc.) will send a representative on an ad hoc basis when issues arise requiring their input or expertise.

5. Meetings

- a. The TCMC Infection Prevention Committee will meet at a minimum quarterly per year. Regular agenda items related to infection prevention, employee health, and performance improvement will be discussed and all conclusions, recommendations and actions will be documented in the minutes.

6. Statement of Authority

- a. The Infection Prevention Committee, or its designee, has the responsibility and authority to ensure compliance with Infection Prevention policies and procedures, to make decisions regarding their implementation, and to institute any specific surveillance, isolation, prevention and/or control measures deemed necessary when there is reason to believe that any patient, healthcare worker or other person may be in danger of contracting or transmitting an infectious disease or an epidemiologically significant microorganism.

E. SCOPE OF PROGRAM:

1. The infection prevention program is multidisciplinary/interdisciplinary and works in conjunction with all facilities, clinics, departments and services associated with TCMC to assess and integrate quality care practices and infection prevention and control principles.
2. Management Processes [TJC IC.01.03.01 – IC.01.05.01]
 - a. Policy Development
 - i. Decisions concerning the design, construction, and appropriateness of Infection Prevention policies are based on published criteria and guidelines from recognized technical sources such as the Centers for Disease Control and Prevention (CDC), the Healthcare Infection Control Practices Advisory Committee (HICPAC), the American Society for Microbiology (ASM), the Association for Professionals in Infection Control and Epidemiology (APIC), the Society for Hospital Epidemiologists of America (SHEA), The Joint Commission (TJC), the California

Department of Public Health (CDPH) and other relevant professional societies, accrediting organizations, and government agencies.

- b. **Risk Assessment**
 - i. Risk assessments are conducted annually and as needed, to proactively evaluate the impact patient care services, infection prevention and control practices, and surveillance methodologies have on controlling and/or reducing healthcare-associated infection (HAI) transmission and the prevalence of epidemiologically significant organisms. These assessments follow standard guidelines and are supported by scientific evidence.
- c. **Performance Improvement**
 - i. The methodologies employed for performance improvement encompass goal-setting, monitoring performance indicators, and assessing sentinel/unusual events, using retrospective root cause analysis (incident review). Incidents in which a healthcare-associated infection is related to serious temporary harm are treated as sentinel events. Performance indicators are defined for organism surveillance, healthcare-associated infection surveillance, and infection prevention surveillance.
- d. **Data Management and Dissemination**
 - i. Data Collection and management is fully described in the *Infection Prevention Program Information Management Pathway* graphic which delineates case finding and database sources, evaluation and analytical techniques, and information dissemination (see Section VI). Data and information derived from these various input sources are then used to compile Quarterly and Annual Reports for dissemination to the Infection Prevention Committee, selected management team members, the QAPI Committee and the Medical Staff Executive Committee.
- e. **Educational Programs [NPSG.07.03.01; NPSG.07.04.01; NPSG 07.05.01, GACHRLS HSC §1288.95]**
 - i. **Healthcare Worker**
 - 1) A variety of educational programs are provided for healthcare worker orientation, in-service, and continuing education. Standard educational methodologies are employed in curriculum design and development and include the use of educational objectives to assess the effectiveness of the instruction. Formal standardized instruction is given to all new employees and physicians during their orientation. Patient care personnel receive additional instruction relevant to the patient care environment. Additionally, healthcare personnel receive annual infection prevention instruction via computer learning modules. Further educational modalities include Infection Prevention rounds. Lastly, EVS are trained by the hospital and observed for compliance with sanitation measures via high touch audits. Training is given at the start of employment, when new prevention measures have been adopted, and annually thereafter.
 - ii. **Patient and/or Family [TJC IC 0.02.01.01 EP 7, NPSG 07.03.01 EP 3]**
 - 1) The patient and/or family is provided various infection prevention related educational materials during their hospital stay. During their hospital stay if the patient is placed in isolation precautions, has specific organisms (i.e.. MRSA, VRE, *Clostridium difficile*) and/or has a healthcare-associated infection (i.e.. surgical site infection (SSI), device-associated

infection) the patient and/or family is given information which addresses frequently asked questions.

3. Surveillance [TJC IC.02.01.01, IC.01.05.01, CMS §482.13, 482.42, 482.51, GACHRLS HSC §1288.8
 - a. Healthcare-Associated Infection Criteria
 - i. All infections identified by surveillance are classified as either healthcare-associated (HA) or community-acquired (CA). The criteria is defined by the Centers for Disease Control and Prevention (CDC) and the National Healthcare Safety Network (NHSN), approved by the Infection Prevention Committee and is used by Infection Prevention to determine whether an infection is healthcare-associated or community-acquired.
 - b. Infection Surveillance Methods
 - i. A variety of surveillance methods are employed to routinely collect standardized information which is analyzed and used to describe and define the occurrence and distribution of infection rates or sentinel/unusual occurrences of infections.
 - 1) *Focused surveillance* is conducted on certain high-risk procedures, patient populations or specific infections/organisms that are determined annually by the Infection Prevention Program Plan with input from the Infection Prevention Committee or as mandated by state or federal requirements.
 - 2) *Periodic priority-directed targeted surveillance* is conducted for specific units or departments, specific patient populations or specific procedures or clinical indicators as a method for identifying problems. This determined by the Infection Prevention program director with input from various departments such as Employee Health, Quality and Risk Management, OR Committee and/or other Medical Committees. Examples include; employee exposures, compliance with isolation precautions or other infection control protocols, etc.
 - 3) *Cluster or outbreak investigation [GACHRLS HSC §70737]* becomes the immediate top priority at any time an unexpected occurrence or frequency of infections becomes evident, such as:
 - a) Clustering of infections above expected levels
 - b) Cases of unusual or epidemiologically significant organism infections, surgical procedures or specific areas with an increased number or an unusually high incidence of infections (i.e. bacteremias, wound infections, respiratory infections). Indicators of such increased incidence may include microbiology reports, or notification from physicians, staff members, or the Health Department.
 - c) Immediate notification will be made to the IP Medical Director as it relates to the cluster/outbreaks.
 - 4) *Communicable/Infectious disease exposure investigation and follow-up [GACHRLS HSC §70737]* becomes an immediate priority whenever a patient and/or employee is involved in an exposure to a communicable disease. Infection Prevention and Employee Health collaborate with the TCMC Infection Prevention Medical Chairperson to implement post exposure follow up:
 - a) Notification of patient/employee exposures from staff or the Quality Reporting Event system (RL Solutions)
 - b) Determining the nature of exposure and level of infectiousness
 - c) Placing involved persons in appropriate precautions or

- work restrictions
 - d) Conducting the appropriate follow-up and record keeping
 - 5) *Notifiable conditions [GACHRLS HSC §70737]* monitoring and reporting is conducted on an ongoing basis throughout the year in accordance with the Title 17 provisions of the California Administrative Code as well as to San Diego County Public Health Services (SDCPH) requirements.
 - 6) *Notification of surgical site infections performed at outside facilities.* When a surgical site infection is identified that was not performed at TCMC, the Infection Prevention department notifies that hospital's infection prevention department that a surgical site infection has occurred.
 - 7) *Surgical Site Infection Investigations:* Surgical site infections will be identified according to NHSN definitions. When a surgical site infection is identified, a notification is provided to the surgeon's office and surgeon, and the IP Medical Director. If trends in SSI are identified by IP staff, it is reported to the appropriate committee and the IP Medical Director. Identification of infections will be conducted through:
 - a) Monitoring daily census for readmissions for wounds/cellulitis.
 - b) Reviewing wound cultures for possible surgical site infections.
 - c) MD self reports via phone or email
 - d) Notification by staff nurses for possible healthcare-associated infections
 - e) Community networking with other Infection Preventionists: Infection Preventionists from other hospitals notify our Infection Prevention Dept. of admissions related to procedures performed at TCMC.
 - 8) *MRSA Screening:* Per Senate Bill 1058, a process is in place to screen select patients for MRSA within 24 hours of admission if the following criteria is met:
 - a) Admit or transfer to Intensive Care Unit (ICU) or Neonatal Intensive Care Unit (NICU) unless tested positive during this admission
 - b) Receiving inpatient dialysis
 - c) Previously discharged from a general acute care hospital; within the last 30 days
 - d) The patient is transferred from a skilled nursing facility
 - e) Pre-op screening for MRSA may be deemed appropriate for other procedures and ordered at the discretion of the surgeon/admitting MD
 - f) Discharge criteria includes patients who were screened on admit and had a negative result but may be at risk for invasive MRSA
- 4. Inter-departmental Oversight [TJC IC.02.02.01 – IC.02.04.01]
 - a. Sterilization and Disinfection
 - i. Sterilization and disinfection practices are based on a technical understanding of the physical, chemical, and microbiological factors which influence these methodologies.
 - ii. Standardized protocols are developed and monitored in compliance with CDC and Association for the Advancement of Medical Instrumentation (AAMI) guidelines.

- b. **Environment of Care**
 - i. Infection Prevention is a member of the Environment of Care (EOC) Rounds team and conducts quarterly rounds with follow-up required by the surveyed department.
 - ii. Air handling system monitoring to ensure that there is proper air exchange, positive and negative air pressure differentials, HEPA filter integrity, and preventive cleaning where appropriate.
 - iii. Infection Prevention oversees renovation and repair activities which includes delineating engineering controls and infection control practices necessary to limit the dispersal of infectious organisms. This management process includes performing a risk assessment and issuing Infection Prevention Permits describing approved containment procedures.
 - iv. Water systems are managed in accordance with Environment of Care standards EC.02.05.01 and EP 1-13, and the ANSI/ASHRAE standard 188 for the purpose of preventing the growth and survival of *Legionella* and other waterborne bacteria in the utility water systems. The details of this are described in the TCMC Waterborne Illness.
 - v. Infection Prevention consults on renovation and construction activities which includes delineating engineering controls and infection prevention practices necessary to limit the dispersal of infectious organisms. This management process includes performing an infection control risk assessment (ICRA) delineating approved containment procedures.
 - vi. Infection Prevention oversees procedures for remediation after environmental emergencies such as air handling system failures, water leaks, mold growth, and loss of structural integrity.
 - vii. Environmental microbiological culturing is not routinely performed except in a few specific situations, i.e. targeted ambient bioaerosol sampling and water used for dialysis procedures. Otherwise, environmental cultures are obtained only when inanimate surfaces, ambient air, equipment, instruments, solutions, drugs, etc. appear to be associated with disease transmission or outbreak investigation.
- c. **Emergency Management [TJC IC 01.06.01]**
 - i. The Infection Prevention department collaborates with the Emergency Management team in the development and implementation of the mitigation, preparedness, and response and recovery phases of the Emergency Management Plan for TCMC. IP provides input and consultation regarding surge capacity, their role in the incident command system, environmental concerns in the physical plant, occupational health during disasters, and prioritizing limited resources that may affect infection transmission. Policies have been developed to prepare TCMC to deliver vital care, treatment and services in the event of an emergency incident or disaster.
 - ii. The Infection Prevention department receives current information about the emergence of epidemics or new infections through California Health Alert Network (CAHAN), San Diego County Public Health alerts, CDC, APIC Alerts, EPI newsletters, and email and fax alerts from the Local Health Officer. In addition, the organization participates in State and Local emergency preparedness drills.
- d. **Product and Program/ Product Line Evaluation**
 - i. Proposed new hospital programs/product lines, or those undergoing substantive alteration, are appropriately subject to review by Infection Prevention while in the planning stage regarding the potential for increased Healthcare- Associated Infection occurrence and the

- 1) The first goal is to provide an effective, ongoing program that prevents or reduces the risk of infection for patients, employees, healthcare providers and visitors through continuous

improvement of the functions and processes involved in the prevention of infection that includes:

- a) Identifying and preventing the occurrences of HAIs by pursuing sound IP practices such as hand hygiene, aseptic technique, environmental sanitation, isolation precautions including standard precautions, proper use of personal protective equipment (PPE), proper cleaning and disinfection of medical equipment and supplies, and monitoring the appropriate use of antibiotics and other antimicrobials.
- ii. The second goal is to promote actions that are designed to limit the spread and/or prevent the occurrence of HAIs by:
 - 1) Identifying and reducing risks of acquiring and transmitting infections among patients, healthcare providers, contract workers, students, volunteers and visitors.
 - 2) Preventing the spread of infections from patients to employees and healthcare providers by enforcing sound IP practices, providing immunization services and reducing potential exposures to blood and body fluids and other potentially infectious material by minimizing unprotected sharps and splash.
 - 3) Supporting the efforts of the Antibiotic Stewardship Program (ASP) to retard the evolution of multidrug-resistant pathogens and minimize antibiotic-associated complications such as CDI.
- iii. In addition, TCMC has identified the following Performance Improvement (PI) goals and strategies for FY2021:
 - 1) Goal #1: FY21 CLABSI Goal (baseline FY20 SIR=0.88):
 - a) Target SIR Goal = 0.61*
 - b) Strategies: Ensure compliance with prevention bundle elements through regular compliance audits performed by nursing and/or Infection Prevention staff. Implement PICC appropriateness guidelines.
 - 2) Goal #2: FY21 CAUTI Goal (baseline FY20 SIR = 1.16)
 - a) Target SIR Goal = 0.67*
 - b) Threshold SIR Goal = 1.01*
 - c) Strategies: Reduce urinary catheter utilization through implementation of a nurse driven removal protocol and ensuring compliance with prevention bundle elements through regular audits by nursing and/or Infection Prevention staff.
 - 3) Goal #3: FY21 CDIFF Goal (baseline FY20 SIR = 1.35)
 - a) Target SIR Goal = 0.51
 - b) Threshold SIR Goal = 0.75
 - c) Strategies: Implement 2-step testing (PCR + Toxin/antigen)
 - 4) Goal #4: FY21 SSI Goal (baseline FY20 Deep/Organ Space SIR = 1.71)
 - a) Target SIR Goal = 0.84*
 - b) Threshold SIR = 1.26*
 - c) Strategy: Establish SSI prevention committee and develop charter

*Target SIR equates to NHSN national SIR 50th percentile (Median); Threshold SIR equates to NHSN national SIR 75th percentile

F. RELATED DOCUMENTS:

1. Infection Control Policy: Infection Prevention Risk Assessment
2. Infection Prevention Annual Goals and Evaluation (Operation Plan Summary)

G. REFERENCES:

1. APIC Text of Infection Control and Epidemiology, 2021.
2. Joint Commission, Hospital Accreditation Standards, Chapter: Infection Prevention and Control, www.jointcommission.org
3. CMS Conditions of Participation: IC
4. Title 22, Calif. Code of Regulations

I. MISSION:

- A. ~~The Infection Prevention and Control Department has been established to address compliance with local, state, and federal regulations as well as standards set by accrediting agencies. The department is committed to reducing adverse outcomes such as health care associated infections (HAIs), improving patient care by supporting the staff in all areas of the facility, minimizing occupational hazards associated with the delivery of health care, and fostering scientific-based decision making~~
- B. ~~Prevention of HAIs is recognized as one of the most important priorities at Tri-City Healthcare District (TCHD) and The Centers of Disease Control and Prevention (CDC) estimates that in 2011, there were approximately 722, 000 HAIs in Acute Care hospitals and about 75,000 hospital patients with HAIs died during their hospital stay. Hospital-acquired infections (HAIs) are estimated to cost \$4.5 to \$5.7 billion per year to treat and approximately 1/3 of HAIs could be prevented. Prevention of infection requires an integrated, responsive process involving collaborative efforts throughout the hospital. This includes the identification of risk as well as efforts directed toward risk reduction for patients, staff, visitors, students and others in the facility.~~
- C. ~~Scope of Service The Infection Control (IC) Program provides a district wide framework, using a coordinated process of sound epidemiological principles, to reduce disease transmission. Activities are consistent with principles of Continuous Quality Improvement and include a multidisciplinary, participative approach to quality care.~~
 - i. ~~The Medical Director of Infection Prevention and Control is the designated infection control officer who, in cooperation with the hospital infection control committee, shall ensure implementation of the Infection Control Program.~~
 - ii. ~~Qualified staff with education and/or credentials that document knowledge and expertise in Infection Control manage the department.~~
 - iii. ~~The Infection Prevention and Control Services utilizes experts and resources such as:~~
 1. ~~The Occupational Safety and Health Administration (OSHA) and other pertinent federal, state, and local regulations.~~
 2. ~~Standards set by the Joint Commission (TJC) for the accreditation of Health Care Organizations~~
 3. ~~Guidelines, position statements, recommendations and studies published by recognized experts, such as, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Prevention and Control (CDC), and the California Healthcare Association (CHA).~~
 - iv. ~~In consultation with the Medical Staff and the Infection Control Committee, the Infection Preventionists (IP) shall implement a systematic process for monitoring and evaluating the quality and effectiveness of the infection prevention and control program. Results shall be forwarded to appropriate parties to exchange findings and/or for action.~~
- D. ~~Department Goals~~
 - i. ~~The department strives to improve the quality of health care and the work environment by enhancing infection prevention and control activities within the district. The IP participates in Council and Committee meetings as the infection prevention and control expert. Examples of actions include:~~

1. Recognize and maintain awareness of requirements, guidelines and recommendations that affect infection prevention and control and disseminate the information.
2. Provide documentation related to compliance with federal, state, and local regulatory and accrediting agencies.
3. Evaluate risks and other adverse events that are present with HAIs and make recommendations for reduction that are fair, scientifically sound, and recognize resource limitations.
4. Provide sound information to those seeking advice on how to decrease the risk of disease and microorganism transmission.
5. Review and revise clinical practice policies and procedures related to infection prevention and control.
6. Provide assistance and participate in staff education to facilitate the creation of an environment of consistent, optimal patient care practices.
 - a. Annually evaluate and update the new employee orientation and the reorientation programs including notes, presentation materials, and handouts as needed.
 - b. Conduct department specific education for areas involved in direct patient care, as requested. Presentations are most often at staff meetings and focused physician, nursing and CNA education classes are also utilized to increase participation.
 - c. When specific problems are identified, there is an educational component to problem solving that may include small group education, one-on-one efforts, or committee presentations. A variety of adult learning techniques are used to educate staff.

E. Surveillance Program

- i. Institution surveillance for infection control activities is a systematic, active, and ongoing observation. The authority for the program rests with the Infection Control Committee as defined in the Medical Staff Bylaws.
 1. A literature review reveals that specific efforts directed toward urinary tract infection, surgical wound infection, and device related infections such as ventilator associated pneumonia and intravascular line infections are strongly associated with reduced infection rates and have been considered in the development of our plan.
 - a. The plan is updated and approved annually by the Infection Control Committee. Please see Infection Prevention and Control Risk Assessment and Surveillance Plan
 - b. The Infection Prevention and Control Department uses the results and interpretations of the surveillance activities as a basis for modification of the surveillance plan during the course of the year if it becomes apparent that this would improve services to patients, staff, students, visitors, or others.
 2. The CDC guidelines (National Healthcare Safety Network - NHSN) for identifying HAIs are used at TCHD to define infections in acute care (Healthcare Associated Infections Plan). TCHD Home Health uses definitions published by APIC.
 3. Outbreak Investigations are included in our plan.
 - a. While a number of factors might be involved in transmission including healthcare workers, equipment, and environment, the most important objective is to control further transmission.
 - b. Should an outbreak be suspected, control measures would be guided by the Infection Preventionist in consultation with the Infection Control Officer and instituted by the department. Collaborative actions are taken with the affected department and/or medical service.

- ~~e. Outside resources and governing agencies will be contacted if appropriate and/or required.~~
 - ~~ii. Reporting Internally/Externally:~~
 - ~~1. Results and interpretations of surveillance activities are reviewed on a regular basis and reported internally to Infection Control Committee and others as appropriate.~~
 - ~~a. Findings, recommendations, actions, and evaluations are documented in meeting minutes.~~
 - ~~b. Results shall be forwarded to appropriate parties to exchange findings and/or for action.~~
 - ~~2. External reporting of communicable diseases as required by law.~~
 - ~~a. Diseases in the California Title 17 Code of Regulations to the local health authority.~~
 - ~~b. Suspected or known active tuberculosis cases to San Diego County TB Control department.~~
 - ~~c. Assist with determining infectious disease exposure of emergency response personnel (local police, ambulance and fire departments).~~
 - ~~d. NHSN enrollment is maintained. HAIs are entered in this national database in compliance with California Department of Public Health and Centers for Medicare and Medicaid Services (CMS) requirements.~~
- ~~F. Employee Health Services~~
 - ~~i. Infection Prevention and Control works closely with Employee Health on issues related to infectious diseases and district staff. Employee Health, plays an important role in the program and responsibilities include the following.~~
 - ~~1. Writes, revises and updates Employee Health policies including restrictions for work related in infectious diseases, OSHA required reporting, and programs to decrease infectious risk~~
 - ~~2. Conducts initial hire screening and annual assessments and offers vaccinations.~~
 - ~~a. Screens new employee for infectious diseases and immunity.~~
 - ~~b. Encourages and/or offers appropriate vaccinations to employees and volunteers~~
 - ~~c. Performs annual screening for symptoms of active tuberculosis and PPD conversions.~~
 - ~~3. Infection Control Department assists in notifying Employee Health of potential employee exposures based upon lab findings for pathogens requiring droplet/airborne isolation.~~
 - ~~4. Follows and treats employee exposures, using the latest department of health and CDC guidelines for:~~
 - ~~a. Blood and body fluids.~~
 - ~~b. Other infectious diseases (for example chickenpox and meningitis)~~
 - ~~5. Reports on worker injury and illness~~
 - ~~a. As required by federal, state and local regulations.~~
 - ~~b. To the Environment of Care and Infection Control Committees at least quarterly and Managers and Directors as appropriate.~~

II. RELATED DOCUMENT(S):

- ~~A. Infection Control Policy: I Risk Assessment and Surveillance Plan~~
- ~~B. Infection Control Policy: Epidemiologic Investigation of a Suspected Outbreak~~
- ~~C. Infection Control Policy: Healthcare Associated Infections, Defined~~

III. REFERENCE(S):

- A. ~~Centers for Disease Control and Prevention, Public Health Focus: Surveillance, Prevention, and Control of Nosocomial Infections MMWR October 23, 1992 / 41(42): 783-787.~~
- B. ~~Centers for Control and Prevention. (2015, January). Healthcare-associated Infections (HAIs). Retrieved from <http://www.cdc.gov/HAI/surveillance/index.html>~~
- C. ~~Pugliese G, Lamberto, B & Kroc, K. Development and Implementation of Infection Control Policies and Procedures In: Mayhall G. ed. Hospital Epidemiology and Infection Control. 2nd ed. Philadelphia: Lippincott, Williams & Wilkins; 1999:1357 - 1366.~~
- D. ~~Friedman, C. (2014). Infection Prevention and Control Programs. In P. Grota (Ed.), APIC Text of Infection Control and Epidemiology (4th ed). Washington DC; 2014.~~

The purpose of the Medication Error Reduction and Prevention Plan (MERP Plan) is to promote safe and effective medication use through the reduction of preventable medication-related errors and adverse events.

MERP 2021

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Medication Error Reduction Plan: 2021 Plan & Goals

Plan Purpose and Overview:

The purpose of the Medication Error Reduction and Prevention Performance Improvement Plan (MERP Plan) is to promote safe and effective medication use through the reduction of preventable medication-related errors and adverse events.

Medication Error Reduction and Prevention Strategies focus on the core procedures and systems of the medication management process; prescribing; prescription order communication; product labeling, packaging and nomenclature; compounding; dispensing; distribution; administration; education; monitoring and medication use.

The Medication Error Reduction and Prevention Plan is updated on an ongoing basis in consideration of the changing needs of patients, staff, quality management and performance improvement, and risk management processes. Modifications to the plan are assessed for effectiveness.

The effectiveness of the Medication Error Reduction and Prevention Plan is reviewed **annually**. The methodology used to assess the effectiveness of the plan should provide objective and relevant evidence that informs policy decision makers in the evaluation and development of corrective actions to effectively prevent and reduce medication errors.

The (MERP Plan) includes:

- Creating and embracing an accountable non-punitive culture for identifying and reporting medication errors and near miss events;
- Utilizing a “systems” approach to understanding and eliminating medication errors through multidisciplinary involvement;
- Using organization-wide quality assurance and performance improvement (QAPI) data to identify and analyze medication errors and, near miss events;
- Implementing system changes to minimize the likelihood of future medication errors and near misses;
- Involvement of multidisciplinary teams and committees to direct and monitor the medication safety and performance improvement effort.

Scope:

The Medication Error Reduction and Prevention Plan is applicable to all patients receiving care within the facility or under the licensure of the facility, including both inpatients and outpatients. The MERP Plan pertains to all areas in which medications are prescribed, prescription orders are communicated, products are labeled, packaged and nomenclature used, compounded, dispensed, stored, distributed, administered, monitored and used.

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Objectives:

- Improve error detection, reporting and analysis of data and use of information to improve medication safety.
 - Evaluate on-line reporting and enhance active reporting.
 - Enhance awareness of on-line reporting tools and methodologies for capturing data and tracking medication related events.
 - Orient and educate staff on processes for reporting medication events. Re-orient staff on a regular basis.
 - Establish a system to encourage staff to report medication errors, participate in identifying system-based causes, make recommendations to improve the system, and facilitate necessary changes.
 - Create methods to enhance error detection by capturing medication errors and near misses through computer surveillance and trigger events, Medication Administration Records (MAR) reconciliation, pharmacy interventions and competency assessment processes. Use the data to identify additional opportunities to improve medication processes.
- Emphasize an accountable non-punitive reporting process that encourages staff to report potential or actual medication safety risks.
 - Widely communicate the organization's commitment to medication safety in specific terms and with concrete examples in staff newsletters and educational programs.
 - Develop methods to obtain frontline staff feedback about medication/patient safety issues.
 - Review **ISMP Medication Safety Alert** and disseminate information to staff involved in the medication management process.
 - Establish a blame-free environment for responding to errors.
 - Involve staff in Root Cause Analysis and Failure Mode Effect Analysis to assist in evaluation of systems and procedures that have or may contribute to errors.
 - Incorporate patient safety tenets in evaluation of employee competence and performance evaluations. (Do not include the absence or presence of errors as a criterion.)
- Evaluate and utilize technology to reduce the risk of medication errors.
 - Maintain an up-to-date compendium of system capabilities and reporting functionalities. Set standards for medication safety alerts and educate staff on functionality.
 - Collect and analyze data to identify areas needing improvement and implement appropriate strategies for medication error reduction.
- Reduce the risk of errors with high-alert medications prescribed and administered to high-risk patient populations or at vulnerable periods of transfer through the health care system.

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Medication Error Reduction Plan: 2021 Plan & Goals

- Evaluate medication management processes for high-risk patients and patients receiving high-alert medications (e.g. pediatric and chemotherapy) to include the following indicators:
 - Establish maximum safe doses for high-alert medications and enter them into the order entry system to electronically alert staff to potentially toxic doses.
 - Evaluate the storage and safe use of high-alert medications and look-alike/sound-alike medications in the hospital and initiate safe practice recommendations.
 - Establish standard order sets for the use of high-alert medications, as appropriate.
 - Standardize drug concentrations of high alert medications and medications used in high-risk patient populations such as pediatrics and ICU.
 - Establish a consistent process for a cognitive, independent double check for defined high-alert medications.
- Implement safe practice recommendations from nationally recognized organizations such as ISMP, Joint Commission Sentinel Event Alerts and California Institute for Health Systems Performance.
- Ensure continuous compliance with medication management safety strategies recognized by professional and accreditation standards. Compliance measures may include:
 - Self-assessment tools and gap analysis
 - Survey preparation assessments
 - Medication Safety Checklist

Organization:

Hospital leadership is committed to maintaining an environment that emphasizes patient safety and supports ongoing error prevention and reduction activities. Hospital leaders actively encourage medication error identification and reporting by all staff. Preventing and reducing medication errors is a high priority. Errors are analyzed and processes, functions and services are established or; procedures and systems are changed to prevent recurrence and reduce risk to patients.

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Process of the Plan:

➤ Plan Development:

A multidisciplinary group comprised of MERP Plan members from the Medication Safety Team/Committee is responsible for development of the Medication Error Reduction and Prevention Plan. The core team is also responsible for recommending the MERP Plan's approval through the Medication Committee, Quality and Patient Safety Council (or equivalent), Medical Executive Committee and the Board of Directors.

Members of the MERP Plan core team includes:

- Director of Pharmacy
- Director of Quality Management and Medical Staff Services or Designee
- Director of Risk Management
- VP Patient Care Services
- Medical Staff representative(s)

➤ Plan Implementation and Assessment:

The Medication Safety Team provides primary oversight of MERP Plan. The team/committee's role is to guide and direct others within the organization towards; the provision of safe medication use; the prevention and reduction of medication errors and the improvement of medication management processes /procedures and systems.

The Medication Safety Team works collaboratively with the hospital and medical staff leadership, medical staff, and hospital staff; working across interdepartmental boundaries as needed, to address medication safety issues and to assess the effectiveness of the MERP Plan.

Methodology used to evaluate each of the eleven medication management procedures or systems to identify weakness or deficiencies which could contribute to medication errors may include but are not limited to:

- Evaluation of external alerts (e.g. ISMP Alert, FDA Alerts, etc.)
- Observation of medication pass
- QAPI studies
- FMEA studies
- Medication Use Evaluations
- Analysis of medication error reports to identify system vulnerabilities

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- Root Cause Analysis
- Monitoring and adjusting implementations of practices/process changes to evaluate and enhance effectiveness
- Technology upgrade feasibility is reviewed when needed, but at least annually.
- GAP analysis of the plan is performed and priorities are established annually.

➤ **Improvement Strategies:**

Current literature is reviewed on an ongoing basis for the development and ongoing review and revision of the Medication Error Reduction and Prevention Plan's improvement strategies. The literature includes publications from the Institute of Medicine (IOM), Institute for Safe Medication Practices (ISMP), American Society of Health System Pharmacists (ASHP), the Joint Commission and other publications/organizations as appropriate.

Medication use systems and procedures are identified to include both current and future improvement strategies.

➤ **Implementation Strategies:**

Annually, improvement strategies are evaluated and resultant implementation strategies are identified. Strategies include both technology and non-technology approaches.

- Review the effectiveness of the existing plan, and make adjustments, when needed, to improve the plan.
- Implement medication use safe practice recommendations
- Optimize medication error prevention and reduction potential of technology systems
- Respond rapidly and effectively to potential errors of, and errors caused by workflow processes

➤ **Education and Awareness:**

Entity specific core curriculums are created to support the MERP Plan initiative. The following methodology will be used to assist with identifying and reporting medication errors with the goal of reducing their incidence:

- An annual medication safety assessment will be used to identify needs.
- Systems will be reviewed to identify current practice and compared to nationally recognized safe medication practices to identify gaps.
- Expected outcomes and measures of success will be defined for identification and reporting of medication errors and to identify process changes for error reduction and prevention.
- Clinical education will include medication safety core curriculum during orientation and annual competency reviews for pharmacy, nursing and other allied health professionals.

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- The medical staff will be informed of MERP Plan progress via committee presentations and Medication Committee newsletters.

Monitoring:

The Medication Safety Team will monitor multiple data sources which may include:

- Adverse drug event review (medication errors, near misses, adverse drug reaction and incompatibilities). See Addendum A
- Concurrent chart reviews and audits (e.g. Medication Use Evaluations)
- Computerized surveillance (e.g. Trigger drug utilization, Automated Dispensing Cabinet (ADC) Reports, Bar-Code Medication Verification (BMV) data reports, etc.

Reporting:

- Findings and recommendations from the Medication Safety Team are first reported to the Medication Committee, which through its representative reports to the Medical Executive Committee
- The Medication Safety Team also presents its findings to the Quality and Patient Safety Council, which are comprised of leadership from the facility's functional departments.
- The Medication Safety Team publishes quarterly newsletters to update patient care staff of MERP PIP's progress.
- If findings or recommendations have an *immediate* impact on patient safety, focused memos and direct communication to affected functional areas is utilized.

Annual Review:

The Medication Error Reduction and Prevention Performance Improvement Plan (MERP PIP) is reviewed annually and modified as needed to focus efforts to reduce medication related errors. The analysis will consist of both concurrent and retrospective review of patterns and trends of clinical care, weakness and deficiencies, and focus on procedure and system related opportunities for improvement. Individual performance issues will not be addressed during an annual review.

The annual assessment of the effectiveness of the MERP PIP will include, but not be limited to, a comprehensive review of prescribing, prescription order communication, labeling, packaging, nomenclature, compounding, dispensing, distribution, administration, patient and staff education, monitoring tools and overall medication use.

Annual review of the MERP PIP will be a function of the Medication Safety Team/Committee (or equivalent) and will be reported to the Medication Committee (P&T), the Quality and Patient Safety Council, the Medical Executive Committee and the Board of Directors.

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Medication Error Reduction Plan: 2021 Plan & Goals

Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
Prescribing							
Decrease number of duplicate medication orders	Profile review during pharmacist order verification	11/2019 11/2020 04/2021	Tracking duplicate orders and working in conjunction with Chief of Medical Staff to evaluate causes and improvement strategies Possible retraining of providers Cerner implementation: Providers are receiving alerts of duplicate medication Cerner Community Work Go-live April 2021	Pharmacy Staff Medical Staff Regulatory Nursing Staff Information Technology	Ongoing Data source development needed. Manual Audit: Auditing an average between 30 and 40 charts per month.	Surveillance Quality Assurance & Performance Improvement (QAPI) Reports Pharmacy Reports Information Technology	General consensus from pharmacists indicates there has been little improvement. Medical Quality has decided to include duplicate orders as part of the ongoing professional practice evaluation. Goal: 0 True Duplicate Therapy. Continues to be discussion at Med Staff level on proper review for duplicate meds. This will be part of the MD Optimization roll out. With further MD input improvements being made. Continue to evaluate.
Eliminate orders coming across as mg/kg rather than total dose	Chart Review	01/2020 11/2020	Identified that Emergency Room patients have an estimated weight placed in Cerner and the weight used for dose calculation comes from the admission weight. As a result, currently doses entered in mg/kg remain this way unless a weight is placed in admission weight field Alert through Cerner: Weight to be entered. As a result the dose will be weight based Cerner Community Work Go-live April 2021	Nursing Pharmacy Medical Staff IT	Ongoing Asking IT for details and update Alert: Order without weight documented	Ongoing RL's Reports	Now that ED is profiled, if calculation is not employed for total dose no med can be accessed in Pyxis. IT stated weight ts must be directly entered into admission, not triage. This finding was corrected with the implementation of Community Works.

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Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
Antimicrobial Stewardship	Antimicrobial Stewardship Program Medication Committee Infection Control	04/2020	Added recommended guidelines for use of antimicrobial agents on 2020 antibiogram Updated TDMS to PrecisePK Updated vancomycin and aminoglycoside dosing policies Updated renal dosing policy to include dosing by indication and by renal function Researched treatment regimens for COVID-19 and implemented ordering and verification procedures	Pharmacy Microbiology Infection Control Quality Risk Information Technology (IT) Medical Staff Administration	Ongoing process 2020 antibiogram now includes treatment recommendations PrecisePK being used by all pharmacists Vanco and Aminoglycoside policies approved by P&T and MEC Medication dosing policy pending ASP/P&T/MEC approval COVID-19 treatments are verified with physician and some monitored by pharmacists (Remdesivir)	ASP Committee P&T Committee Infection Prevention QAPI	Appropriate prescribing of empiric antimicrobial therapy Appropriate dosing of antimicrobials Appropriate monitoring of antimicrobials
Prescribing restricted Antimicrobials	Chart Review	05/2020	Limited ordering restricted antimicrobials to one dose stat Order reviewed by ID team	Pharmacy Microbiology Infection Control Quality Risk Information Technology (IT) Medical Staff Administration	Decreased and controlled the use of restricted antimicrobials	ASP Committee P&T Committee Infection Prevention QAPI	Appropriate use of restricted antimicrobials

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Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
Prescription Order Communication							
Improve Accuracy of Medication History and Reconciliation Process	Audit by Medical Staff	07/2020	A multidisciplinary group has been put together to address improving the meaningfulness and accuracy of the medication history and reconciliation process from admission to discharge. With Covid-19 our 2 ED pharmacy technician's positions were eliminated. Educated nursing staff on performing the medication reconciliation upon admission and discharge	Nursing Pharmacy Medical Staff	Ongoing RL'S Reports	Surveillance by PI and reported to Medication Safety and P&T. Med Staff review for provider compliance of med reconciliation	Medication Reconciliation reports showed Further review on medication reconciliation not done by technicians needed. Audits show we often miss the last dose given info. Continue to evaluate process Transitions of Care program is ideal. From 07/2019 through 07/2020 medication history has been performed by providers only when needed and upon transition of phase of care.
Improve CPOE compliance rates	ISMP	2019	Order Set Development needed for CPOE Order Sets updated regularly based on Current Guidelines and approved by P&T and MEC CPOE Compliance Rate Staff Education	Nursing Pharmacy Medical Staff	12/2020	Pharmacy Reports Community Works implementation on April 2021	Set the rate at 9% or greater Increased CPOE Compliance Rate Will analyze the reports post Cerner implementation
Medication shortage communication	CDPH	06/2019	Shortages needed to be communicated and managed well	Nursing Pharmacy Medical Staff	12/2020	P&T Shortage Report	Shortages identified Coordination with the buyer Communication with med and nursing staff Looking for therapeutic alternatives Using CPS resources (Purchasing Analyst, Reports...etc., Using 503B for sterile compounds

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Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
Product Labeling, Packaging, and Nomenclature							
Ensure proper Beyond Use Date (BUD) on product labeling	CDPH	10/2019	Repackaging oral unit dose did not have the correct BUD	Pharmacy Staff	12/2020	Education provided to staff	Started repackaging with the correct BUD
Ensure appropriate labeling process for NMB in place	CDPH Med Errors	10/2019	NMB were not labeled appropriately, nor stored accordingly	Pharmacy Staff Nursing Staff	10/2020	No NMB med errors	Stored NMB in a separate Bins Ensured they have a NMB labels Stocked only in appropriate area
Compounding							
Implement USP 797 guidelines	USP 797 Chapter	03/2019	Clean Room did not meet USP797 standards. Used glove box while the Clean Room was being built	Pharmacy	03/2020	Successful inspection from CDPH and CABOP surveys	Built a new Clean Room Successful surveys
Dispensing							
Review Overrides	Medication Safety	01/2019	A high rate of medication override	Nursing Staff Medical Staff	05/2020 Reviewed Medication Override policy and list Last revision approved by P&T on 05/2020 Hired 2 ED pharmacist to review all ED orders	Monitoring override rate	Decrease of inappropriate override

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Medication Error Reduction Plan: 2021 Plan & Goals

Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
Distribution							
Bar Code Scanning (Patient and Meds)	Leap Frog	01/2020	Not meeting Leap Frog criteria for patients and medication bar code scanning	Pharmacy Staff Nursing Staff Medical Staff	Utilized Pyxis BCS feature Educated nursing medical and pharmacy staff	Community works reports showing both rates trending down	Increased medication bar code scanning rate
Administration							
Unclamping Medication Using Alaris Pump	CDPH Med Errors	07/2020	Discussed at Medication Safety meeting Working to push Cerner admin times through to Pyxis in order to utilize Remove by time feature on Pyxis Evaluating the Pyxis Link product	Nursing Staff Medical Staff	Nursing Education Be A Champ on Clamping	Med Errors Reports	Reduction of med errors
Education							
Pharmacists Qualification	Request for pharmacist Code Blue and Stroke participation	01/2020	At this time the ICU pharmacist attends codes when possible. Attendance is mainly limited to ICU but occasionally other areas and only when ICU trained pharmacist is in house. The value of a pharmacist present is recognized but not all pharmacists are ACLS trained. Hired 2 ED pharmacists to attend Stroke Code.	All Pharmacists	All inpatient Pharmacists are ACLS and BLS Certified Participation in Code Blue The 2 ED pharmacists attend Stroke Code	Critical Medication Administration	Participation in Code Blue

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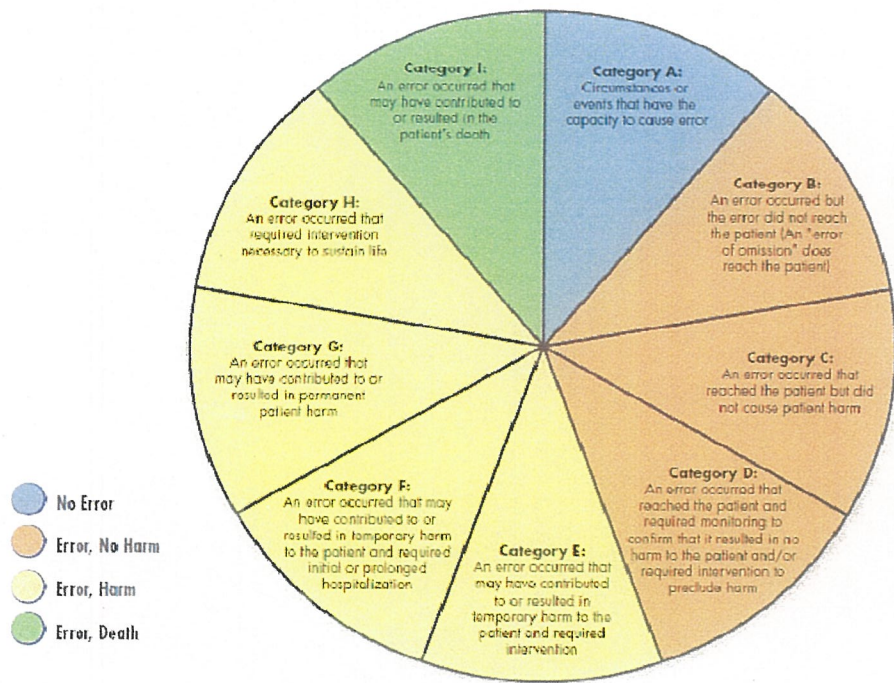
Medication Error Reduction Plan: 2021 Plan & Goals

Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
Monitoring							
Percentage of ED population come in for purpose of seeking opioids	Discussion with ED team regarding improvements to opioid use	01/2020	Working with ED Chief. Data Analyst and Pharmacist to see if the data can be gathered and then use it to drive prescribing habits to some extent.	Nursing Medical Staff Information Management (HIM) Pharmacy	Ongoing	Waiting for reports to be built by IT	Pending because of Covid-19
Use Strategies							
Technology Elements							
Lack of Anesthesia Cart in the OR, Accountability/ Inventory Control	MERP Audits of Shingle sheets	12/2019	Review of Overrides and Discrepancies Pending Approval for Anesthesia Carts Non Scan Report	Pharmacy Nursing Medical Staff Information Management (HIM) Nursing Cardiopulmonary Laboratory Pharmacy Medical Staff IT	Ongoing Pending Approval	Pharmacy Reports	Pending

Tri-City Medical Center Medication Error Reduction Plan: 2021 Plan & Goals

Addendum A

NCC MERP Index for Categorizing Medication Errors



Definitions

Harm
Impairment of the physical, emotional, or psychological function or structure of the body and/or pain resulting therefrom.

Monitoring
To observe or record relevant physiological or psychological signs.

Intervention
May include change in therapy or active medical/surgical treatment.

Intervention Necessary to Sustain Life
Includes cardiovascular and respiratory support (e.g., CPR, defibrillation, intubation, etc.)

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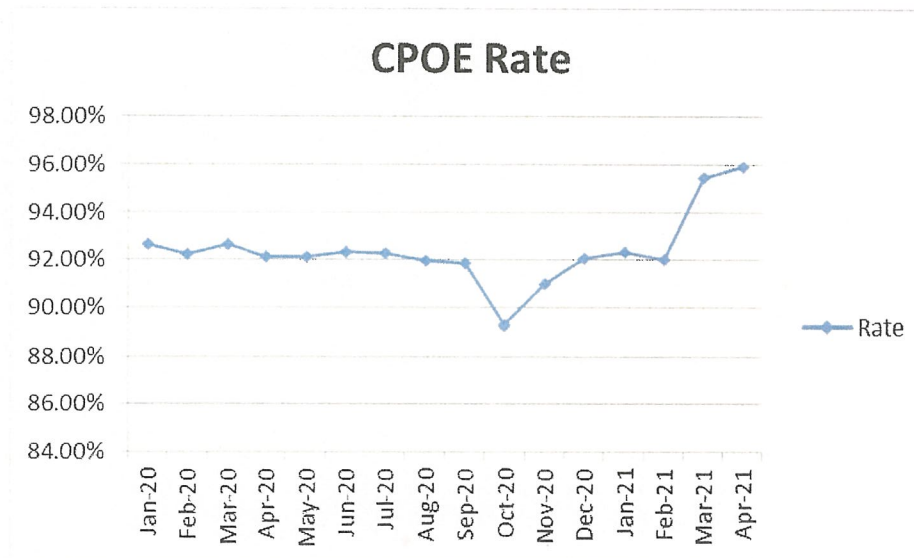
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Medication Error Reduction Plan: 2021 Plan & Goals

Addendum B

CPOE Rate

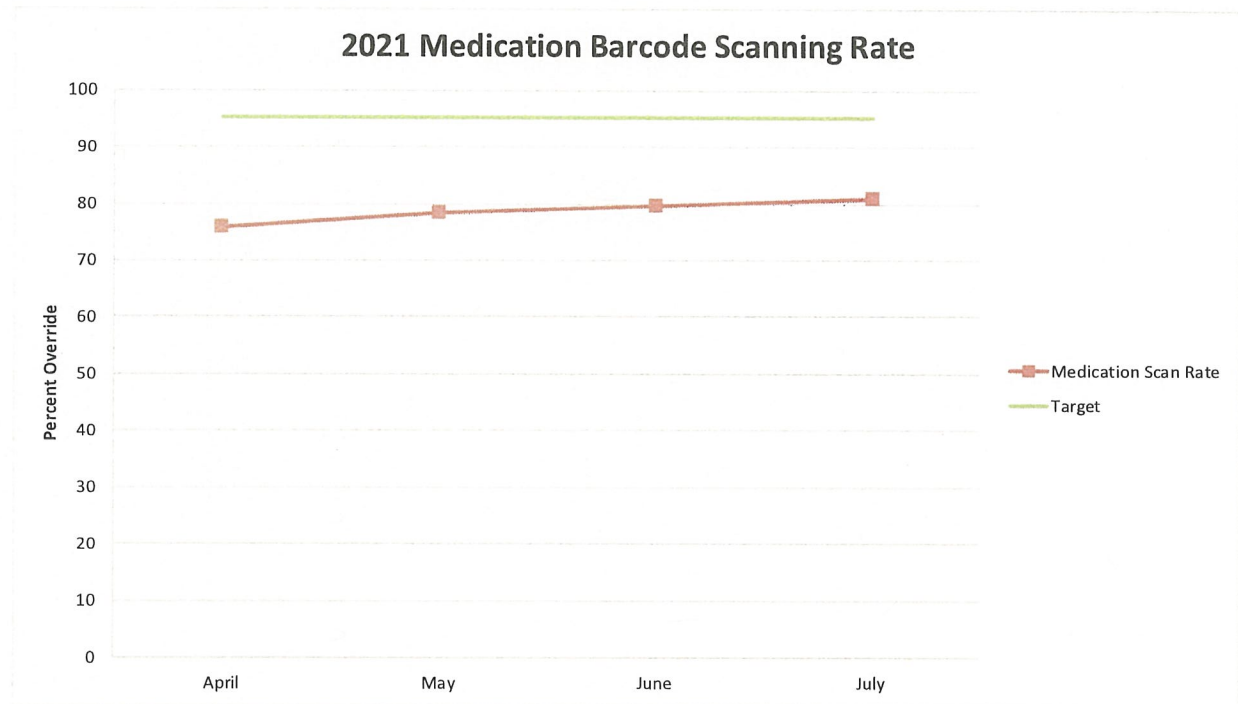
CPOE	Rate
Jan-20	92.65%
Feb-20	92.20%
Mar-20	92.63%
Apr-20	92.10%
May-20	92.09%
Jun-20	92.31%
Jul-20	92.28%
Aug-20	91.94%
Sep-20	91.87%
Oct-20	89.27%
Nov-20	90.96%
Dec-20	92.04%
Jan-21	92.35%
Feb-21	92.00%
Mar-21	95.44%
Apr-21	95.88%



Tri-City Medical Center

Medication Error Reduction Plan: 2021 Plan & Goals

	January	February	March	April	May	June	July	August	September	October	November	December
% Removal												
Medication Scan Rate				75.7	78.3	79.5	80.9					
Target	95	95	95	95	95	95	95	95	95	95	95	95



Tri-City Medical Center

Medication Error Reduction Plan: 2021 Plan & Goals

This plan was approved by:

Director of Pharmacy

Director of Patient Care Services

Director of Quality and CRS

Director of Medical Staff Services

Pharmacy & Therapeutics Committee Chairperson

Medication Safety Committee

Medical Executive Committee

Date: _____

TRI-CITY MEDICAL CENTER	POLICIES AND PROCEDURES
Formulation: October 20, 1992 Reviewed: 5/94, 3/96, 10/97, 5/03, 11/06, 3/09, 6/11 Revision: 7/03 Approvals: Director of Security	Subject: Universal Exposure Precautions (Prevention of Exposure to Body Fluids) DELETE – follow Infection Control policies Page 1 of 1
Submitted By: Security Department	Procedure Manual: Security Department SDPPM - # 601

Security Department Approval: 10/20
 Environmental Health & Safety Committee Approval: 03/22
 Administration Approval: 03/22
 Professional Affairs Committee Approval: n/a
 Board of Directors Approval:

1.0 Purpose:

To establish guidelines for Security Officers, who in the course of their assigned duties may come into contact with bodily fluids.

2.0 Policy:

It is the policy of the Security Department to maintain a standardized equipment list and guidelines for Security Officers to follow when they may be exposed to blood or other body fluids during the course of their assigned duties.

3.0 Procedure:

- 3.1 Each Officer, while on duty, will have in their possession the equipment listed below.
 - 3.1.1 Protective Safety Glasses
 - 3.1.2 Isolation Mask
 - 3.1.3 Disposable Protective Gloves
 - 3.1.4 Spit Sock
- 3.2 Prior to performing any required duty, which could place the Officer in a position of coming into contact with any body fluid; the Officer will properly apply and utilize any necessary personal protective equipment.
- 3.3 During the performance of any duty that has the potential of a "needle stick", each Officer will take the necessary precautionary measures and actions to avoid any type of "needle stick".
- 3.4 Upon completion of any duty with the potential of exposure to any body fluid or "needle stick" all Security Officers will remove all protective equipment and properly dispose of the items used. Each Officer will thoroughly wash their hands after removal of any protective devices.
- 3.5 If the Security Officer has, in fact, come in contact with body fluids, the Officer will thoroughly wash the contact area, scrub thoroughly with an antiseptic substance and immediately contact Employee Health or and Emergency Department Physician if necessary for treatment.
- 3.6 It will be the responsibility of the exposed Security Officer to complete all necessary Security Departmental and Medical Center paperwork regarding the exposure.
- 3.7 It is highly recommended that all Security Officers receive the Hepatitis B immunization inoculation from the Employee Health Services Department.
- 3.8 Failure to follow recommended practices of wearing protective equipment in any high exposure situations may result in corrective action, up to and including an intent to terminate.

TRI-CITY MEDICAL CENTER	POLICIES AND PROCEDURES
Formulation: August 05, 1992 Reviewed: 4/94, 10/97, 5/03, 11/06, 3/09, 6/11 Revision: 7/03 Approvals: Director of Security Submitted By: Security Department	Subject: Use of Personal Protective Equipment <div style="border: 1px solid black; padding: 5px; display: inline-block;"> DELETE – follow Infection Control policies </div> Page 1 of 1 Procedure Manual: Security Department SDPPM - # 602

Department Approval: 10/20
Environmental Health and Safety Committee Approval: 03/22
Administration Approval: 03/22
Professional Affairs Committee Approval: n/a
Board of Directors Approval:

1.0 Purpose:

To establish guidelines for the use of personal protective equipment by Security Officers during the performances of their assigned duties.

2.0 Policy:

It is the policy of the Security Department to supply all Security Officers with personal protective equipment for use when performing

3.0 Procedure:

3.1 Every Security Officer will be supplied with the following personal protective equipment and carrying pouch and will carry these items on their equipment belt while performing their shift duties.

3.1.1 Carrying case for protective equipment

3.1.2 Filtration Isolation Mask

3.1.3 Exam Gloves

3.1.4 Safety Glasses

3.2 Each Officer will be responsible for maintaining all personal protective equipment in good working condition and immediately replace any damaged items.

3.3 If any Security Officer is unable to utilize their personal protective equipment and is exposed to any infectious substances, a detailed report will be completed and submitted to the Security Supervisor or Shift Lead Officer. In addition, the exposed Officer will immediately notify the Security Supervisor or Shift Lead Officer.

ISSUE DATE: 9/2001

SUBJECT: Department Specific – Security

REVIEW DATE: 5/2004, 11/06, 03/09

STANDARD NUMBER: IC. 7.2

Department Approval: 10/20
Environmental Health and Safety Committee Approval: 03/22
Administration Approval: 03/22
Professional Affairs Committee Approval: n/a
Board of Directors Approval:

CROSS REFERENCE:

Surveillance QI Plan IC .02
Epidemiologic Investigation of a Suspected Outbreak IC .03
Definitions of Facility Acquired Infections IC .04
Employee Health Services Policies
Administrative Policy #401 Injury Prevention Program

REVISED: APPROVAL: Infection Control Committee 5/14/2001

1. Although security officers do not come in contact with, handle, or dispose of medical waste, personnel are expected to be aware of the policy and associated procedures governing medical waste management.
2. Security officers might be required to assist with a patient restraint episode that would expose them to an infectious disease. They will follow Standard and Transmission Based Precautions as appropriate.
 - Judgment is required in assessing the need for personal protective equipment during security activities.
 - Officers are given a fanny pack to wear that is stocked with gloves, face protection and a "spit sock".
 - At the minimum, hand washing is performed after physical restraint of a patient, see the Personal Protective Equipment table below.

SR= Strongly Recommended Avail.= Available N/A= Not Applicable	Exposed Body Parts						Contamination of Clothing					
	Hands			Face			Soiling			Saturation		
	Gloves			Face Shield or Mask with Goggles			Cloth Gown			Water-proof Gown		
	SR	Avail	N/A	SR	Avail	N/A	SR	Avail	N/A	SR	Avail	N/A
ASSISTING WITH RESTRAINTS	*				*			*			*	
MORGUE RELEASE	*					*			*			*

References:

Amori, G, Isolation Systems, in APIC Text of Infection Control and Epidemiology. Wash. DC, 2000.

TRI-CITY MEDICAL CENTER		POLICIES AND PROCEDURES	
Formulation:	May 05, 2003	Subject:	Infection Control Plan for Security Department
Reviewed:	11/06, 3/09, 6/11	Page 1 of 1	DELETE – follow Infection Control policies
Revision:			
Approvals:	Director of Security		
Submitted By: Security Department		Procedure Manual: Security Department SDPPM - # 603	

Security Department Approval: 10/20
 Environmental Health & Safety Committee Approval: 03/22
 Administration Approval: 03/22
 Professional Affairs Committee Approval: n/a
 Board of Directors Approval:

1.0 Purpose:

~~To set standard guidelines for Security Officers to utilize during the course of their regular assigned duties to reduce disease transmission to patients, visitors, and staff members.~~

2.0 Policy:

~~It is the policy of the Security Department for all Security Officers to utilize standard precautions during patient contact to reduce the risk of disease transmission to patients, visitors, and staff members.~~

3.0 Procedure:

~~3.1 Security Officers will follow the guidelines outlined in the Infection Control Manual section 7.2 related to Security Department Specific precautions.~~

~~3.2 Attached is the Infection Control Guidelines for the Security Department. Security Department personnel are responsible for being familiar with and utilizing the standard precautions outlined in this policy.~~

4.0 Attachments:

~~4.1 Infection Control Department Specific guidelines for Security Department~~

**PROCEDURE: SPONGE AND SHARPS COUNT FOR VAGINAL DELIVERIES**

Purpose: To provide guidelines for the registered nurse to establish a baseline count for sponges, sharps and temporary packing of the genital tract post-delivery, including packing that is kept in place beyond the immediate recovery period (one to two hours after delivery). Careful examination of all equipment used during the procedure to ensure that the equipment is intact and no incidental pieces are retained.

Supportive Data: Strict adherence to the count process and documentation of all packed materials are important for the prevention of an unintentionally retained object. Imaging is recommended only when the final count cannot be reconciled.

Equipment:

1. ~~510-Lap Sponges (4"x18") and ten raytecs (4"x4" gauze with radiopaque marker)~~
2. Sutures per provider preference card
3. Sharp counter box
4. Equipment components needed for vaginal delivery
5. Dry erase board and marker
6. **Instruments for a Vaginal Delivery**
7. **Blue sponge counter bag and pole**

5.

A. POLICY:

1. All sponges, **instruments**, sharps and small miscellaneous items opened ~~to~~ **on** the delivery table for a vaginal delivery ~~shall~~ **must** be counted.
2. Distractions shall be minimized during the count process. If the count is interrupted the process must start over.
3. All counts shall be conducted audibly and visually.
 - a. Counted items shall be visualized by both the Labor and Delivery (L&D) registered nurse (RN) and the attending provider before the delivery table is used.
 - i. Another L&D RN or an OB technician (OB tech) may perform the initial count in anticipation of vaginal delivery where the provider has not yet arrived.
 - 1) The RN and/or OB tech/designee must be trained in the counting process.
 - b. The final count should be performed before the provider leaves the room.
 - i. If **the** delivering provider is called away for an emergency but anticipates returning before the end of the immediate recovery period, the final count may be completed when the delivering provider returns.
 - ii. If the provider is not available for the final count, the count shall be performed by two members of the L&D team (one of which is an RN)
4. ~~Counts may be omitted in an extreme emergency.~~
- 5.4. All sponges shall be x-ray detectable.
 - a. Never detach a sponge from its radiopaque string.
 - i. Never use regular 4"x4" gauze without radiopaque markers.
- 6.5. **Pre-Delivery and Post-Delivery** ~~C~~counts shall be written on the dry erase board.

~~Baseline count is documented on the dry erase board prior to the start of the procedure~~

~~Items added to the delivery table during the procedure are added to the baseline count on the dry erase board.~~

~~The final count includes all items documented on the dry erase board.~~
- 7.6. The sponge, and sharps **and instrument** count shall be performed as follows:
 - a. Before the delivery table is accessed for the vaginal delivery to establish baseline
 - b. At the end of the delivery:

Review Revision Date	Clinical Policies and Procedures	Nurse Executive Committee	Department of OB/GYN Committee	Department of Pediatrics	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
08/10	02/13	02/13	01/13, 06/21	n/a	n/a	05/13, 01/22	03/22	06/13, n/a	06/13

~~Sponges and soft goods shall not be placed in the fluid collection container until after the final count has been performed and reconciled~~

- c. Anytime a member of the L&D team has concerns about the accuracy of the count.
- d. At the time of permanent relief of the L&D nurse
 - i. Direct visualization of all items may not be possible
- ~~8-e.~~ A count is not required at the time of permanent change of an L&D team member other than the RN, or if the L&D RN is relieved for a short period of time (i.e. lunch break).

B. PROCEDURE:

1. Pre-Delivery: L&D RN and attending provider, ~~or OB Tech,~~ **or second L&D RN**
 - ~~4-a.~~ Perform baseline count of ~~sponges, and sharps~~ **sponges, sharps and instruments and write on the dry erase board** before the delivery table is used.
 2. ~~The L&D RN shall record the count on the dry erase board.~~
 - ~~a-b.~~ Include the number and type of sponges, sharps, **instruments** and small miscellaneous items
 - ~~b-c.~~ The second person involved in the count verifies the documentation on the dry erase board
 - 3-d. Ensure the sponges included have their x-ray detectable strings and/or markings.
 - ~~a-i.~~ Count each sponge and separate from other sponges during the count
 - ~~b-ii.~~ Remove all packing and wrapping materials
 - ~~c-iii.~~ If the detectable indicator is not present, the entire package of sponges must be removed from the room and given to the designated person for follow-up with the manufacturer
 - ~~i-1)~~ Including all pre-packaged laps or raytecs where the labeling on the package does not match the actual number of sponges in the package
 - ~~d-iv.~~ Sponges/~~soft goods~~ used by anesthesia will not enter the delivery field or be mixed in with the sponges/~~soft goods~~ used and counted for the delivery process
 - 4-e. Count all additional sponges, sharps, **instruments** and miscellaneous items when opened onto the delivery field, and document on the dry erase board.
 2. Post-Delivery: L&D RN and attending provider, **OB Tech, or second L&D RN**
 - 4-a. Audibly and visually count all sponges, sharps, **instruments** and small miscellaneous items at the end of the procedure
 - ~~a-b.~~ Verify with the count documented on the dry erase board.
 - 2-c. **Separate and place used sponges/soft goods in a designated basin blue sponge counter bag**
 - d. Sponges/~~soft goods~~ must not be placed in the fluid collection container. ~~until after the final counts have been performed and reconciled.~~
 - ~~— All sponges and soft goods must be separated to aid in the counting process.~~
 - i. Inspect all sharps and miscellaneous items (e.g., fetal scalp electrodes, intrauterine pressure catheters, etc.) for broken or missing pieces.
 - ii. Broken items must be accounted for in their entirety.
 - e. Any items dropped during the procedure shall be retrieved, isolated from the delivery field, and included in the final count.
 - f. **No trash, linen, or table is removed from the room until the count is verified**
 - 5-g. **Record the final count on the dry erase board**
 - 6-h. Incorrect Counts:
 - ~~a-i.~~ The attending provider shall be informed of any discrepancies in the count
 - ~~b-ii.~~ The attending provider will inspect the vaginal vault for missing items
 - ~~c-iii.~~ L&D staff members shall search the room for the missing items, including the floor, trash, linen, and infant high-care bed
 - ~~d-iv.~~ The L&D RN shall inform **the charge nurse** ~~assistant nurse manager/designee of~~ count discrepancies
- e.3. A portable x-ray should be performed prior to the patient leaving the Labor and Delivery room if:

- i.a. All above steps have been taken and count is not reconciled
- ii.b. Counts were omitted due to an extreme emergency and/or patient's condition
- iii.c. Any member of the L&D team has a concern about the accuracy of the count
- iv.d. The provider and/or radiologist should review the x-ray prior to patient leaving the Labor and Delivery room

C. **DOCUMENTATION:**

1. Document verification of all counts in the **patients EMR.**~~Cerner "L&D-Delivery Summary" form on the patient's chart.~~
 - a. ~~Types of counts~~
 - b. ~~The number of counts~~
 - c.b. Names and titles of persons performing the counts
 - d.c. Any items intentionally left in the patient
 - e.d. Results of counts
 - i. ~~Notification of attending provider~~
 - ii.i. Actions taken if count discrepancies occur
 - iii. ~~Rationale if counts are not performed or completed~~
 - iv. Complete a QRR (incident report) for all incorrect counts

D. **REFERENCES:**

1. National Guideline: Prevention of unintentionally retained foreign objects during vaginal deliveries. Health care protocol. Retrieved on 7/30/2010 from: <http://www.guidelines.gov>
2. Chagolla B. A., Gibbs V. C., Keats J.P., & Pelletreau B. (2011). A System wide Initiative to Prevent Retained Vaginal Sponges. Accepted for publication, *The American Journal of Maternal Child Nursing*.
3. Minnesota Hospital Association. (2011). Road Map to Preventing Retained Objects in Vaginal Deliveries.
4. Lutgendorf, M. A., Schindler, L. L., Hill, B. J., Magann, F. E., O'Boyle, D., J. (2011). Implementation of a Protocol to Reduce Occurrence of Retained Sponges After Vaginal Delivery. *Military Medicine*. 176(6). P702-704
5. The Joint Commission. (2013). Preventing Unintended Retained Foreign Objects. *The Joint Commission Sentinel Event Alert*. 51, p 1-5.
- 4-6. Garry, J. D., Asanjarani, S., Geiss, M. D. (2012). Policy for Prevention of a Retained Sponge After Vaginal Delivery. *Hindawai Publishing Corporation*. Vol 2012. doi:10.1155/2012/317856

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

**February 24, 2022 – 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 February 24, 2022.

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 Gleason
Director Adela Sanchez

Absent was Director Tracy Younger

Also present were:

Steven Dietlin, Chief Executive Officer
Candice Parras, Chief, Patient Care Services
Ray Rivas, Chief Financial Officer
Aaron Byzak, Chief External Affairs Officer
Dr. Gene Ma, Chief Medical Officer
Jennifer Paroly, Foundation President
Anna Aguilar, Vice President, Human Resources
Jeremy Raimo, SVP, Business Development
Susan Bond, General Counsel
Dr. Jamie Johnson, Chief of Staff
Jeffrey Scott, Board Counsel
Teri Donnellan, Executive Assistant

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

2. Approval of Agenda

It was moved by Director Chaya to approve the agenda as presented. Director Coulter seconded the motion. The motion passed unanimously (5-0-0-1) with Director Younger absent.

3. Pledge of Allegiance

Director Chavez led the Pledge of Allegiance.

4. Public Comments – Announcement

Chairperson Chavez read the Public Comments section listed on the February 24, 2022 Regular Board of Directors Meeting Agenda.

The following individuals requested to speak under Public Comments:

- Kathy Cronce, RN

5. January, 2022 Financial Statements – Ray Rivas, Chief Financial Officer

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

- Net Operating Revenue – \$199,675
- Operating Expense - \$212,092
- EBITDA - \$1,055
- EROE (\$6,482)

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

- Average Daily Census – 157
- Adjusted Patient Days – 65,300
- Surgery Cases – 3,796
- ED Visits – 29,377

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

- Net Operating Revenue – \$29,356
- Operating Expense - \$31,235
- EBITDA – (\$105)
- EROE – (\$1,172)

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

- Average Daily Census – 193
- Adjusted Patient Days – 10,203
- Surgery Cases – 469
- ED Visits – 4,257

Mr. Rivas commented on the length of stay (LOS) which is quite high and has a big impact on the financials.

6. New Business

- a) Consideration to approve Resolution 809, a Resolution of Tri-City Healthcare District Board of Directors Authorizing Execution and Delivery of a Loan and Security Agreement, Promissory Note and Certain Actions in Connection therewith for the California Health Facilities Financing Authority Non-designated public Hospital Bridge Loan Program.

Mr. Rivas explained the hospital previously participated in a program called PRIME which is a pay for performance program based on improving clinical outcomes for patients particularly in the MediCal population. Under PRIME the

funds were received ahead of time and the government matched those funds. The Quality Incentive Program (QIP) replaced PRIME and is also a program based on clinical outcomes and the hospital gets reimbursed on a pay for performance basis. However under QIP, monies are routed through the health plans and there is a 24-month delay on payment of these funds. The bridge loan presented today is for \$2.4 million which is 40% of the \$6 million the District is anticipating receiving through QIP and will allow the District to receive funds in approximately three weeks as opposed to 24 months. The loan is repaid as the funds come in from the health plans. Mr. Rivas stated he anticipates a second Resolution coming to the Board for the remaining 60% that the District anticipates receiving from QIP.

Chairperson Chavez questioned the impact on the budget. Mr. Rivas explained the bridge loan is a means of getting additional funding to help with cash flow however it does not affect the bottom line.

It was moved by Director Coulter to approve Resolution 809, a Resolution of Tri-City Healthcare District Board of Directors Authorizing Execution and Delivery of a Loan and Security Agreement, Promissory Note and Certain Actions in Connection therewith for the California Health Facilities Financing Authority Non-designated public Hospital Bridge Loan Program. Director Chaya seconded the motion.

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

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

7. Old Business – None

8. Chief of Staff

- a) Consideration of the February 2022 Credentialing Actions Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on February 21, 2022.

Dr. Johnson presented the Medical Staff and Allied Health Credentials. The Medical Staff credentials included five Initial Appointments, 16 Reappointments and five Resignations. Allied Health Professional credentials included one reinstatement from a nurse midwife from TruCare who decided to stay on at Tri-City.

It was moved by Director Chaya to approve the February 2022 Credentialing Actions Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on February 21, 2022. Director Coulter seconded the motion.

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

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

9. Consideration of Consent Calendar

It was moved by Director Coulter to approve the Consent Calendar as presented. Director Chaya seconded the motion.

Director Gleason pulled the Regular and Special Meeting Minutes of January 27, 2022.

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

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

10. Discussion of items pulled from Consent Calendar

Director Gleason stated she would be abstaining from the minutes of the Special and Regular meetings on January 27, 2022 due to her absence from the meetings.

It was moved by Director Coulter to approve the minutes of the Regular and Special meetings of January 27, 2022 as presented. Director Sanchez seconded the motion.

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

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

11. Comments by Members of the Public

Chairperson Chavez recognized Kathy Cronic, RN.

Ms. Cronic stated she was speaking today on behalf of union members to urge the Board to intervene with labor negotiations. She commented on a strike vote that she stated was taken on February 1st and a mediation scheduled for March 3rd. Ms. Cronic stated the union remains committed to breaks for nurses and prioritization of recruitment and retention.

12. Comments by Chief Executive Officer

Mr. Steve Dietlin, CEO reported QIP is the successor to the Prime program which is a pay for performance program based on improving outcomes for patients particularly in the MediCal population. He explained under QIP there is a 24-month delay on payment of these funds. The Resolution approved earlier this afternoon is a loan for 40% of the expected outcome for calendar year 2021.

Mr. Dietlin stated with surgeries down and length of stay (LOS) and acuity high it does have an impact on the finances of the facility. On a positive note, surgeries are picking back up and there have been fewer cancellations recently.

Mr. Dietlin reported requests for vaccinations have decreased however the hospital continues to offer weekly vaccination clinics on Tuesdays and Wednesdays. He stated the county's COVID inpatient numbers are also trending downward similarly from 1,400 a couple of weeks ago down to 513. Workforce remains a primary challenge and a few hospitals were forced to go on internal disaster; however, Tri-City was able to manage the COVID and non-COVID patient volume and did a tremendous job in doing so.

Mr. Dietlin provided an update on the 16-bed inpatient psych facility which will improve the continuum of care for Behavioral Health in our community. Community and informational meetings are currently taking place which will be followed by the Oceanside planning commission. Mr. Dietlin stated we hope to break ground within the next few months.

Mr. Dietlin provided an update on the Emergency Department remodel which will improve the look, function and flow of the Emergency Department. He stated the Foundation along with other philanthropic organizations have partnered with Tri-City together for the first time on this project. Mr. Dietlin stated we are currently awaiting CDPH approval in order to get the project moving.

Lastly, Mr. Dietlin reported Labor & Delivery has been transitioned. Last month, the Board approved a 24-7 laborist coverage agreement that goes into effect next week. Mr. Dietlin stated negotiations are continuing with community physicians and recruitments and in the coming weeks the Board will be asked to consider approval of a multi-physician office for long-term healthcare which will demonstrate our commitment to OB services.

13. Board Communications

Director Chaya commented on the pandemic wherein everyone has sacrificed one thing or another. She stated each and every day our team made sure the patients were taken care and the community had a place to go and it is imperative that the parties come together for the good of the hospital and our community.

14. Report from Chairperson

Chairperson Chavez stated he is pleased to hear that the bargaining teams will be participating in mediation next week and is hopeful an agreement can be reached. Chairperson Chavez commented that the Board respects and supports our nurses; however an agreement must be financially sustainable for the District as well.

Chairperson Chavez reported earlier this afternoon the Board held a Special Meeting regarding Redistricting. Zones 6 and 7 will be slightly impacted based on the proposed map.

Chairperson Chavez reported tomorrow the Board will hold a Special Meeting to Interview two stellar candidates for the Zone 5 vacancy.

In closing, Chairperson Chavez encouraged everyone to take time to reflect on world peace and taking care of our community.

15. Move to adjourn

It was moved by Director Coulter and seconded by Director Chaya to adjourn the meeting. The motion passed (5-0-0-1) with Director Younger absent.

16. There being no further business Chairperson Chavez adjourned the meeting at 4:11 p.m.

Rocky J. Chavez, Chairperson

ATTEST:

Gigi Gleason, Secretary

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

**February 24, 2022 – 1:00 o'clock p.m.
Via Teleconference**

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held via teleconference at 1:00 p.m. on February 24, 2022.

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

Director Rocky Chavez
Director Nina Chaya, M.D.
Director George Coulter
Director Gigi Gleason
Director Adela Sanchez

Absent was Director Tracy Younger

Also present were:

Steve Dietlin, Chief Executive Officer
Ray Rivas, Chief Financial Officer
Aaron Byzak, Chief External Affairs Officer
Candice Parras, Chief Patient Care Services
Jeff Scott, Board Counsel
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant

1. The Board Chairperson, Director Chavez, called the meeting to order at 1:00 p.m. via teleconference with attendance as listed above.

2. Public Comments – Announcement

Chairperson Chavez read the Public Comments section listed on the Board Agenda.

3. Approval of agenda.

It was moved by Director Coulter to approve the agenda as presented. Director Sanchez seconded the motion. The motion passed (4-0-0-2) with Director Younger absent.

4. Presentation by National Demographics Corporation and Public Hearing for Redistricting in accordance with Election Code 22001

Board Counsel Jeff Scott introduced Kay Vinson, Consultant with National Demographics Corporation (NDC) who is assisting the District with the redistricting process.

Ms. Vinson provided a PowerPoint Presentation that explained Redistricting is necessary because every 10 years the federal government conducts the Census, requiring review of zones to insure balanced population. From the 2010 census to the

2020 census, the current zones have become slightly out of balance with a 12.33% deviation. Ms. Vinson showed the existing boundaries map and demographics which reflected this deviation. Because the deviation is above 10%, approval of an updated map is required. Ms. Vinson then showed the minimal change map with the demographics resulting in a deviation of 6.89%. The zones impacted by the redistricting are Zones 6 and 7 which resulted in the least impact. There were no changes to Zone 1-5.

At the conclusion of Ms. Vinson's presentation she asked for input from Board members and the public now and the goal is to bring the proposed map back to the March 31st Regular meeting for adoption by the Board.

Chairperson Chavez asked Board members for comments.

Director Sanchez questioned if there are other maps available. Chairperson Chavez explained the proposed map was developed by the demographer and reflects the least impact, however board members may provide their comments or proposed map to the demographer for consideration.

Director Coulter had no questions.

Director Gleason stated she appreciates there are no apparent disruptions to any of the zones and is pleased with the proposed map.

Mr. Chavez opened the Public Hearing to receive public input related to the current district and map and zone boundaries.

Chairperson Chavez recognized Linda Slater. Ms. Slater questioned if the map would be available to study and provide feedback. Mr. Dietlin responded the District would be happy to provide the map and it is also available in the agenda packet on the District's website. Director Gleason also offered to meet with Ms. Slater.

Chairperson Chavez closed the Public Hearing.

Ms. Vinson stated that to meet the next public hearing scheduled for March 31, 2022, any changes or proposed maps must be received no later than March 15, 2022. The proposed minimal change proposed map is included in today's agenda packet and will be posted to the Tri-City website.

5. Adjournment

6. **It was moved by Director Chaya and seconded by Director Sanchez to adjourn the meeting at 1:34 p.m. The motion passed (5-0-0-1) with Director Younger absent.**

Rocky J. Chavez
Chairperson

ATTEST:

Gigi Gleason
Secretary

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

February 25, 2022 – 2:00 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 2:00 p.m. on February 24, 2022.

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

Director Rocky Chavez
Director Nina Chaya, M.D.
Director George Coulter
Director Gigi Gleason
Director Adela Sanchez

Absent was Director Tracy Younger

Also present were:

Steve Dietlin, Chief Executive Officer
Jeff Scott, Board Counsel
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant

1. The Board Chairperson, Director Chavez, called the meeting to order at 2:00 p.m. with attendance as listed above.

2. Public Comments – Announcement

Chairperson Chavez read the Public Comments section listed on the Board Agenda.

3. Approval of agenda.

It was moved by Director Coulter to approve the agenda as presented. Director Chaya seconded the motion. The motion passed (5-0-0-1) with Director Younger absent.

4. New Business

- a) Consideration of Appointment of New Board Member from Zone 5.

1. Introductory comments from the Board Chairman and interviews of the Applicants by the Board

Chairperson Chavez announced two candidates would be interviewed for the vacancy in Zone 5. Chairperson Chavez explained the interview process and ground rules to both Board members and applicants. The order of the candidates was based on a random draw.

Mr. Marvin Mizell was the first candidate interviewed by Board members. Each Board member asked the candidate a series of questions. At the conclusion of Mr. Mizell's interview he exited the meeting.

Mr. Jack Cumming was the second candidate to be interviewed by Board members. Each Board member asked Mr. Cumming the same series of questions.

At the conclusion of the interview Mr. Mizell rejoined the meeting with Mr. Cumming. Board members made comments and gave applicants the opportunity to speak.

Chairperson Chavez explained the nomination process.

Chairperson Chavez opened the floor for nominations. Director Sanchez nominated Marvin Mizell to fill the vacancy in Zone 5. Director Gleason nominated Jack Cumming to fill the vacancy in Zone 5.

Upon the close of nominations, paper ballots with each of the Directors' names on the ballots were distributed by Board Counsel. Each Board member was given the opportunity to write in the name of their selection. In keeping with the requirement for transparency and open voting, the completed ballots were handed back to Board Counsel, whereupon the voted selection of each board member was read aloud.

Board Counsel read the votes as follows:

Director Sanchez voted for Marvin Mizell
Director Gleason voted for Jack Cumming
Director Coulter voted for Jack Cumming
Director Chavez voted for Marvin Mizell
Director Chaya voted for Marvin Mizell

The vote was recorded 3-2 in favor of Marvin Mizell.

Chairperson Chavez gave Directors Gleason and Coulter the opportunity to change their vote.

The final vote was recorded 5-0 in favor of Marvin Mizell.

It was moved by Director Gleason to approve Resolution No. 808, a Resolution of the Board of Directors of the Tri-City Healthcare District Appointing Marvin E. Mizell to Serve as the Representative from Zone 5 on the Board of Directors until the Next District General Election in November 2022. Director Chaya seconded the motion. The vote passed unanimously (5-0-0-1) with Director Younger absent.

Directors congratulated Mr. Mizell. Board members also thanked Mr. Cumming for participating in today's interview process, noting both candidates were highly qualified.

Chairperson Chavez congratulated Mr. Mizell and invited him to be sworn in. Chairperson Chavez administered the Oath of Office to Mr. Marvin Mizell. The Oath was notarized and will be sent to the county for recording.

5. Adjournment

It was moved by Director Coulter and seconded by Director Chaya to adjourn the meeting at 3:15 p.m. The motion passed (5-0-0-1) with Director Younger absent.

Rocky J. Chavez
Chairperson

ATTEST:

Gigi Gleason
Secretary

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

**March 11, 2022 – 2:00 o'clock p.m.
Via Teleconference**

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 3:00 p.m. on March 11, 2022.

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

Director Rocky J. Chavez
Director Nina Chaya, M.D.
Director George W. Coulter
Director Gigi Gleason
Director Marvin E. Mizell
Director Adela Sanchez

Absent was Director Tracy Younger

Also present were:

Steve Dietlin, Chief Executive Officer
Jeff Scott, Board Counsel
Susan Bond, General Counsel
Candice Parras, Chief Patient Care Officer
Anna Aguilar, Vice President/Human Resources
Ray Rivas, Chief Financial Officer
Rick Crooks, Security Protection Agent

1. The Board Chairperson, Director Chavez, called the meeting to order at 3:00 p.m. with attendance as listed above.
2. Approval of agenda

It was moved by Director Coulter to approve the agenda as presented. Director Gleason seconded the motion. The motion passed (5-0-0-1) with Director Younger absent.

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

Chairperson Chavez made an oral announcement of the item listed on the March 11, 2022 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Labor Negotiators: Agency Negotiator: Chief Executive Officer; Employee Organization: California Nurses Association.

5. Motion to go into Closed Session

It was moved by Director Gleason and seconded by Director Coulter to go into Closed Session at 3:05 p.m. The motion passed (5-0-0-1) Nina Chaya with Director Younger absent.

6. At 4:50 p.m. the Board returned to Open Session with attendance as previously noted.
7. Report from Chairperson on any action taken in Closed Session.

The Board in closed session heard a report from the hospital negotiator. After Board discussion, the Board voted unanimously with Director Younger absent, to direct the hospital CEO to take appropriate action concerning the closed session matter.

8. Adjournment

It was moved by Director George Coulter and seconded by Director Sanchez to adjourn the meeting at 4:50 p.m. The motion passed (5-0-0-1) with Director Younger absent.

Rocky J. Chavez
Chairperson

ATTEST:

Gigi Gleason
Secretary

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

**March 23, 2022 – 5:00 o'clock p.m.
Via Teleconference**

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held via teleconference at 5:00 p.m. on March 23, 2022.

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 Gleason
Director Marvin E. Mizell
Director Adela Sanchez
Director Tracy M. Younger

Also present were:

Steve Dietlin, Chief Executive Officer
Ray Rivas, Chief Financial Officer
Candice Parras, Chief Patient Care Officer
Anna Aguilar, Vice President/Human Resources
Jeff Scott, Board Counsel
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant

1. The Board Chairperson, Director Chavez, called the meeting to order at 5:00 p.m. with attendance as listed above.
2. Approval of agenda

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

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

Chairperson Chavez made an oral announcement of the items listed on the March 23, 2022 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Labor Negotiators: Agency Negotiator: Chief Executive Officer; Employee Organization: California Nurses Association and Reports Involving Trade Secrets with a disclosure date of April 1, 2022.

5. Motion to go into Closed Session

It was moved by Director Coulter and seconded by Director Gleason to go into Closed Session at 5:05 p.m. The motion passed unanimously.

6. At 5:30 p.m. the Board returned to Open Session with attendance as previously noted.

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

The Board in closed session heard a report from the District's negotiator concerning the collective bargaining agreement with the California Nurses Association and took no action.

The Board also heard a report concerning hospital trade secrets and took no action.

8. Consideration to approve a successor collective bargaining agreement with the California Nurses Association (CNA) per the terms tentatively agreed to on March 17, 2022 and ratified by the California Nurses Association (CNA) Bargaining Unit on March 21, 2022.

It was moved by Director Coulter to approve a successor collective bargaining agreement with the California Nurses Association (CNA) per the terms tentatively agreed to on March 17, 2022 and ratified by the California Nurses Association (CNA) Bargaining Unit on March 21, 2022. Director Gleason seconded the motion.

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

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

9. Consideration to approve the formation of a 1206(b) OB/GYN ambulatory clinic and related documents including:

1. A professional services agreement between Kari Lynn Purcott, M.D. Inc. and Tri-City Healthcare District
2. A professional services agreement between Gwynneth Horner, M.D. and Tri-City Healthcare District
3. A Management Services Agreement between Tri-City Healthcare District and Physicians Datatrust.

It was moved by Director Younger to approve the formation of a 1206(b) OB/GYN ambulatory clinic and related documents including:

1. A professional services agreement between Kari Lynn Purcott, M.D. Inc. and Tri-City Healthcare District
2. A professional services agreement between Gwynneth Horner, M.D. and Tri-City Healthcare District
3. A Management Services Agreement between Tri-City Healthcare District and Physicians Datatrust.

Director Gleason seconded the motion.

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

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

8. Adjournment

It was moved by Director Sanchez and seconded by Director Coulter to adjourn the meeting at 5:40 p.m. The motion passed unanimously (7-0).

Rocky J. Chavez
Chairperson

ATTEST:

Gigi Gleason
Secretary



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
FY22	63.3	63.8	64.7	68.2	65.6	67.0	73.8	73.6					67.5	48-52
FY21	51.1	50.9	52.7	50.7	50.9	50.7	55.4	54.6	50.9	53.0	62.4	60.9	52.1	

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
FY22	102.6	96.5	99.7	93.7	95.8	94.8	92.0	92.3					95.9	75-100
FY21	107.1	103.1	101.1	99.6	99.6	92.7	93.9	94.6	94.0	100.5	103.5	98.1	99.0	

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
FY22	(\$900)	(\$1,011)	(\$733)	\$132	(\$1,441)	(\$1,358)	(\$1,172)	\$275					(\$6,207)	(\$4,581)
FY21	(\$1,489)	(\$923)	(\$930)	\$508	(\$175)	(\$881)	\$1,109	(\$245)	\$210	(\$554)	\$4,682	\$4,774	(\$3,027)	

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
FY22	-3.24%	-3.67%	-2.55%	0.43%	-5.23%	-4.87%	-3.99%	0.95%					-2.71%	-2.07%
FY21	-6.12%	-3.74%	-3.60%	1.78%	-0.64%	-3.12%	4.13%	-0.92%	0.73%	-1.89%	14.69%	15.52%	-1.42%	



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
FY22	\$190	\$76	\$340	\$1,190	(\$359)	(\$277)	(\$105)	\$1,343					\$2,398	\$4,844
FY21	(\$191)	\$291	\$302	\$1,738	\$879	\$332	\$2,344	\$935	\$1,383	\$422	\$5,782	\$5,855	\$6,630	

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
FY22	0.69%	0.28%	1.19%	3.85%	-1.30%	-1.00%	-0.36%	4.63%					1.05%	2.19%
FY21	-0.78%	1.18%	1.17%	6.09%	3.22%	1.18%	8.73%	3.50%	4.79%	1.44%	18.14%	19.03%	3.12%	

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
FY22	5.73	5.35	4.97	5.28	5.09	5.60	4.78	4.54					5.15	5.16
FY21	5.38	5.66	5.40	5.87	5.25	5.75	5.10	5.61	6.18	6.33	5.64	5.83	5.49	

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

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		
FY22	\$81.4	\$76.9	\$71.5	\$57.3	\$52.4	\$54.6	\$51.2	\$58.6						
FY21	\$59.5	\$57.4	\$83.5	\$76.9	\$71.3	\$68.5	\$71.4	\$75.4	\$83.2	\$67.3	\$59.6	\$86.8		



Building Operating Leases
Month Ending February 28, 2022

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)	34,544.61	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)	20,197.50	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)	17,002.20	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)	7,169.67	04/01/20	03/31/22	La Costa Urology 3907 Waring Road, Suite 4 Oceanside, CA 92056	7082
Mission Camino LLC 4350 La Jolla Village Drive San Diego, CA 92122 V#83757	Approx 4,508	\$1.75	(a)	24,825.82	09/01/21	08/31/31	Seaside Medical Group 115 N EL Camino Real, Suit A Oceanside, CA 92058	7094
500 W Vista Way, LLC & HFT Melrose P O Box 2522 La Jolla, CA 92038 V#81028	Approx 7,374	\$1.67	(a)	12,605.44	07/01/21	06/30/26	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)	39,237.00	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)	14,026.32	06/01/21	05/31/26	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	02/28/22	Pulmonary Specialists of NC 3231 Waring Court Suit D Oceanside, CA 92056	7088
Total				221,834.83				

(a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.



Education & Travel Expense
Month Ending February 2022

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
7680	STROKE CONFERENCE	12722EDU	292.00	81346	FADER, SEAN
7894	CHEMO	21222EDU	310.00	83629	WIEBOLDT BERNADETTE
8740	BCOP UPDATES	12022	190.00	84047	ANGELA ANSON
8740	ECC MONITORING	12822EDU	145.00	84048	JACQUELINE CUNNINGHAM
8740	ONC ONCC	21722EDU	103.00	33286	HITT, HEIDI

**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.