TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
June 30, 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: 874 4357 0100; Passcode: 641570

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

	Agenda Item	Time Allotted	Requestor
1	Call to Order	3 min.	Standard
2	Approval of agenda		
3	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	May, 2022 Financial Statement Results	10 min.	CFO
6	New Business – None	--	--
7	Old Business – None	--	--
8	Chief of Staff a) Consideration of June 2022 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on June 27, 2022.	5 min.	COS

Note: This certifies that a copy of this agenda was posted in the entrance to the Tri-City Medical Center at 4002 Vista Way, Oceanside, CA 92056 at least 72 hours in advance of the meeting. Any writings or documents provided to the Board members of Tri-City Healthcare District regarding any item on this Agenda is available for public inspection in the Administration Department located at the Tri-City Medical Center during normal business hours..

Note: If you have a disability, please notify us at 760-940-3348 at least 48 hours prior to the meeting so that we may provide reasonable accommodations.

	Agenda Item	Time Allotted	Requestor
9	Consideration of Consent Calendar ***Requested items to be pulled require a second*** (1) Approval of Resolution No. 815, A Resolution of the Tri-City Healthcare District Establishing the Appropriations Limit for Tri-City Healthcare District for the Fiscal Year Commencing July 1, 2022 and Ending June 30, 2023. (2) Approval of Resolution 816, 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. (3) Approval of the renewal of the Emergency Department On-Call Coverage Panel for Oral Maxillofacial Surgery with Brian Mudd, DDS, for a term of 24 months, beginning July 1, 2022 and ending June 30, 2024, with an annual cost of $182,500 for 2023 and $183,000 for 2024, and a total term cost of $365,500. (4) Approval of the renewal of an agreement with Mohammad Jamshidi-Nezhad, D.O.as the CVHI Vascular Surgery Medical Director for a term of 12 months, beginning July 1, 2022 and ending June 30, 2023, not to exceed an average of 12 hours per month or 144 hours annually, at an hourly rate of $210 for an annual and term cost of $30,240. (5) Approval of the renewal of an agreement with Ashish Kabra, M.D., as the CVHI Non-Invasive Cardiology Medical Director for a term of 12 months, beginning July 1, 2022 and ending June 30, 2023, not to exceed an average of 12 hours per month or 144 hours annually, at an hourly rate of $210 for an annual and term cost of $30,240. (6) Approval of the renewal of an agreement with Donald Ponec, M.D., as the Cardiovascular Health Institute Medical Director for a term of 12 months, beginning July 1, 2022 and ending June 30, 2023, not to exceed an average of 8 hours per month or 96 hours annually, at an hourly rate of $210, for an annual and term cost of $20,160. (7) Approval of the renewal of an agreement with Yuan Hwang Lin, M.D. as the Cardiothoracic Medical Director for a term of 12 -months, beginning July 1, 2022 and ending June 30, 2023, not to exceed an average of 12 hours per month or 144 hours annually, at an hourly rate of $210 for an annual and term cost of $30,240. (8) Approval of the renewal of an agreement with David Spiegel, M.D. as the Cardiovascular Health Institute Invasive Cardiology Medical Director for a term of Coverage Physician for a term of 12 months, beginning July 1, 2022 and ending June 30, 2023, not to exceed an average of 12 hours per month or 144 hours annually, at an hourly rate of $210 for an annual and term cost of $30,240. (9) Approval of the renewal of an agreement with Yuan Lin, M.D. as a member of the Cardiovascular Health Institute – Operations Committee for a term of 12 months, beginning July 1, 2022 and ending June 30, 2023, not to exceed two hours per month at an hourly rate of $210, for an annual and term cost of $5,040.00.	10 min.	Standard

	Agenda Item	Time Allotted	Requestor
	(10)Approval of the renewal of an agreement with David Spiegel, M.D., as a member of the Cardiovascular Health Institute – Operations Committee for a term of 12 months, beginning July 1, 2022 and ending June 30, 2023, not to exceed two hours per month at an hourly rate of $210 for an annual and term cost of $5,040.00.		
	(11) Approval of the renewal of an agreement with Mohammad Jamshidi-Nezhad, D.O., as a member of the Cardiovascular Health Institute – Operations Committee for a term of 12 months, beginning July 1, 2022 and ending June 30, 2023, not to exceed two hours per month at an hourly rate of $210 for an annual and term cost of $5,040.00.		
	(12) Approval of the renewal of an agreement with Drs. Kenneth Carr, David Spiegel, Ashish Kabra, Karim El-Sherief, Mohmmad Pashmforoush, Samani Pargol, Aaron Yung, George Clements, Anitha Rajamanickam, and Hanh Bui for the Cardiology Physician EKG and Echocardiology Panel Agreement for a term of 12 months starting July 1, 2022 AND ending on June 30, 2023, for an annual and total term cost not to exceed $216,320.		
	(13) Approval of the renewal of an agreement with Andrew Deemer, M.D., as a member of the Cardiovascular Health Institute- Quality Committee for a term of 12 months, beginning July 1, 2022 and ending June 30, 2023, not to exceed two hours per month at an hourly rate of $210 for an annual and term cost of $5,040.		
	(14)Approval of the renewal of an agreement with Ashish Kabra, M.D. as Cardiovascular Health Institute – Quality Committee member for a term of 12 months, beginning July 1,2022 and ending June 30, 2023, not to exceed two hours per month at an hourly rate of $210 for an annual term cost of $5,040.		
	(15) Approval of the renewal of an agreement with Donald Ponec, M.D. as Cardiovascular Health Institute – Quality Committee member for a term of 12 months, beginning July 1, 2022 and ending June 30, 2023, not to exceed two hours per month, at an hourly rate of $210 for an annual and term cost of $5,040.		
	(16) Approval of the renewal of an agreement with South Coast Perfusion, Inc. for a term of 24 months, beginning July 1, 2022 and ending June30, 2024, for an annual cost of $444,000 and a total term cost of $888,000.		
	(17) Approval of the renewal of an agreement with Andrew R. Deemer, M.D., and Mohammad Jamshidi-Nehaddd, D.O. as the Vascular Surgery Emergency Department Call Coverage physicians for a term of 24 months, beginning July 1, 2022 and ending June 30, 2024, for an annual cost of $365,000 in FY 2023 and $366,000 in FY2024, and a total term cost of $731,000.		
	(18) Approval of an agreement with North County Neonatology Specialists as the NICU Call Coverage physicians and to provide NICU Medical Directorship for a term of 36 months, beginning July 1, 2022 and ending June 30, 2025, for an annual cost of $433,250 and a 36-month total term cost not to exceed $1,299,750.		

	Agenda Item	Time Allotted	Requestor

(19) Approval of the renewal of the Service Agreement with Intuitive Surgical, Inc., for the da Vici Xi System for a term of 48 months, beginning May 31, 2022 and ending May 30, 2026 for a total cost for the term of $616,000.00.

(20) Approval of the renewal of an agreement with Aaron Yung, M.D., as the Supervising Physician for Cardiac Rehab for a term of 36 months beginning June 1, 2022 and ending May 31, 2025, not to exceed an average of 44 hours per month or 528 hours annually, at an hourly rate of $148.30 for an annual cost of $78,302.40 and a total cost for the term of $234,907.20.

(21) Approval of an agreement with Sharon Slowik, M.D. as the Home Health Coverage Physician for a term of 24 months, beginning May 1, 2022 and ending April 30, 2024, not to exceed an average of 20 hours per month or 240 hours annually, at an hourly rate of $169 for an annual cost of $40,560 and a total cost for the term of $81,120.

(22) Approval of the 2nd Amendment for Equipment Sensor with Masimo Corporation for a term of 60 months, beginning July 1, 2022 and ending June 30, 2027, for an annual cost of $451,327.56 and a total cost for the term of $2,256,637.75.

(23) Approval of an agreement with Michael J. Ammar, M.D., Heather Chen, M.D., Jim Davies, M.D., Alexander S. Foster, M.D., Kevin Garff, M.D., Jessica Gomez, M.D., Logan Haak, M.D., Srinivas Iyengar, M.D., Atul Jain, M.D., Eric Johnston, M.D, Peter Krall, M.D., Vincent Q. Nguyen, M.D., Neeta Varshney, M.D., Maulik Zaveri, M.D., and Charles Zenzen, M.D., as the Ophthalmology ED Call Coverage physicians for a term of 12 months, beginning July 1, 2022 and ending June 30, 2023, for an annual and total term cost of $127,750.

(24)Approval of an agreement with MedPro International for a Laboratory Staffing Agreement for a term of 36 months, beginning July 01, 2022 and ending June 30, 2025 for an annual cost of $707,200, and a total cost for the term of $2,121,600.

(25)Approval of an agreement with Synergy Health Partners as the General Surgery Hospitalist Coverage physicians for a term of 24 months, beginning July 1, 2022 and ending June 30, 2024, for an annual cost not to exceed $990,440 and a total term cost not to exceed $1,980,880.

(26)Approval of the Lease Agreement Renewal with 3905 Waring Road, Oceanside, CA for an additional twenty-five (25) month term beginning July 1, 2022 and ending July 31, 2024 for a monthly expense of $34,930.23, for a total expense for the twenty-five (25) month term of $854,618.13.

(27) Administrative Committees

A. Policies

1. Patient Care Services Policies & Procedures

a. Care for Recalcitrant Children Policy

b. Discharge of Patients AMA Policy

	Agenda Item	Time Allotted	Requestor
	c. Nursing Students Advanced Practice Policy d. Nutritional Screening Care & Assessment for Infants, Pediatrics & Adolescents Policy (DELETE) e. Patient Safety Plan f. Pronouncement of Death Procedure g. Reporting Suspected Dependent Adult/Elder Abuse/Neglect h. Wearable Defibrillator (Life Vest) **2. Administrative 200 District Operations; 300 Patient Care; 600 Information Technology** a. Assignment of Medical Record Numbers and Standard Naming Guidelines 390 **3. Employee Health & Wellness** a. Immunization b. Hepatitis A Vaccine (DELETE) c. Hepatitis B Vaccine (DELETE) **4. Food & Nutrition** a. Safety in Food Nutrition Policy **5. Home Care** a. Administrative On Call Supervision b. Agency Evaluation c. Budget d. Contracted Services e. Dress Cod f. Elsevier Clinical Index of Nursing Skills g. Group of Professional Personnel (DELETE) h. Home Health Advance Beneficiary Notice (HHABN) i. Leadership (DELETE) j. Mileage Expense Reimbursement k. Notice of Medicare Non Coverage HMO l. Orientation and Competency Validation m. Patient Rights and Responsibilities n. Philosophy o. Risk Management and Patient Safety Reporting p. Scope of Services – Description of Setting q. Staff Safety r. Staffing s. Vacations (Delete) t. Certified Home Health Aide Oversight u. Emergent Care v. Notice of Medicare Provider Non Coverage w. Outcome and Assessment Data Set Submission (OASIS) x. Patient Complaint and Grievances y. Patient Education z. Policy Development aa. Recertification		

	Agenda Item	Time Allotted	Requestor
	bb. Staff Development **6. Pharmacy** a. Automatic Dose Rounding b. Clinical Intervention/Activity Documentation c. Decreasing Medication Errors d. Medication Preparation e. Pharmacy and Therapeutics Committee f. Receiving and Tracking Narcotic Pump Refills Prepared by Outside Vendors (28) Minutes a) May 26, 2022, Special Meeting (29) Meetings and Conferences – None (30) Dues and Memberships - None (31) Reports (a) Dashboard – Included (b) Lease Report – (May, 2022) (c) Reimbursement Disclosure Report – (May, 2022)		
10	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
11	Comments by Members of the Public NOTE: Per Board Policy 19-018, members of the public may have three (3) minutes, individually and 15 minutes per subject, to address the Board on any item not on the agenda.	5-10 minutes	Standard
12	Comments by Chief Executive Officer	5 min.	Standard
13	Board Communications (three minutes per Board member)	18 min.	Standard
14	Report from Chairperson	3 min.	Standard
15	Total Time Budgeted for Open Session	1 hour	
16	Adjournment		

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
June 8, 2022

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 7/01/2022 – 6/30/2024)

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 7/01/2022 through 6/30/2024:

- **CAMBRIDGE, Christine MD/OB/GYN (TeamHealth)**
- **FAIQ, Nadia MD/Emergency Medicine (TeamHealth)**
- **FALABELLA, Andres MD/Anesthesia (ASMG)**
- **PARKER, John MD/Neurology (Real Time Neuromonitoring)**
- **SCHWERKOSKE, John MD/Oncology (The Oncology Institute)**
- **SHIRKA, Romina DO/Neurology (Real Time Neuromonitoring)**
- **STOYCHEFF, Lindsey DO/OB/GYN (Kaiser)**
- **SUPAT, Benjamin MD/Emergency Medicine (TeamHealth)**
- **TOLEN, Jennifer MD/OB/GYN (Kaiser)**
- **ZAWADA, Nicole MD/Emergency Medicine (TeamHealth)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 1 of 3
June 08, 2022

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 7/01/2022 – 6/30/2024)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 7/01/2022 through 6/30/2024, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- **AHMED, Mohammed, MD/Psychiatry/Refer and Follow**
- **BHARNE, Anjali, MD/Oncology/Active**
- **BOONJINDASUP, Aaron, MD/Urology/Active**
- **CHIANG, Pengta, MD/Emergency Medicine/Active**
- **CHU, James, MD/Pediatric Cardiology/Active Affiliate**
- **CLANCY, Tara, DO/Internal Medicine/Refer and Follow**
- **EL-SHERIEF, Karim, MD/ Cardiology/Active**
- **EVTIMOV, Stoimen, MD/Internal Medicine/Active**
- **FOSTER, Alexander, MD/Ophthalmology/Active Affiliate**
- **GOLD, Evan, DMD/Oral & Maxillofacial Surgery/Refer and Follow**
- **HERGESHEIMER, Charles, MD/Internal Medicine/Refer and Follow**
- **KARANIKKIS, Christos, DO/Obstetrics & Gynecology/Active**
- **LIU, Richard, MD/Otolaryngology/Provisional**
- **MILLER, Jeffrey, MD/Diagnostic Radiology/Active**
- **MOVAHHEDIAN, Hamid, MD/Neonatology/Active**
- **NASIRI, Arian, MD/Interventional Radiology/Provisional**
- **NASSERY, Kristen, MD/General Surgery/Provisional**
- **NAUDIN, Veronica, MD/Pediatrics/Active**

- **PENRY, Jackson, MD/Diagnostic Radiology/Active**
- **PERKINS, Rachel, MD/Pediatrics/Active**
- **PHAM, Martin, MD/Neurological Surgery/Active**
- **POLLACK, Melanie, DO/Emergency Medicine/Active**
- **SHETH, Manish, MD/Psychiatry/Active**
- **SHUMPERT, Stephen, MD/Anesthesiology/Provisional**
- **SOUZA, Victor, MD/Internal Medicine/Active**
- **SUBRAMANIAN, Rupa, MD/Oncology/Active**
- **WADHWA, Ashish, MD/Otolaryngology/Active Affiliate**

REINSTATEMENT: (Effective Dates 07/01/2020 – 06/30/2022)

Any items of concern will be "red" flagged in this report. The following application was recommended for reinstatement to the medical staff office effective 07/01/2020 through 06/30/2022, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- **HERGESHEIMER, Charles, MD/Internal Medicine/Refer and Follow**

RESIGNATIONS: (Effective date 6/30/2022 unless otherwise noted)

Automatic Resignation:

- **MATTHEWS, Oscar, MD/Cardiology**

Voluntary:

- **ESFANDIARI, Raheleh, MD/Obstetrics & Gynecology**
- **GARNER, Darin, MD/Emergency Medicine**
- **LANDRETH, Riley, DO/Anesthesiology**
- **LIU, Wilson, MD/Family Medicine**

Attachment B

- **PAZ, Alejandro, MD/Family Medicine**
- **SHELLENBERGER, Jeffry, MD/Emergency Medicine**
- **SMITH, David, DDS/Oral & Maxillofacial Surgery**
- **STUPIN, Jeremy, MD/Radiology**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
June 8, 2022

AUTOMATIC RELINQUISHMENT OF PRIVILEGES

The following practitioners were given six months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and therefore the listed privileges will automatically expire as of **July 1, 2022**

- **FARNSWORTH, William, MD** — **Neurology**
- **NASSERY, Kristen, MD** — **General Vascular Surgery**

ADDITIONAL PRIVILEGE REQUEST (Effective 07/01/2022, unless otherwise specified)

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

- **LUO, Ran MD** — **General Surgery**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
June 8, 2022

PROCTORING RECOMMENDATIONS

Any items of concern will be "red" flagged in this report.

- **SHEREV, Dimitri, MD** — **Cardiology**
- **RAJAMANICKAM, Anitha, MD** — **Cardiology**

RESOLUTION NO. 815

A RESOLUTION OF THE BOARD OF DIRECTORS OF TRI-CITY HEALTHCARE DISTRICT ESTABLISHING THE APPROPRIATIONS LIMIT FOR TRI-CITY HEALTHCARE DISTRICT FOR THE FISCAL YEAR COMMENCING JULY 1, 2022 AND ENDING JUNE 30, 2023 IN ACCORDANCE WITH ARTICLE XIII B OF THE CONSTITUTION OF THE STATE OF CALIFORNIA; CODE OF THE STATE OF CALIFORNIA

WHEREAS, Section 1 of Article XIII B of the Constitution of the State of California provides that the total annual appropriations of each local government shall not exceed the appropriations limit of such entity of government for the prior year, adjusted for changes in the cost of living and population, subject to certain specified exceptions in said Article; and

WHEREAS, Section 8 of Article XIII B of the Constitution of the State of California defines "Appropriations subject to limitation" of an entity of local government as "any authorization to expand during a fiscal year the proceeds of taxes levied by or for that entity and the proceeds of state subventions to that entity" (other than subventions made pursuant to new programs or services mandates by the State Legislature) "exclusive of refunds to taxes"; and

WHEREAS, Section 7910 of the Government Code of the State of California provides that each year the governing body of each local jurisdiction shall, by resolution, establish its appropriations limit for the following fiscal year pursuant to Article XIII B of the Constitution of the State of California at a regularly scheduled meeting or noticed special meeting; and

WHEREAS, the documentation used in determining the appropriations limit adopted in this resolution has been available to the public for fifteen (15) days prior to the adoption of this resolution.

NOW, THEREFORE, THE BOARD OF DIRECTORS OF TRI-CITY HEALTHCARE DISTRICT DOES HEREBY RESOLVE AND ORDER AS FOLLOWS:

1. The appropriations limit for TRI-CITY HEALTHCARE DISTRICT, pursuant to Article XIII B of the Constitution of the State of California for the fiscal year commencing July 1, 2022 and ending June 30, 2023 is not to exceed $17,951,869.00

2. In accordance with Section 2, Article XIII B of the Constitution of the State of California, any revenues received by TRI-CITY HEALTHCARE DISTRICT in excess of that

amount, which is appropriated in compliance with Article XIII B of the Constitution of the State of California, during the fiscal year shall be returned by a revision of tax rates or fee schedules within the next two subsequent fiscal years.

ADOPTED, SIGNED AND APPROVED this 30th day of June, 2022.

Rocky J. Chavez, Chairperson of the
TRI-CITY HEALTHCARE DISTRICT and
of the Board of Directors thereof

ATTEST:

Gigi S. Gleason, Secretary of the
TRI-CITY HEALTHCARE DISTRICT
and of the Board of Directors thereof

STATE OF CALIFORNIA)
)
COUNTY OF SAN DIEGO) **ss.**

I, Tracy M. Younger, Secretary of TRI-CITY HEALTHCARE DISTRICT and of the Board of Directors thereof, do hereby certify that the foregoing Resolution was duly adopted by the Board of Directors of said District at a Regular Meeting of said Board held on the 30th day of June, 2022, and that it was adopted by the following vote:

AYES:	**DIRECTORS:**	**Coulter, Chavez, Chaya, Gleason, Mizell, Sanchez and Younger**
NOES:	**DIRECTORS:**	**None**
ABSTAIN:	**DIRECTORS:**	**None**
ABSENT:	**DIRECTORS:**	**None**

Gigi S. Gleason, Secretary
of the TRI-CITY HEALTHCARE DISTRICT
and of the Board of Directors thereof

RESOLUTION NO. 816

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 June 30, 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

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: June 30, 2022
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – ORAL/MAXILLOFACIAL SURGERY

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

Vendor's Name: Brian Mudd, D.D.S.

Area of Service: Emergency Department On-Call: Oral Maxillofacial Surgery

Term of Agreement: 24 months, Beginning, July 1, 2022 - Ending, June 30, 2024

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Increase from $350 to $500/24-hours

Rate/Day	Term	Annual Cost
$500	FY2023 FY2024 (leap year)	$182,500 $183,000
	Total Term Cost	**$365,500**

Description of Services/Supplies:

- Provide 24/7 patient coverage for all Oral Maxillofacial Surgery 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:		Yes	X	No
Budgeted Item:	X	Yes		No

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

Motion:

I move that the TCHD Board of Directors authorize the renewal of the Emergency Department On-Call Coverage Panel for Oral-Maxillofacial Surgery with Brian Mudd, D.D.S., for a term of 24 months, beginning July 1, 2022 and ending, June 30, 2024, with an annual cost of $182,500 for 2023 and $183,000 for 2024, and total term cost of $365,500.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: June 30, 2022
PHYSICIAN AGREEMENT for Cardiovascular Health Institute Vascular Surgery Medical Director

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

Physician's Name: Mohammad Jamshidi-Nezhad, D.O. - Vascular Surgery, Medical Director

Area of Service: Cardiovascular Health Institute

Term of Agreement: 12 months, Beginning, July 1, 2022 – Ending, June 30, 2023

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 Month (Term) Cost
$210	12	144	$2,520	$30,240	$30,240

Position Responsibilities:

- Physician shall serve as Medical Director and shall be responsible for the medical direction of the listed specialty area and the performance of the other medical administrative service as outlined in the previously approved Co-Management Agreement for the Institute.

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: Eva England, Sr. Director-Cardiovascular Service Line

Motion:

I move that the TCHD Board of Directors authorize the renewal of an agreement with Mohammad Jamshidi-Nezhad, D.O. as the CVHI Vascular Surgery Medical Director for term of 12 months, beginning July 1, 2022 and ending June 30, 2023, not to exceed an average 12 hours per month or 144 hours annually, at an hourly rate of $210 for an annual and term cost of $30,240.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: June 30, 2022
PHYSICIAN AGREEMENT for CVHI Non-Invasive Cardiology Medical Director

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

Physician's Name: Ashish Kabra, M.D. – Non-Invasive Cardiology, Medical Director

Area of Service: Cardiovascular Health Institute

Term of Agreement: 12 months, Beginning, July 1, 2022 – Ending, June 30, 2023

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 Month (Term) Cost
$210	12	144	$2,520	$30,240	$30,240

Position Responsibilities:

- Physician shall serve as Medical Director and shall be responsible for the medical direction of the listed specialty area and the performance of the other medical administrative service as outlined in the previously approved Co-Management Agreement for the Institute.

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: Eva England, Sr. Director-Cardiovascular Service Line

Motion:

I move that the TCHD Board of Directors authorize the renewal of an agreement Ashish Kabra, M.D. as the CVHI Non-Invasive Cardiology Medical Director for term of 12 months, beginning July 1, 2022 and ending June 30 2023, not to exceed an average 12 hours per month or 144 hours annually, at an hourly rate of $210 for an annual and term cost of $30,240.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: June 30, 2022
PHYSICIAN AGREEMENT for Cardiovascular Health Institute Medical Director

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

Physician's Name: Donald Ponec, M.D., Cardiovascular Health Institute Medical Director

Area of Service: Cardiovascular Health Institute

Term of Agreement: 12 months, Beginning, July 1, 2022 – Ending, June 30, 2023

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 Month (Term) Cost
$210	8	96	$1,680	$20,160	$20,160

Position Responsibilities:

- Physician shall serve as the Institute Medical Director and shall be responsible for the medical direction of the Institute and the performance of the other medical administrative service as outlined in the previously approved Co-Management Agreement for the Institute.

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: Eva England, Sr. Director-Cardiovascular Service

Motion:

I move that the TCHD Board of Directors authorize the renewal of an agreement with Donald Ponec, M.D. as the Cardiovascular Health Institute Medical Director for term of 12 months, beginning July 1, 2022 and ending June 30, 2023, not to exceed an average 8 hours per month or 96 hours annually, at an hourly rate of $210 for an annual and term cost of $20,160.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: June 30, 2022
PHYSICIAN AGREEMENT for Cardiovascular Health Institute Cardiothoracic Medical Director

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

Physician's Name: Yuan Hwang Lin, M.D. - Cardiothoracic Medical Director

Area of Service: Cardiovascular Health Institute

Term of Agreement: 12 months, Beginning, July 1, 2022 – Ending, June 30, 2023

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 Month (Term) Cost
$210	12	144	$2,520	$30,240	$30,240

Position Responsibilities:

- Physician shall serve as Medical Director and shall be responsible for the medical direction of the listed specialty area and the performance of the other medical administrative service as outlined in the previously approved Co-Management Agreement for the Institute.

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: Eva England, Sr. Director-Cardiovascular Service Line

Motion:

I move that the TCHD Board of Directors authorize the renewal of an agreement with Yuan Hwang Lin, M.D. as a Cardiothoracic Medical Director for term of 12 months, beginning July 1, 2022 and ending June 30 2023, not to exceed an average 12 hours per month or 144 hours annually, at an hourly rate of $210 for an annual and term cost of $30,240.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: June 30, 2022
PHYSICIAN AGREEMENT for Cardiovascular Health Institute Invasive Cardiology Medical Director

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

Physician's Name: David Spiegel, M.D. - Invasive Cardiology, Medical Director

Area of Service: Cardiovascular Health Institute

Term of Agreement: 12 months, Beginning, July 1, 2022 – Ending, June 30, 2023

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 Month (Term) Cost
$210	12	144	$2,520	$30,240	$30,240

Position Responsibilities:

- Physician shall serve as Medical Director and shall be responsible for the medical direction of the listed specialty area and the performance of the other medical administrative service as outlined in the previously approved Co-Management Agreement for the Institute.

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: Eva England, Sr. Director-Cardiovascular Service Line

Motion:

I move that the TCHD Board of Directors authorize the renewal of an agreement with David Spiegel, M.D. as the Cardiovascular Health Institute Invasive Cardiology Medical Director for term of 12 months, beginning July 1, 2022 and ending June 30 2023, not to exceed an average 12 hours per month or 144 hours annually, at an hourly rate of $210 for an annual and term cost of $30,240

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: June 30, 2022
PHYSICIAN AGREEMENT for Cardiovascular Health Institute – Operations Committee

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

Vendor's Name: Yuan Hwang Lin, M.D.

Area of Service: Cardiovascular Health Institute – Operations Committee

Term of Agreement: 12 months, Beginning, July 1, 2022 – Ending, June 30, 2023

Maximum Totals:

Rate/Hour	Hours Per Month	Hours per Year	Monthly Cost	Annual Cost	Total Term Cost
$210	2	24	$420	$5,040	$5,040

Description of Services/Supplies:

- Physician shall serve as an Operations Committee Member and shall be responsible for the services as outlined in the previously approved Co-Management Agreement for the Institute

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: Eva England, Sr. Director-Cardiovascular Service Line

Motion:
I move that the TCHD Board of Directors authorize the renewal of an agreement with Yuan Hwang Lin, M.D. as a member of the Cardiovascular Health Institute –Operations Committee for a term of 12 months, beginning July 1, 2022 and ending, June 30, 2023, not to exceed 2 hours per month at an hourly rate of $210 for an annual and term cost of $5,040.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: JUNE 30, 2022
PHYSICIAN AGREEMENT for Cardiovascular Health Institute – Operations Committee

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

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

Area of Service: Cardiovascular Health Institute – Operations Committee

Term of Agreement: 12 months, Beginning, July 1, 2022 – Ending, June 30, 2023

Maximum Totals:

Rate/Hour	Hours Per Month	Hours per Year	Monthly Cost	Annual Cost	Total Term Cost
$210	2	24	$420	$5,040	$5,040

Description of Services/Supplies:

- Physician shall serve as an Operations Committee Member and shall be responsible for the services as outlined in the previously approved Co-Management Agreement for the Institute

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: Eva England, Sr. Director-Cardiovascular Service Line

Motion:
I move that the TCHD Board of Directors authorize the renewal of an agreement with David Spiegel, M.D. as a member of the Cardiovascular Health Institute – Operations Committee for a term of 12 months, beginning July 1, 2022 and ending, June 30, 2023, not to exceed 2 hours per month at an hourly rate of $210 for an annual and term cost of $5,040.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: June 30, 2022
PHYSICIAN AGREEMENT for Cardiovascular Health Institute – Operations Committee

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

Vendor's Name: Mohammad Jamshidi-Nezhad, M.D.

Area of Service: Cardiovascular Health Institute – Operations Committee

Term of Agreement: 12 months, Beginning, July 1, 2022 – Ending, June 30, 2023

Maximum Totals:

Rate/Hour	Hours Per Month	Hours per Year	Monthly Cost	Annual Cost	Total Term Cost
$210	2	24	$420	$5,040	$5,040

Description of Services/Supplies:

- Physician shall serve as an Operations Committee Member and shall be responsible for the services as outlined in the previously approved Co-Management Agreement for the Institute

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: Eva England, Sr. Director-Cardiovascular Service Line

Motion:
I move that the TCHD Board of Directors authorize the renewal of agreement with Mohammad Jamshidi-Nezhad, D.O. as a member of the Cardiovascular Health Institute – Operations Committee for a term of 12 months, beginning July 1, 2022 and ending June 30, 2023, not to exceed 2 hours per month at an hourly rate of $210 for an annual and term cost of $5,040.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: June 30, 2022
PHYSICIAN EKG/ECHOCARDIOGRAM PANEL AGREEMENT RENEWAL for COVERAGE

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

Physician's Name: Drs. Kenneth Carr, David Spiegel, Ashish Kabra, Karim El-Sherief, Mohmmad Pashmforoush, Samani Pargol, George Clemens, Anitha Rajamanickam, Aaron Yung, and Hanh Bui

Area of Service: Cardiology

Term of Agreement: 12 months, Beginning, July 1, 2022 – Ending, June 30, 2023

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

Weekly Cost Not to Exceed	Total Term Cost Not to Exceed
$4,160	$216,320

Position Responsibilities:

- Panel Physician shall interpret echocardiographic studies of unassigned patients for which the attending physician does not specify an interpreting cardiologist.
- Electrocardiograms are to be interpreted twice daily on weekdays (Monday-Friday) and at least once per day on weekends (Saturday, Sunday or holidays).
- The final report for all echocardiograms is to be dictated within twenty-four (24) hours of the performance of the study.
- For exercise of pharmacological stress test, if the scheduled panel physician cannot be available within 15 minutes of the scheduled start time to personally supervise the test, it is that panel physician's responsibility to assure that another cardiologist will do so. The final report shall be dictated on the day of the study.

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: Eva England, Sr. Director-Cardiovascular Service Line

Motion:

I move that the TCHD Board of Directors authorize the renewal of an agreement with Drs. Kenneth Carr, David Spiegel, Ashish Kabra, Karim El-Sherief, Mohmmad Pashmforoush, Samani Pargol, Aaron Yung, George Clements, Anitha Rajamanickam, and Hanh Bui for the Cardiology Physician EKG and Echocardiology Panel Agreement for a term of 12 months beginning July 1, 2022 and ending on June 30, 2023, for an annual and total term amount not to exceed $216,320.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: June 30, 2022
PHYSICIAN AGREEMENT for Cardiovascular Health Institute – Quality Committee

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

Vendor's Name: Andrew Deemer, M.D.

Area of Service: Cardiovascular Health Institute – Quality Committee

Term of Agreement: 12 months, Beginning, July 1, 2022 – Ending, June 30, 2023

Maximum Totals:

Rate/Hour	Hours Per Month	Hours per Year	Monthly Cost	Annual Cost	Total Term Cost
$210	2	24	$420	$5,040	$5,040

Description of Services/Supplies:

- Physician shall serve as a Quality Committee Member and shall be responsible for the services as outlined in the previously approved Co-Management Agreement for the Institute.

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: Eva England, Sr. Director-Cardiovascular Service Line

Motion:
I move that the TCHD Board of Directors authorize the renewal of an agreement with Andrew Deemer, M.D. as a member of the Cardiovascular Health Institute – Quality Committee for a term of 12 months, beginning July 1, 2022 and ending, June 30, 2023, not to exceed 2 hours per month at an hourly rate of $210 for an annual and term cost of $5,040.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: June 30, 2022
PHYSICIAN AGREEMENT for Cardiovascular Health Institute – Quality Committee

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

Vendor's Name: Ashish Kabra, M.D.

Area of Service: Cardiovascular Health Institute – Quality Committee

Term of Agreement: 12 months, Beginning, July 1, 2022 – Ending, June 30, 2023

Maximum Totals:

Rate/Hour	Hours Per Month	Hours per Year	Monthly Cost	Annual Cost	Total Term Cost
$210	2	24	$420	$5,040	$5,040

Description of Services/Supplies:

- Physician shall serve as a Quality Committee Member and shall be responsible for the services as outlined in the previously approved Co-Management Agreement for the Institute

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: Eva England, Sr. Director-Cardiovascular Service Line

Motion:

I move that the TCHD Board of Directors authorize the renewal of an agreement with Ashish Kabra, M.D. as Cardiovascular Health Institute – Quality Committee member for a term of 12 months, beginning July 1, 2022 and ending June 30, 2023, not to exceed 2 hours per month at an hourly rate of $210 for an annual and term cost of $5,040.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: June 30, 2022
PHYSICIAN AGREEMENT for Cardiovascular Health Institute – Quality Committee

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

Vendor's Name: Donald Ponec, M.D.

Area of Service: Cardiovascular Health Institute – Quality Committee

Term of Agreement: 12 months, Beginning, July 1, 2022 – Ending, June 30, 2023

Maximum Totals:

Rate/Hour	Hours Per Month	Hours per Year	Monthly Cost	Annual Cost	Total Term Cost
$210	2	24	$420	$5,040	$5,040

Description of Services/Supplies:

- Physician shall serve as a Quality Committee Member and shall be responsible for the services as outlined in the previously approved Co-Management Agreement for the Institute.

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: Eva England, Director-Cardiovascular Service

Motion:
I move that the TCHD Board of Directors authorize the renewal of an agreement with Donald Ponec, M.D. as Cardiovascular Health Institute – Quality Committee member for a term of 12 months, beginning July 1, 2022 and ending June 30, 2023, not to exceed 2 hours per month, at an hourly rate of $210 for an annual and term cost of $5,040.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: June 30, 2022
SERVICE AGREEMENT RENEWAL

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

Vendor's Name: South Coast Perfusion Associates, Inc

Area of Service: Surgery-OR

Term of Agreement: 24 months, Beginning, July 1, 2022 – Ending, June 30, 2024

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$37,000	$444,000	$888,000

Description of Services/Supplies:

- Perform perfusion services at TCMC Hospital to include: Cardiopulmonary Perfusion, Intra-Aortic Balloon Pump, Ventricular Assist Device, Extracorporeal Membrane Oxygenation, and Auto-Transfusion. Contractor shall provide such services within 30 minutes from the time of call from the Hospital to contractor.

- Contractor shall provide quarterly QA/QI reports, in conjunction with Hospital Medical Staff (cardiac surgeons), attend and participate in Division meetings at least quarterly, designate a lead perfusionist assigned to Hospital, complete all required reporting forms, including STS forms relating to cardiac surgeries.

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: (Donna Ferguson, Interim Director PeriOp Services/ Candice Parras, Chief Patient Care Services Officer).

Motion:
I move that the TCHD Board of Directors Board of Directors authorize the renewal of an agreement with South Coast Perfusion, Inc. for a term of 24 months, beginning July 1, 2022 and ending June 30, 2024, for an annual estimated cost of $444,000 and a total term cost of $888,000.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: JUNE 30, 2022
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE: VASCULAR SURGERY

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

Physician's Names: Andrew R. Deemer,M.D., Mohammad Jamshidi-Nezhad,D.O.

Area of Service: Emergency Department On-Call: Vascular Surgery

Term of Agreement: 24 months, Beginning, July 1, 2022 – Ending, June 30, 2024

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Increase in daily rate from $750 to $1000

Rate/Day	Annual Cost	24 Month(Term) Cost
$1000	FY2023: $365,000 FY2024: $366,000	**$731,000**

Position Responsibilities:

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

Document Submitted to Legal 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: Gene Ma, M.D., Chief Medical Officer

Motion:
I move that the TCHD Board of Directors authorize Andrew R. Deemer,M.D. and Mohammad Jamshidi-Nezhad,D.O., as the Vascular Surgery ED Call Coverage physicians for a term of 24 months, beginning July 1, 2022 and ending June 30, 2024, for an annual cost of $365,000 in FY2023 and $366,000 in FY2024, and a total term cost of $731,000.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: JUNE 30, 2022
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE: NEONATAL INTENSIVE CARE UNIT

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

Physician's Names: North County Neonatology Specialists

Area of Service: Neonatal Intensive Care Unit: 24/7 coverage with Medical Directorship

Term of Agreement: 36 months, Beginning, July 1, 2022 – Ending, June 30, 2025

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Increase in NICU coverage annual rate by $100,000 supported by market survey

Service	Rate/Hour	Hrs/Month(NTE)	Annual Cost	36 Month(Term) Cost
NICU Coverage 24/7, 365 days	n/a	n/a	$337,250	**$1,011,750**
NICU Medical Director	$200/hr	40 hrs	$96,000(NTE)	**$288,000(NTE)**
		TOTAL COSTS:	$433,250(NTE)	**$1,299,750(NTE)**

Position Responsibilities:

- Provide 24/7 patient coverage for all NICU 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:		Yes	X	No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Gene Ma, M.D., Chief Medical Officer, Melissa Terah, Director of Women and Newborn Services

Motion:
I move that the TCHD Board of Directors authorize North County Neonatology Specialists as the NICU Call Coverage physicians and to provide NICU Medical Directorship for a term of 36 months, beginning July 1, 2022 and ending June 30, 2025, for an annual cost not to exceed $433,250 and a 36-month total term cost not to exceed $1,299,750.

Tri-City Medical Center

TCHD BOARD OR DIRECTORS
DATE OF MEETING: June 30, 2022
DA VINCI XI SYSTEM SERVICE AGREEMENT RENEWAL

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

Vendor's Name: Intuitive Surgical, Inc.

Area of Service: Surgery-OR

Term of Agreement: 48 months, Beginning, May 31, 2022 – Ending, May 30, 2026

Maximum Totals:

Annual Cost	Total Term Cost
$154,000	**$616,000**

Description of Services/Supplies:

- Guaranteed Response Time: Intuitive's Field Service Engineers will use commercially reasonable efforts to respond to Customer's requests within 24 hours of notification to Intuitive's Customer Service Center.
- Technical Support: Immediate access to Intuitive's Technical Support Engineers for time-sensitive issues. Available by phone: 24 hours a day, 7 days a week, 365 days a year.
- On-site Access & Remote Monitoring: Allows Intuitive's Technical Support Engineers to remotely access system logs in real time for pre-operative and intra-operative troubleshooting and actively monitor system performance.
- Software Updates: Periodic Software updates to improve system reliability and performance (excludes technology updates).
- System Inspections: System maintenance inspections to keep up current factory specifications.
- Parts Exchange: All parts required for the repair of the System (excludes instruments and accessories).
- Labor & Travel Expense: Labor and travel expenses for service calls conducted during regular business hours: Monday - Friday 8:00 a.m.- 5:00 p.m. Customer's local time, (excludes Intuitive's company holidays).
- Advance Exchange Program: Preferred pricing and next day service on replacements related to accidental damage of endoscopes, camera heads, and the da Vinci Skills Simulator.
- Access to Instruments and Accessories (I&A) Support: On site visits for support of advanced training of hospital personnel on sterile reprocessing process.
- Certified Trained Technicians: The scheduled maintenance and service calls will be performed by Intuitive trained personnel in accordance with the Agreement.

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

Person responsible for oversight of agreement: Donna Ferguson, Interim Director, OR / Candice Parras, Chief Patient Care Services Officer

Motion:

I move that the TCHD Board of Directors authorize the renewal of the Service Agreement with Intuitive Surgical, Inc., for the da Vinci Xi System for a term of 48 months, beginning May 31, 2022 and ending May 30, 2026 for an annual cost of $154,000 and a total term cost of $616,000.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: June 30, 2022
PHYSICIAN AGREEMENT for Cardiac Rehabilitation Supervision

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

Physician's Name: Aaron Yung, M.D.

Area of Service: Cardiac Rehabilitation Services

Term of Agreement: 36 months, Beginning, June 1, 2022 – Ending, May 31, 2025

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

Adding physician to existing Cardiac Rehab services coverage, no increase in expense for Cardiac Rehab program.

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	36 Month (Term) Cost
$148.30	44	528	$6,525.20	$78,302.40	$234,907.20

Position Responsibilities:

- Cardiac rehabilitation Supervising Physician in accordance with CMS 42 CFR 410.49 (Direct supervision of the Cardiac Rehabilitation program by a physician is a requirement).
- Maintain cardiac rehabilitation program as a physician directed clinic.
- Providing medical supervision of patients receiving services in the Department, and clinical consultation for the Department as requested by attending physicians including, without limitation, daily review and monitoring of patients receiving services in or through the Department.
- Supervising the preparation and maintenance of medical records for each patient receiving services in or through the Department

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: Eva England, Sr. Director-Cardiovascular Service Line

Motion:
I move that the TCHD Board of Directors authorize Aaron Yung, M.D. as the Supervising Physician for Cardiac Rehab for a term of 36 months beginning, June 1, 2022 – Ending, May 31, 2025. Not to exceed an average of 44 hours per month or 528 hours annually, at an hourly rate of $148.30 for an annual cost of $78,302.40, and a total cost for the term of $234,907.20.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: June 30, 2022
PHYSICIAN AGREEMENT for Home Health Medical Director

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

Physician's Name: Sharon Slowik, M.D.

Area of Service: Home Health

Term of Agreement: 24 months, Beginning, May 1, 2022 - Ending, April 30, 2024

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

Rate/Hour	Hours per Month (Not to Exceed)	Hours per Year (Not to Exceed)	Monthly Cost (Not to Exceed)	Annual Cost (Not to Exceed)	24 Month (Term) Cost (Not to Exceed)
$169	20	240	$3,380	$40,560	$81,120.

Position Responsibilities:

- Monitors and assures the delivery of quality, efficient, medically needed, safe home health services.
- Provides professional guidance and oversight for Tri-City Home Health Services. Attends case conference and department meetings.
- Conducts in-service training on (discipline/home health) specific issues and/or topics for physicians and home health staff.
- Participates in the development and implementation of the Home Care quality assurance program and risk management program, as directed by Hospital, and shall assist Department in establishing, implementing, reviewing, and maintaining policies and procedures to maintain the quality of Medical Services provided.
- Develop and maintain ongoing dialogue with members of Hospital's Medical Staff concerning Department services.

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: Monica Trudeau, Director-Home Health / Candice Parras, R.N., Chief Patient Care Services

Motion:

I move that the TCHD Board of Directors authorize Sharon Slowik, M.D. as the Home Health coverage physician for a term of 24 months beginning May 1, 2022 and ending April 30, 2024. Not to exceed an average of 20 hours per month or 240 hours annually, at an hourly rate of $169 for an annual cost not to exceed $40,560, and a total cost for the term not to exceed $81,120.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: June 30, 2022
Deferred Equipment Agreement, 2nd Amendment Proposal
Annual Minimum Sensor Commitment

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

Vendor's Name: Masimo Corporation

Area of Service: Respiratory/ICU/Surgery/Telemetry

Term of Agreement: 60 months, Beginning, July 1, 2022 – Ending, June 30, 2027

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$37,610.63	$451,327.56	$2,256,637.75

Description of Services/Supplies:

- The existing Masimo -Tri-City Medical Center Deferred Equipment Sensor Agreement, expires in June of this year. This Masimo renewal agreement provides Tri-City Medical Center with technology upgrades and the newest sensor lines
- The agreement includes cost savings on the disposable consumables (minimum $104,903 savings) .
- Cost-savings on disposable SpO2 sensors for capnography, brain function monitoring, cerebral oximetry, compared to current competitive product
- Capital equipment for capnography, brain function monitoring, cerebral oximetry, non-invasive SpHb and Hemodynamic monitoring at no up-front capital cost
- As a value-add Masimo will include a refresh of all patient monitoring cables

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

Person responsible for oversight of agreement: Eva England-Sr. Director, Cardiovascular Service Line.

Motion:
I move that the TCHD Board of Directors authorize the agreement with Masimo Corporation for Equipment Sensor Agreement 2nd Amendment for a term of 60 months, beginning, July 1, 2022 – ending, June 30, 2027 for an annual cost of $451,327.56 and a total cost for the term of $2,256,637.75.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: JUNE 30, 2022
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE: OPHTHALMOLOGY

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

Physician's Names: Michael J. Ammar, M.D., Heather Chen, M.D., Jim Davies, M.D., Alexander S. Foster, M.D., Kevin Garff, M.D., Jessica Gomez, M.D., Logan Haak, M.D., Srinivas Iyengar, M.D., Atul Jain, M.D., Eric Johnston, M.D., Peter Krall, M.D., Vincent Q. Nguyen, M.D., Neeta Varshney, M.D., Maulik Zaveri, M.D., Charles Zenzen, M.D.

Area of Service: Emergency Department On-Call: Ophthalmology

Term of Agreement: 12 months, Beginning, July 1, 2022 – Ending, June 30, 2023

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Increase in daily rate from $300 to $350

Rate/Day	Annual Cost	12 Month (Term) Cost
$350	$127,750	**$127,750**

Position Responsibilities:

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

Document Submitted to Legal for Review:	X	Yes		No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	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 Michael J. Ammar, M.D., Heather Chen, M.D., Jim Davies, M.D., Alexander S. Foster, M.D., Kevin Garff, M.D., Jessica Gomez, M.D., Logan Haak, M.D., Srinivas Iyengar, M.D., Atul Jain, M.D., Eric Johnston, M.D, Peter Krall, M.D., Vincent Q. Nguyen, M.D., Neeta Varshney, M.D., Maulik Zaveri, M.D., and Charles Zenzen, M.D., as the Ophthalmology ED Call Coverage physicians for a term of 12 months, beginning July 1, 2022 and ending June 30, 2023, for an annual and total term cost of $127,750.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: JUNE 30, 2022
LABORATORY STAFFING PROPOSAL

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

Vendor's Name: MedPro International

Area of Service: Laboratory

Term of Agreement: 36 months, Beginning, July 1, 2022 – Ending, June 30, 2025

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$58,933	$707,200	$2,121,600

Description of Services/Supplies:

- Staffing agreement to bring trained CLS staff to the Laboratory
- MedPro shall present to Client Long-Term Healthcare Professionals (CLS), to fill Client's needs. Prior to presentation, MedPro shall carefully screen each Long-Term Healthcare Professional to determine their competence
- MedPro is in the business of identifying, training, and employing healthcare professionals (each a "Long-Term Healthcare Professional") and placing them on a supplemental basis at third-party healthcare facilities

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

Person responsible for oversight of agreement: Eva England, Sr. Director- CV Service Line.

Motion:

I move that the TCHD Board of Directors authorize the agreement with MedPro International for Laboratory Staffing for a term of 36 months, beginning July 01, 2022 and ending June 30, 2025 for an annual cost of $707,200, and a total cost for the term of $2,121,600

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: JUNE 30, 2022
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE: SURGICAL HOSPITALIST PROGRAM

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

Physician's Names: Synergy Health Partners

Area of Service: Emergency Department On-Call: General Surgery-Surgical Hospitalist

Term of Agreement: 24 months, Beginning, July 1, 2022 – Ending, June 30, 2024

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Transition from ER call panel to full-service, surgical hospitalist program
Would sunset current ER call agreements for general surgery
*Cost estimates contingent upon actual professional fee collections received by Synergy which are credited back to TCMC in this agreement

Daily Cost	Annual Cost	24 Month(Term) Cost
$2,714*	$990,440*	**$1,980,880***

Position Responsibilities:

- Provide 24/7 patient coverage for all general surgery ED call and Surgical Hospitalist 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.
- Develop a Surgical Hospitalist model dedicated to Tri-City providing general surgery management for all inpatient and ED needs. Responsibilities include hospital-based consultations, daily rounding of inpatients, and evaluation of discharged patients at an outpatient follow-up clinic.
- Appoint a medical director to provide leadership responsibilities over the program to align quality and performance metrics with the overall goals of the organization.

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 Synergy Health Partners as the General Surgery Hospitalist Coverage physicians for a term of 24 months, beginning July 1, 2022 and ending June 30, 2024, for an estimated annual cost of $990,440 and an estimated total term cost of $1,980,880.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: June 30, 2022
Lease Agreement Proposal – 3905 Waring Rd., Oceanside – OSNC

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

Practice Name: Orthopaedic Specialist of North County – Oceanside location (TCMC 1206b practice)

Premises: 3905 Waring Rd., Oceanside, CA 92056 (10,218 sq. ft.)

Term of Agreement: 2 years + 1 month, Beginning, July 1, 2022 – Ending, July 31, 2024

Within Fair Market Value: Yes (FMV was determined by Lease Comparables)

Rental Rate:		**Monthly Expense**
Rental Rate of $2.85 per square foot, per month, - 1 mo. rent abatement - 3% rent increase each year (10,218 sq. ft.)	Year 1 Year 2	$29,121.30 $29,994.94
Common Area Monthly Maintenance Fees, ($0.57 per SF)		$5,808.93
Total 25 Month Term Expense Amount:		**$854,618.13**

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

Person responsible for oversight of agreement: Jeremy Raimo, Sr. Director Business Development

Motion:

I move that the TCHD Board of Directors authorize the Lease Agreement Renewal with 3905 Waring Rd., Oceanside, CA, for an additional 25-month term beginning July 1, 2022, ending July 31, 2024. This proposal remains within the current fair market value rental rate of $2.85 per square foot, plus monthly CAM fees of $0.57 for a monthly expense of $34,930.23, for a total expense for the 25-month term of $854,618.13.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 05/09	**SUBJECT:** Care For Recalcitrant Children
REVISION DATE: 08/12, 08/18	~~**POLICY NUMBER: IV.TT**~~

Department Approval:	~~09/17~~03/22
Clinical Policies & Procedures Committee Approval:	~~10/17~~04/22
Nursinge Leadership~~Executive Committee~~ Approval:	~~10/17~~05/22
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~11/17~~05/22
Administration Approval:	06/22
Professional Affairs Committee Approval:	~~01/18~~ n/a
Board of Directors Approval:	01/18

A. **PURPOSE:**

1. To ensure minor patients are provided with appropriate resources to identify and treat behavioral and psychological challenges.
2. To ensure that a minor's behavior is appropriately and consistently managed by all healthcare providers so the minor will receive maximum benefit from all necessary intervention.

B. **POLICY:**

1. Healthcare providers requiring assistance to manage the behavior of inpatients will contact a California Children's Services (CCS) paneled Social Worker.
2. The Social Worker will assess the situation and develop a behavior management plan.
   a. Meet with the patient/family and advise regarding the possible eligibility for CCS benefits
   b. Provide the patient/family with the CCS application and assist with completion of the document
   c. Provide the family with a list of the CCS special care centers and assist in making appointments
3. Referrals to approved facilities authorized by the patient's insurance shall be given to the parents and/or guardian for follow-up. This may include either inpatient or outpatient resources.

C. **REFERENCE(S):**

1. The American Academy of Child and Adolescent Psychiatry, 3615 Wisconsin Avenue, N.W., Washington D.C. 20016-3007, www.aacap.org.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 08/01

SUBJECT: Discharge of Patients and Discharge Against Medical Advice (AMA)

REVISION DATE: 06/03, 01/04, 06/07, 07/07, 09/09, 02/10, 06/10, 03/11, 02/15, 06/18

Department Approval:	**10/17**
Clinical Policies & Procedures Committee Approval:	**~~04/18~~04/22**
Nursing Leadership~~Executive Council~~ Approval:	**~~04/18~~05/22**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~05/18~~05/22**
Administration Approval:	**06/22**
Professional Affairs Committee Approval:	**~~06/18~~ n/a**
Board of Directors Approval:	**06/18**

A. **POLICY:**

1. Patients are discharged by order of the appropriate physician
   a. In the event of an internal or external disaster, the established policies and procedures for patient discharge are followed as per the **Emergency Operations Procedures (EOP) Manual Policy:** Emergency **Operations**~~Preparedness~~ Plan.
   ~~b. Observation patients may be discharged after meeting predetermined discharge criteria on the order of a physician. (Refer to Patient Care Services Standardized Procedure: Discharge from Outpatient Post-Anesthesia Nursing Service)~~
   ~~c.~~**b.** Justice Involved Patients
      i. Justice Involved Patients are to be discharged following the Progressive Care Departmental discharge process.
      ii. Justice Involved Patients have the right to sign out AMA and leave the hospital in the care of their custodial agency.
   ~~d.~~**c.** Behavioral Health Services
      i. A voluntary patient may leave the hospital at any time by giving notice to any member of the hospital staff on his/her desire to leave and by completing usual discharge processes.
      ii. A Conservatee may leave in a like manner if the patient's Conservator gives notice.
      iii. If a voluntary patient cannot be persuaded to continue his or her hospitalization, cannot be safely discharged, and meets criteria for involuntary hospitalization, an appropriately credentialed clinician will initiate a 72 hour hold and the patient will not be permitted to leave the unit.
2. The primary nurse is responsible for providing verbal and written discharge instructions to the patient, family, and/or caregiver.
3. All patients discharged will receive discharge education completed by nursing.
4. A Registered Nurse (RN) and/or Case Manager are responsible for explaining discharge plans to patients and their family members.
   a. Discharge instructions including medication list, signs/symptoms of potential complications, educational information, and instructions for follow-up appointment will be sent with patient and/or family upon discharge.

b. Patients will be evaluated within one (1) hour of discharge for any change in condition. This shall include documentation of vital signs. Any abnormality will be communicated to the primary care physician/AHP prior to discharge.
c. Patients and/or family members will be advised if it is necessary to stop at the business office before leaving the hospital.
d. All patients being transferred to a Skilled Nursing Facility (SNF) or another hospital/facility (justice involved patients) will receive a transition of care document prior to transfer.

5. All inpatients who are ambulatory are to be discharged from the front entrance via wheelchair ~~or stretcher, if appropriate,~~ by a hospital employee or volunteer.
   a. In the event the patient has a car in the Medical Center parking lot, the patient may be escorted by an employee or volunteer.
   b. If patient has no transportation to their residence after the discharge order is processed, contact Case Management/Social Services personnel or Administrative Supervisor for further assistance in obtaining transportation.
   c. Staff members are not to transport patients to their place of residence.
6. If being discharged via ambulance, patient will be discharged from the Emergency Department (ED) entrance. Hand-off communication shall be provided to the ambulance personnel before the patient leaves the unit.
7. A discharge transaction shall be entered into Cerner within one (1) hour after the patient has left the unit.
8. When a patient is discharged to Acute Rehabilitation ~~or the Inpatient Behavioral Health Unit~~, the acute care chart is closed and a new encounter is created.
9. Provision of Transfer Summary to Patient Upon Transfer (Health and Safety Code [HSC] Section 1262.5)
   a. HSC Section 1262.5 (d) requires that a transfer summary be signed by the physician and accompany the patient upon transfer to a SNF or intermediate care facility or to the distinct part-skilled nursing or intermediate care service unit of the hospital.
   b. A copy of the transfer summary must also be given to the patient, patient's closest available relative or patient's legal representative, if any, prior to the transfer.
      i. To ensure compliance with HIPAA and California Privacy Law, ensure "the patient's legal representative" is clearly identified by a document signed by the patient approving release of information to that person.
   c. The transfer summary must include essential information relative to:
      i. Patient's diagnosis
      ii. Hospital course
      iii. Pain treatment and management
      iv. Medications
      v. Treatments
      vi. Dietary requirement
      vii. Rehabilitation potential
      viii. Known allergies
      ix. Treatment plan

B. DISCHARGE AGAINST MEDICAL ADVICE (AMA):

1. When a patient demands to leave the hospital and the patient's physician has not ordered his/her discharge and has specifically indicated that the discharge is against medical advice, the following steps shall be completed:
   a. Verify the patient is an adult with the capacity to make healthcare decisions regarding medical treatment.
   b. If the patient lacks the legal authority to make healthcare decisions (minor) or if the patient lacks the capacity to make healthcare decisions, the patient has the right to have legal representative make the decision to stay or leave against medical advice for him/her.

c. The RN will notify attending physician immediately.
d. The attending physician will be asked to discuss the request with the patient, either by person or by telephone as appropriate.
e. If the patient attempts to leave the hospital before discussing the matter with his/her physician, the RN shall:
   i. Inform the patient his/her physician has been contacted
   ii. Explain the risks and consequences of leaving the hospital to the patient before he/she leaves.
   iii. Notify the ~~Assistant~~ Nurse **Leader**~~Manager~~**/designee** ~~(ANM)/Relief Charge~~
   ~~1) The ANM shall notify the unit director/manager as soon as possible.~~
f. The patient or a patient's legal representative shall complete the Leaving Hospital Against Medical Advice (AMA) Form.
   i. ED:
      1) The RN shall request the patient to sign the AMA form.
      2) The RN shall remove the patient from the electronic medical record as AMA.
g. The AMA form shall state the patient has been provided information regarding possible risks that may result from the decision to leave AMA, the benefits of continued hospitalization, and any alternatives, such as transfer to another hospital or outpatient treatment.
   i. The AMA form must be witnessed by a **Registered Nurse**~~responsible hospital employee~~ and signed by the attending physician he/she has explained the risks and benefits of continued hospitalization, when possible.
      1) If the attending physician is not present to sign, the primary nurse shall document he/she called the physician.
h. If the patient refuses to sign the AMA form, the responsible hospital employee and/or RN shall:
   i. Document Physician Notified
   ii. Document on the patient's signature line, "patient refuses to sign"
   iii. The hospital employee shall sign the form in the designated space, including the exact time and date.
i. The primary nurse shall document a brief note concerning the interactions with the patient:
   i. Risks/benefits were reviewed.
   ii. Actions taken to ensure the patient's safety.
   iii. Refusal to sign the AMA form, if applicable.
j. The AMA form shall be placed in the medical record.
k. An quality review report shall be completed.

2. Transportation Arrangements
   a. The following reasonable steps shall be documented in the medical record:
      i. Attending physician was consulted regarding patient's intent to leave and any concerns regarding transportation
         1) Inform the patient his/her physician has been contacted
         2) Explain the risks and consequences of leaving the hospital to the patient before he/she leaves.
      ii. Document disposition of patient off unit, i.e. ambulatory, wheelchair, with family member.
      iii. Caution patient that driving is not advisable due to their medical condition and/or medications taken.
      iv. If the patient appears helpless or in a condition which indicates he/she should not be allowed to leave the hospital alone, every attempt shall be made to arrange transportation that is appropriate for the patient's condition.

v. If patient refuses the appropriate recommended transportation and is under the influence of any narcotic or medication that would impair their ability to operate a vehicle safely contact the hospital security and the local police.

vi. Hospital personnel shall not accompany the patient once he/she leaves the hospital premises.

3. If there are concerns regarding the patient's psychiatric stability, the physician may consider a ~~72-hour~~ hold **per the Patient Care Services Policy: Holds, Evaluation and Treatment of Involuntary Patients**.

a. In the Inpatient Units:

i. A psychiatric consult shall be requested by the admitting or attending physician to determine if patient meets criteria for a ~~72-hour~~ hold.

~~b. In the Behavioral Health Unit:~~

~~i. The Psychiatrist must be notified to determine if the patient meets the criteria for a 72-hour hold.~~

~~ii. The RN is responsible for documenting the psychiatrist's final decision in the progress note or clinical note.~~

~~iii. Any orders (i.e., to place the patient on an involuntary hold) shall be documented as a physician's order.~~

~~iv. Explain to the patient the reason they will not be permitted to leave unit~~

~~v. Complete involuntary hold advisement as applicable per PCS Policy: 72 Hour Hold, Evaluation and Treatment of the Involuntary Patient Policy and Behavioral Health Services Policy: Advisement of Legal Status 72-Hour Hold~~

C. PATIENTS NO LONGER NEEDING ACUTE CARE WHO REFUSE TRANSFER OR DISCHARGE:

1. If the patient has been discharged from the facility and the patient and/or patient's family is refusing or even actively blocking the patient's transfer or discharge, a case by case approach must be initiated.
2. Consider all available options. Try to identify the concerns and issues raised by the patient and/or family to see if resolution is possible.
3. Notify ~~your~~ **Nursing/Department Leader**~~immediate manager~~. If unable to resolve, the **Nursing/Department Leader**~~immediate manager~~ must notify Administration and Risk Management of the situation. Social Services and/or Security shall also be involved as appropriate.
4. Inform the patient's physician of the refusal to leave.
5. Should all efforts fail, legal remedies may be available and legal counsel shall be consulted.
6. Some permissible actions may apply during this duration, such as:
   a. The television is considered a luxury, not a necessity, and may be turned off.
   b. Food is a necessity and food trays must be nutritionally balanced. Depending on the patient's physical/medical condition, the diet may exclude such items as sodas, coffee, desserts, candies, and snacks, etc.
   c. Clean linen changes are not required. If the patient needs extra linen, it may be delivered, but staff is not required to make the bed.
   d. The issue of continuing nursing care shall be determined on a case by case basis, in consultation with the treating physician.
7. Follow all requirements of the applicable payer with respect to the patient's right to challenge a determination that they no longer need inpatient care. Medicare patients, for example, have the right to receive notice of their rights, including the right to appeal denials of benefits for continued services, as well as notice of any determination that they no longer require hospitalization.

D. DISCHARGE TO SKILLED NURSING FACILITY:

1. To ensure all appropriate steps and actions are taken to promote SNF placement expeditiously, case managers, in collaboration with the interdisciplinary team, will identify patients who are appropriate for SNF.

2. The Case Manager and RN may arrange for SNF placements. Refer to Patient Care Services Policy: Discharge Planning.
3. Prior to discharge to a SNF or an intermediate care facility, primary nurse shall provide a copy of the following to the patient, family, and/or caregiver:
   a. Physician Discharge/Transfer summary
   b. Discharge (Medication Home List)
   c. Discharge instructions
4. The primary nurse shall ensure the following information is copied by the unit secretary or designee and sent with the patient to the SNF:
   a. Facesheet
   b. History and Physical (H&P), Consultations
   c. Physician transfer summary
   d. Physician transfer orders
   e. Physician progress notes
   f. Printed MAR (14 days)
   g. Medication reconciliation form (refer to Patient Care Services Policy: Medication Reconciliation)
   h. Nursing transfer summary
   i. Lab results
   j. X-ray reports
   k. Therapy notes
5. The transferring/discharging nurse shall provide a hand-off communication to the SNF prior to discharge of the patient.

E. DISCHARGE TO TCHD ACUTE REHABILITATION UNIT:

1. When the primary physician requests a stroke/neuro rehab assessment and/or a rehab consultation.
   ~~a. The Unit Secretary enters into the computer a request for an acute rehab evaluation through Cerner.~~
   ~~b.~~**a.** The Rehab Admission Coordinator, in collaboration with the Acute Rehab Medical Director, will complete the pre-assessment form and document the outcome in the medical record.
   ~~c.~~**b.** When a patient is not accepted into the program or the patient is a potential rehab candidate and a bed will not be available for several days:
      i. A request for an order for a case manager/discharge planner consult will be made by the rehab admission coordinator in Cerner.
      ii. If the case manager/discharge planner is already involved, the rehab admission coordinator will notify the unit case manager of bed availability on the acute rehab unit.
   ~~d.~~**c.** When the patient is discharged the primary nurse shall send the patient's chart and Discharge (Medication Home List).
   ~~e.~~**d.** The primary nurse shall provide hand-off communication to the receiving nurse.

F. ARRANGING TRANSPORTATION FOR THOSE WITHOUT MEANS:

1. All patients shall be encouraged to arrange their own means of transportation whenever possible.
2. Case managers and social workers shall assist with difficult transportation needs.
3. During off hours, bus passes/taxi vouchers may be obtained from either the Administrative Supervisors or designee.
4. Refer to Patient Care Services Policy: Ambulance Transport for Patients for patients requiring ambulance transport.
5. The TCHD Patient Transport Express is a free service providing transportation between TCHD facilities and the patient's home (within a seven [7] mile radius). This free service operates

Monday-Friday 0630 - 1400. To schedule a ride, call 940-RIDE (7433) at least 24 hours in advance.

G. FORM(S):

1. Leaving Hospital Against Medical Advice (AMA) Form - Sample

H. RELATED DOCUMENT(S):

1. **Emergency Operations Procedures (EOP) Manual Policy: Emergency Operations Plan**
~~1.~~**2.** Patient Care Services Policy: Ambulance Transport for Patients
3. Patient Care Services Policy: Discharge Planning
~~2.~~**4.** **Patient Care Services Policy: Holds, Evaluation and Treatment of Involuntary Patients**
~~3.~~**5.** Patient Care Services Policy: Medication Reconciliation
~~4.~~**6.** Patient Care Services Standardized Procedure: Discharge from Outpatient Post-Anesthesia Nursing Service

I. REFERENCE(S):

1. Cal. HSC § 1262.5 (1973).

5-Hole 1/4 1 3/8 c-to-c

Patient's Name: _____

I am voluntarily leaving the hospital against the advice of Dr. _____ and a representative of the hospital administration.

I have been told by the doctor about the risks and consequences involved in leaving the hospital at this time, the benefits of continued treatment and hospitalization, and the alternatives, if any, to continued treatment and hospitalization.

I hereby release the doctor, any other doctors involved in my care, the hospital and its employees and agents from all responsibility for any injury or ill effects which may result from this action.

I understand that the doctor named above and other doctors who provide services to me are not employees or agents of the hospital. They are independent medical practitioners.

Signature: _____
(patient/parent/conservator/guardian) Date/Time

If signed by other than patient, indicate relationship:

_____

Witness: _____
Date/Time

I declare that I have personally explained to the patient the risks and consequences involved in leaving the hospital at this time, the benefits of continued treatment and hospitalization, and the alternatives, if any, to continued treatment and hospitalization.

Remarks:

_____

Signature: _____
(physician) Date/Time

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

8723-1001
(Rev 2/10)

LEAVING HOSPITAL AGAINST MEDICAL ADVICE

White - Chart Yellow - Patient

Affix Patient Label

5-Hole 1/4 1 3/8 c-to-c

Nombre del Paciente: _____

Voluntariamente salgo del hospital en contra del consejo del Dr. _____ y un representante de la administración del hospital.

El doctor me ha informado de los riesgos y consecuencias relacionados con salir del hospital en este momento, de los beneficios del tratamiento y hospitalización continuados.

Por medio de la presente exonero al médico, a cualesquiera otros médicos involucrados en mi atención médica, al hospital y a sus empleados y representantes de toda responsabilidad por cualquier lesión o efecto adverso que pueda resultar de esta acción.

Entiendo que el médico cuyo nombre se indica anteriormente y otros médicos que me brindan servicios no son empleados ni agentes del hospital. Son médicos facultativos independientes.

Firma: _____
(paciente/padre/madre/conservador/tutor) Fecha/Hora

En caso de firmarse por una persona que no sea el paciente, indique la relación:

_____

Testigo *(Witness)*: _____
Fecha/Hora

I declare that I have personally explained to the patient the risks and consequences involved in leaving the hospital at this time, the benefits of continued treatment and hospitalization, and the alternatives, if any, to continued treatment and hospitalization.

Remarks:

_____

Signature: _____
(physician) Date/Time

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

8723-1003
(Rev. 2/10)

LEAVING HOSPITAL AGAINST MEDICAL ADVICE
(SALIDA DEL HOSPITAL EN CONTRA DEL CONSEJO MEDICO)

White - Chart Yellow - Patient

Affix Patient Label

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 02/14	**SUBJECT:** Nursing Students; Advanced Practice
REVISION DATE: 02/14	

Patient Care Services Content Expert Approval:	~~10/19~~03/22
Clinical Policies & Procedures Committee Approval:	~~10/19~~03/22
Nursinge Leadership~~Executive Council~~ Approval:	~~10/19~~05/22
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~11/19~~05/22
Administration Approval:	~~11/19~~06/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/19

A. **POLICY:**

1. Masters Degree Students
   a. Students must be enrolled in a nursing related program.
   b. Students are responsible for identifying preceptor and obtaining approval through the Education Department.
      i. TCMC must have opportunities available to meet the goals of the Masters program.
2. **Nursing Educator Degree**
   a. Students are responsible for identifying preceptor and obtaining approval through their school Instructor, Education Department, and the Director of the Department(s) where they will be precepting.
   b. TCMC must have opportunities available to meet the goals of the Nursing Education Degree program.

~~2.~~**3.** Clinical Nurse Specialist
   a. Students are responsible for identifying preceptor and obtaining approval through the**ir school instructor,** Education Department**, and the Director of the Department(s) where they will be precepting**.
      i. TCMC must have opportunities available to meet the goals of the Clinical Nurse Specialist program.

~~3.~~**4.** Nurse Practitioner Students
   a. Nurse Practitioner students receive supervision from a designated physician/nurse practitioner as arranged through the nursing practitioner's program.
      i. The physician/nurse practitioner supervisor will ensure that the student functions within the scope of practice
   b. Nurse practitioner students shall perform, under the direction of their supervisor, assessments and will collaboratively develop appropriate plans of care.
   c. Nurse practitioner students may suggest treatments or medications but may not order them in the patient's medical record; nor may they dictate.
   d. Nurse practitioner students may document in the progress note.
   e. All care provided shall be discussed with the designated supervisor

~~4.~~**5.** Nurse Midwife Students
   a. Nurse midwife students **function under** ~~receive~~ supervision from a designated**, active, credentialed** physician/nurse midwife ~~as arranged through~~ **recognized by** the nurse midwife's program.
      i. The physician/nurse midwife supervisor will ensure that the student functions within the scope of practice **for Certified Nurse Midwives.**

b. Nurse midwife students shall perform, under the direction of their supervisor, assessments and will collaboratively develop **and carry our** appropriate plans of care **for Antepartum, Intrapartum and Postpartum patients**.
c. Nurse midwife students ~~may suggest treatments or medications but~~ may not **place** order**s** ~~them~~ in the patient's medical record~~; nor may they dictate~~.
d. Nurse midwife students may document in the progress note.
e. All care provided **will be reviewed** ~~shall be discussed~~ with the designated supervisor

Tri-City Me
Oceanside, C

PATIENT CARE

DELETE - Community Works automatically consults the RD for high risk criteria. If we are not consulted, we see the patient within 7 day. This policy is no longer needed or valid with current work flow.

ISSUE DATE: 3/88

SUBJECT: Nutritional Screening, Care, and Assessment for Infants, Pediatrics & Adolescents

REVISION DATE(S): 10/04, 01/07, 10/07, 01/08, 01/11 06/15, 09/18

Patient Care Services Content Expert Approval:	~~07/18~~10/21
Clinical Policies & Procedures ~~Committee~~ Approval:	~~07/18~~11/21
Nursinge Leadership~~Executive Committee~~ Approval:	~~07/18~~12/21
Department of Pediatrics:	~~08/18~~04/22
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~08/18~~05/22
Administration Approval:	09/18
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	09/18

~~A. **DEFINITIONS:**~~

~~1. Malnourished or Nutritionally at Risk:~~

~~a. Five (5) percent or greater weight loss over one month~~

~~b. Body Mass Index (BMI) Percentile less than 5th percentile and greater than or equal to the 95th percentile~~

~~i. Indication of underweight and overweight/obesity~~

~~c. Weight below 5th percentile on growth chart~~

~~d. Decreased percentage scores of height and/or weight~~

~~e. Increased metabolic requirements~~

~~f. Low birth weight (less than 2500 grams) or prematurity (less than 37 weeks)~~

~~g. Inadequate provision or tolerance of nutrients/feedings (rate or volume)~~

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

~~1. The Registered Dietitian shall provide nutrition assessment, consultation, and/or medical nutrition therapy for patients, families, and for medical professionals providing care for infant, pediatric or adolescent patients.~~

~~2. Referrals for a nutrition assessment are generated if certain criteria are met via the admission database and/or as requested by the physician. Clinical Dietitians shall assess nutritional status of triggered patients within 48 hours of referral, considering age of patient, disease states, diet history, medical history, and laboratory values.~~

~~3. Referrals for nutrition assessment are generated if the following criteria are met upon completion of the admission data base:~~

~~a. Currently receiving total parental nutrition (TPN)/enteral feedings~~

~~b. Unplanned weight loss~~

~~c. Presence of pressure ulcer or skin breakdown~~

~~d. Eating disorder~~

~~e. Impaired nutrient intake, nausea, vomiting, diarrhea~~

~~f. Intake of less than 50% normal in 3 days~~

~~g. Aspiration risk~~

~~h. BMI Percentile less than 5th percentile and greater than or equal to the 95th percentile~~

~~4. Additional criteria for infants and pediatric patients include:~~

a. Weight/length less than 5th percentile or greater than or equal to 95th percentile on growth charts for children under two (2) years of age
b. Difficulty with suck/swallow
c. Poor weight gain
d. Failure to thrive
e. Presence of enteral tube/button

5. The dietitian shall complete the assessment with consideration of:
a. Diet order
b. Diagnosis
c. Chronological age and/or gestational age
d. Weight
e. Height or length
f. Head circumference as appropriate
g. Food allergies
h. Diet prior to admission
i. Birth weight - if available
j. History of weight changes
k. Potential drug nutrient interactions
l. Labs and biochemical values: to include, among others, serum albumin, hemoglobin (Hgb), hematocrit (Hct), mean corpuscular volume (MCV)
m. Feeding problems such as chewing, swallowing, and appetite changes
n. Nutrition/diet history
o. Psychosocial, physiological, social and/or environmental issues
p. Clinical assessment changes
q. Any other general nutrition concerns
r. BMI percentile

6. Clinical dietitian shall document nutrition assessment in the electronic medical record. Assessments shall be based on the following information provided by admission assessment, review of history and physical, physician notes, other disciplines' notes, and interview with patients, parents, or nursing:
a. Diet order
b. Diagnosis
c. Age
d. Weight, height
e. Food allergies
f. Labs and biochemical values: pertinent to assessment
g. History of weight changes
h. Feeding problems such as chewing, swallowing, appetite
i. Psychosocial, physiological, social and/or environmental issues
j. Nutrition/diet history
k. Pregnancy/Lactating
l. BMI percentile

7. The Dietitian shall also calculate the following:
a. Weight for height percentile or weight for age/weight for height percentile
b. Weight change percentile
c. BMI percentile
d. Estimation of calories and is based on the child's age, gender, weight, disease state, and nutrition status
e. Grams of protein per day
f. Fluid requirements

8. A nutrition care plan shall be developed and individualized based on assessment and shall meet specific needs of the patient. Goals shall be individually determined with delineation of methods of achievement of goals and time frames.

9. Normally nourished and malnourished children who have adequate intake to satisfy nutrient requirements shall be monitored on at least a 3-day follow-up basis or as indicated by nursing/physician referral.
10. Normally nourished and malnourished children who have inadequate intake may require nutrition support (i.e., parenteral or enteral nutrition) after 5 days of inadequate nutrition intake. These patients shall be monitored on a 1-3 day follow-up basis or as indicated by nursing/physician referral.

Estimated Energy and Protein Requirements/Dietary Reference Intakes			
Age (yr)	Protein g/kg/d	kcal/Kg/d	kcal/d
0.0-0.5	2.2	108	kg x 108
0.5-1.0	1.5	98	kg x 98
1-3	1.3	102	1300
4-6	1.2	90	1800
7-10	1.0	70	2000
Males: 11-14 15-18	 1.0 0.9	 55 45	 2500 3000
Females: 11-14 15-18	 1.0 0.8	 47 40	 2200 2200

11. Clinical Dietitian shall confer with Physician, Registered Nurse, and/or Pharmacist regarding pertinent factors affecting nutrition status (i.e., medication, intake and output (I&O), Braden Score).
12. Clinical Dietitian shall provide and document follow-up visits for patients assessed at risk as necessary or at least every three (3) days depending on medical status and revise therapy as indicated. Patients with adequate intake shall be followed throughout their stay with documentation in the medical record within at least seven (7) days. Follow-up assessment is documented on the Nutrition Reassessment PowerForm, to include nutrient intake, tolerance to diet, weight changes, laboratory parameters, and I&O. Follow-up assessments may be triggered sooner as warranted by change in status.
13. Clinical Dietitian shall provide nutrition counseling and education explaining rationale to patient/parent/significant other as ordered by physician, as requested by nursing, or family, or as deemed appropriate by RD.
    a. Documentation of education is completed on the Patient/Family Education All Topics PowerForm.
    b. Relevant nutrition and education and referral information are documented in the discharge plan.
14. **1.** Standard adult and pediatric menus and snacks are utilized. If enteral formulas are required, adult formulas are utilized for children ages 7-12 and adolescents; pediatric formulas are used for children ages 1-6. Infant formulas are available as 20kcal/oz and can be concentrated to 24 kcal/oz, 27kcal/oz, or 30kcal/oz as needed.

Tri-City Medical Center
Oceanside, California

Patient Safety ~~& Risk Management Plan~~ ~~2021 to~~ 2022

A. PURPOSE

1. The ~~Risk Management and~~ Patient Safety Plan is designed to:
   a. Support the mission and vision of Tri-City Medical Center (TCMC) as it pertains to ~~clinical risk,~~ patient safety, **the work force and** ~~TCMC employees,~~ visitor~~., third-party, volunteer,~~ **and** ~~business associate,~~. ~~operational, and property risks.~~
   b. Reduce system-related errors and potentially unsafe conditions by implementing continuous improvement strategies to support an organizational culture of safety by implementing standardized processes throughout the organization.
   c. Implementing activities which contribute to the maintenance and improvement of patient safety**.**

B. GUIDING PRINCIPLES

1. The ~~Risk Management and~~ Patient Safety Plan e.g., the Plan is an overarching conceptual framework that guides the development of a program for ~~risk management,~~ patient safety initiatives, and activities. It is operationalized through various activities in the realm of both **patient safety and** ~~risk management and~~ patient safety **risk**.
2. The plan supports TCMC philosophy that patient safety and risk management are everyone's responsibilities. Teamwork and participation among management, providers, employees, and volunteers is essential for an efficient and effective risk management and patient safety program.
3. The Plan is implemented through the coordination of activities in multiple departments. TCMC supports the establishment of a just culture that emphasizes evidence-based, best practices, learning from error analysis, and providing constructive feedback, rather than blame and punishment. In a just culture, unsafe conditions and hazards are readily and proactively identified and reported.
   a. Medical and/or patient care errors are reported and analyzed, mistakes are openly discussed, and suggestions for systemic improvements are welcomed.
   b. Individuals are still held accountable for compliance with patient safety**.** ~~and risk management practices.~~ As such, if evaluation and investigation of an error or event reveal reckless behavior or willful violation of policies, disciplinary actions may be taken.
4. The Plan stimulates the development, review, and revision of the organization's practices and protocols in light of identified **risk to patient safety,**~~risks~~ and chosen loss prevention and reduction strategies. These principles provide**s** the foundation for developing and updating key policies and procedures for day-to-day risk management activities, including the following:
   ~~a. Complaint resolution~~
   ~~b. Event investigation, root-cause analysis, and follow-up~~
   ~~c. Adverse event disclosure to patients~~
   ~~d. Failure mode and effects analysis~~
   ~~e.~~**a.** Reporting and management of adverse events and near misses
   ~~f. Trend analysis of events, near misses, and claims~~
   ~~g.~~**b.** Staff education as it pertains to ~~risk and~~ patient safety matters

Patient Care Service Content Expert	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
03/22	05/22	06/22	n/a	

C. **GOVERING BODY LEADERSHIP**

1. The governing Board authorizes the formal program and adoption of this plan through a resolution documented in the Board meeting minutes.
2. The governing Board is committed to promoting the safety of all patients, visitors, employees, volunteers, and other individuals involved in organization operations.
3. The governing body empowers the organization's leadership and management teams with the responsibility for implementing risk management and patient safety strategies by their leadership, commitment and support.

D. **DEFINITIONS**

1. Adverse Event or Incident: An undesired outcome or occurrence not expected within the normal course of care or treatment, disease process, condition of the patient, or delivery of services. The outcome may or may not be a patient safety incident.
2. Culture of Safety: The collective product of individual and group values, attitudes, competencies, and patterns of behavior in safety performance. It is an environment that regards safety as its primary goal through promotion of teamwork, effective communication, and the implementation of modern safety concepts. A culture of safety is concerned with preventing errors, accidents, and adverse events. This is accomplished by way of an environment that promotes open and honest communication.
3. ~~Error: Failure to carry out a planned action as intended or application of an incorrect plan.~~
4. ~~Failure Mode and Effects Analysis: Proactive process-driven analysis undertaken prior to a process change in order to prioritize and analyze current risks then, propose and analyze steps to improve the process.~~
5. ~~5.~~**3.** Healthcare Associated Harm: Harm arising from or associated with plans or actions taken during the provision of health care rather than an underlying disease or injury. Also known as iatrogenic.
6. ~~6.~~**4.** Just Culture: An organizational paradigm that emphasizes evidence-based best practices, learning from error analysis, and providing constructive feedback, rather than blame and punishment.
7. ~~7.~~**5.** National Patient Safety Goals (NPSGs): Annual list published by The Joint Commission (TJC). The purpose of the NPSGs is to improve patient safety by focusing on problems widely identified in healthcare and ways to mitigate or solve them. Identified goals include but are not limited to accurate patient identification, hand-off communication, and medication safety, decreasing clinical alarm fatigue, Universal Precautions, and infection prevention.
8. ~~8.~~**6.** ~~Near Miss or Good Catch: An event or situation that could have resulted in an accident, injury, or illness but did not, either by chance or but for one or more persons' timely intervention. Near misses are "low cost" opportunities for learning and afford the chance to develop preventive strategies and actions. Near misses must receive the same level of scrutiny as adverse events that result in actual injury~~.
9. ~~9.~~**7.** Patient Safety Evaluation System: The collection, management, and analysis of patient safety information.
10. ~~10.~~**8.** Patient Safety Event: An event that negatively impacts a patient including patient safety incidents and near misses.
11. ~~11.~~**9.** Patient Safety Incident: A patient safety event that reaches a patient and resulted either in no harm (no harm incident) or harm (harm incident). The concept "reaches a patient" encompasses any action by a workforce member or environmental circumstances that exposes a patient to harm.
12. ~~12.~~**10.** Preventive Measure: Process designed, or course of action taken, to keep something possible or probable from happening or existing; i.e., to prevent a patient safety event
13. ~~Potentially Compensable Event (PCE): An unusual occurrence or serious injury, for which there is neither an active claim nor institution of formal legal action but that, in the organization's judgment, is reportable to the entity providing insurance. Examples include but are not limited to a fall with injuries, delay or failure in diagnosing a patient's condition, an unanticipated adverse~~

~~reaction to treatment, significant complaints from a patient or family regarding care or treatment, and an attorney request for medical records.~~

~~14. Risk Analysis: Determination of the causes, potential probability, and potential harm(s) of an identified risk and alternatives for dealing with the risk. Examples of risk analysis techniques include failure mode and effects analysis, root-cause analysis, and tracking and trending of adverse events and near misses, among others.~~

~~15. Risk Assessment: Activities undertaken in order to identify potential risks and unsafe conditions inherent in the organization or within targeted departments, systems, or processes.~~

~~16. Online Incident Reporting: A computerized system used for data collection and processing, information analysis, and generation of statistical trend reports for the identification and monitoring of adverse or potentially adverse events in the healthcare environment.~~

~~17. Root-Cause Analysis (RCA): A comprehensive systematic analysis retrospective process for identifying the actual causal factor(s) that underlie(s) the occurrence or possible occurrence of an adverse event.~~

~~18.~~**11.** Sentinel Event: Defined by the Joint Commission as an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse event.

~~19.~~**12.** Time of Discovery: Date/time when a patient safety concern was discovered.

~~20.~~**13.** Time of Occurrence: Date/time when a patient safety event occurred or began if it occurred over a period of time.

~~21.~~**14.** Unsafe and/or Hazardous Condition: Any set of circumstances, exclusive of a patient's own disease process, that significantly increases the likelihood of a serious adverse outcome or loss for a patient due to an accident or injury to a visitor, workforce member, volunteer, or other individual. These are reported in our on-line incident reporting system.

E. SCOPE AND FUNCTIONS

1. The Patient Safety Plan in collaboration with the Risk Management Program interfaces with many operational and clinical departments and services throughout the organization. These operational and clinical departments include, but are not limited to the following:
   - a. Administration and Senior Management
   - b. Ancillary Services
   - c. Buildings and Grounds
   - ~~d. Claims Management~~
   - ~~e.~~**d.** Disaster Preparation and Management
   - ~~f.~~**e.** Education Department / Staff Education
   - ~~g.~~**f.** Employee Health Services
   - ~~h.~~**g.** Event/Incident/Accident Reporting and Investigation
   - ~~i. Finance/Billing~~
   - ~~j. Human Resources~~
   - ~~k.~~**h.** Infection Control
   - ~~l.~~**i.** Information Technology
   - ~~m. Legal and Contracts~~
   - ~~n.~~**j.** Marketing/Advertising/Public Relations
   - ~~o.~~**k.** Medical Records
   - ~~p. Medical Staff Services, Provider Credentialing~~
   - ~~q.~~**l.** Nursing Administration
   - ~~r.~~**m.** Nursing Services
   - ~~s. Patient Representative~~
   - ~~t.~~**n.** Pharmaceuticals and Therapeutics
   - ~~u.~~**o.** Product/Materials Management
   - ~~v.~~**p.** Pulmonary Department
   - ~~w.~~**q.** Quality/Performance Improvement
   - ~~x.~~**r.** Regulatory Compliance

~~y.~~**s.** Safety and Security
~~z. Social Service and Case Management Programs~~

~~F.~~ **~~RISK MANAGEMENT~~**

~~1. Goals and Objectives~~

~~a. The Risk Management goals and objectives are as follows:~~

~~b. Continuously improve patient safety and minimize or prevent the occurrence of errors, events, and system failures leading to harm to patients, staff, volunteers, visitors, and others through proactive risk management.~~

~~c. Minimize adverse effects of errors, events, and system failures when they do occur~~

~~d. Minimize losses to the organization by proactively identifying, analyzing, preventing, and controlling potential clinical, business, and operational risks~~

~~e. Facilitate compliance with regulatory, legal, and accrediting agency requirements~~

~~f. Protect human and intangible resources (e.g., reputation)~~

~~g. Provide education in aspects of risk management and patient safety~~

~~2. Scope and Functions~~

~~a. Risk Management functional responsibilities include the following:~~

~~i. Developing systems for and overseeing the reporting of adverse events, near misses, and potentially unsafe conditions. Reporting responsibilities may include internal reporting as well as external reporting to regulatory, governmental, or voluntary agencies. This includes the development and implementation of event reporting policies and procedures.~~

~~ii. Ensuring the collection and analysis of data to monitor the performance of processes that involve risk or that may result in serious adverse events (e.g., processes in emergency care, labor and delivery, perioperative care, diagnostic testing, medication use, etc.,).~~

~~iii. Overseeing the organization's online incident reporting system for data collection and processing, information analysis, and generation of statistical trend reports for the identification and monitoring of adverse events and the effectiveness of the risk management program.~~

~~iv. This system may include, but is not limited to, the following:~~

~~1) Event, incident, or near-miss reports~~
~~2) Medical record reviews~~
~~3) Monitoring systems based on objective criteria~~
~~4) Patient complaints and Grievances~~
~~5) Physician and other medical professionals' input~~
~~6) Results of failure mode and effects analysis of high-risk processes~~
~~7) Root-cause analyses~~

~~v. Analyzing data collected on adverse events, near misses, and potentially unsafe conditions; providing feedback to providers and staff; and using this data to facilitate systems improvements to reduce the probability of similar future events.~~

~~vi. Ensuring compliance with data collection and reporting requirements of governmental, regulatory, and accrediting agencies.~~

~~vii. Facilitating the implementation of patient safety initiatives such as pressure injury prevention, falls prevention, infection prevention, medication safety, and wrong-site surgery prevention.~~

~~viii. Facilitating provider and staff participation in educational programs on risk management and patient safety.~~

~~ix. Nurturing a culture of safety in the organization that embodies an atmosphere of mutual trust in which all providers and staff can speak freely about safety concerns and potential solutions, without fear of retribution. This involves performing safety culture surveys and assessments.~~

x. ~~Proactively advising the organization on strategies to reduce unsafe situations and improve the overall environmental safety of patients, visitors, staff, and volunteers.~~
xi. ~~Reducing the probability of events that may result in losses to the physical plant and equipment (e.g., biomedical equipment maintenance, fire prevention).~~
xii. ~~Preventing and minimizing the risk of liability to the organization while protecting the financial, human, and other tangible and intangible assets.~~
xiii. ~~Decreasing the likelihood of claims and lawsuits by developing a patient and family communication and education plan. This includes communicating and disclosing errors and events that occur in the course of patient care, with a plan to manage any adverse effects or complications.~~
xiv. ~~Decreasing the likelihood of lawsuits through effective claims management. Investigating and assisting in claim resolution to minimize financial exposure in coordination with the liability insurer and the legal department.~~
xv. ~~Reporting potentially compensable events (PCE) to the legal department within appropriate timeframes to comply with reporting requirements of the insurance carrier.~~
xvi. ~~Supporting quality assessment and improvement programs throughout the organization.~~
xvii. ~~Implementing programs that fulfill regulatory, legal, and accreditation requirements.~~
xviii. ~~Establishing an ongoing patient safety program composed of representatives from key clinical and administrative departments and services.~~
xix. ~~Monitoring the effectiveness of risk management and patient safety initiatives. Performance monitoring data may include the following:~~
1) ~~Claims and claim trends~~
2) ~~Culture-of-safety surveys~~
3) ~~Event trending data~~
4) ~~Ongoing risk assessment information~~
5) ~~Patients' and/or families' perceptions of how well the organization meets their needs and expectations~~
6) ~~Quality performance data~~
xx. ~~Developing and monitoring effective handoff processes for continuity of patient care.~~

3. ~~Administrative Committee Structure and Mechanisms for Coordination~~
a. ~~The Risk Manager or designee Administrative Committee Structure and Mechanisms for Coordination includes but is not limited to~~
i. ~~Reports to the Chief Medical Officer (CMO)~~
ii. ~~Interfaces with administration, staff, medical providers, other professional and has the authority to cross operational lines in order to meet goals and objectives outlined in the Plan~~
iii. ~~Responsible for overseeing day-to-day monitoring of patient safety and risk management activities and for investigating actual or potential clinical, operational, or business claims or lawsuits arising out of the organization.~~
iv. ~~Serves when in consultation with the General Counsel as the primary contact between the organization and other external parties on all matters relative to risk identification, prevention, and control, as well as risk retention and risk transfer.~~
v. ~~Assists the Regulatory Compliance Manager when required with the reporting of events to external organizations, per regulations and contracts, and communicates analysis and feedback on reported risk management and patient safety information to the organization for action.~~

4. ~~Monitoring and Continuous Improvement~~
a. ~~The Risk Manager reports activities and outcomes (e.g., risk and safety assessment results, event report summaries and trends) regularly to the governing Board. This report~~

~~informs the governing Board of efforts made to identify and reduce risks as well as the success of these activities.~~

~~b. The Risk Manager also communicates outstanding issues that need input and/or support for action or resolution.~~

~~c. Data reporting may include event trends, frequency and severity data, relevant staff education, and risk management/patient safety activities. In accordance with the organization's bylaws, recommendations from the Patient Safety Committee are submitted to the Board either for action or merely to inform.~~

~~d. Performance improvement goals are developed to remain consistent with the stated risk management and patient safety goals and objectives. Documentation is in the form of quarterly risk management reports to the Patient Safety Committee, and the Quality Assurance Performance Improvement Committee. These reports on risk management activities and outcomes are forwarded to the Board.~~

~~G.~~F. PATIENT SAFETY (PS) PROGRAM

1. Patient Safety (PS) plan is administered through by the Patient Safety Officer or alternate as designated by the Chief of Patient Care Services and/or Director Clinical Quality Resources with the support of the Leadership and the Patient Safety Committee
2. Goals and Objectives
   a. The PS plan goals and objectives are as follows:
      i. Encourage organizational learning about medical and health care errors
      ii. Incorporate recognition of patient safety as an integral job responsibility
      iii. Provide education on patient safety in job specific competencies
      iv. Encourage recognition and reporting of medical and health care errors without judgment or blame
      v. Involve patients in decisions about their health care ~~and promote open communication about medical errors and their consequences when they occur~~
      ~~vi. Collect and analyze data and care processes to identify opportunities to reduce risk and initiate preventative measures~~
      ~~vii.~~**vi.** Report investigative findings internally including actions taken to refine and optimize systems and processes **related to patient safety**
      ~~viii.~~**vii.** Collaborate with Risk Management, Nurse Managers and TCMC clinical and non-clinical staff to promote a Just Culture
      ~~ix.~~**viii.** Pursue opportunities to improve the quality of patient care, services, and safety
      ~~x. Support sharing of knowledge to effect behavioral changes within the Health Care District by sharing information~~
3. Patient Safety Committee
   a. The PS committee will be chaired by the Patient Safety Officer or designee
   b. The Patient Safety Officer (PSO) will be the Manager of Regulatory Compliance or designee **identified** by the Director Clinical Quality Resources. The PSO reports to the Chief **Nurse Executive**~~of Patient Care Services~~ **or designee**.
   c. The responsibilities of the Patient Safety Officer include but are not limited to compliance with patient safety standards and initiatives, evaluation of work performance as it relates to patient safety, reinforcement of the expectations of the PS plan and reporting patient safety measures and activities to the Quality Assessment and Performance Improvement (QAPI) Committee
      i. The PS Committee is an interdisciplinary group that manages the Patient Safety Program through a systematic, coordinated, continuous approach
      ii. The PS Committee membership includes a medical staff representative and services involved in patient care i.e., Pharmacy, Laboratory, Surgical Services, Risk Management, Infection Control, Radiology, Rehabilitation Services, and Nursing and non-clinical services and departments ~~such as Human Resources~~
      iii. The team shall meet at least quarterly to assure the maintenance and improvement of patient safety in establishment of plans, processes and

mechanisms identified in the Centers for Medicare and Medicaid (CMS) Conditions of Participation provisions and The Joint Commission (TJC) PS standards

d. Scope and Functions

i. The scope of the PS committee includes the sharing of knowledge and practices across multiple disciplines to optimize the use of findings from internal reports e.g., incident reporting, quality measures, risk management, and committee discussions.

ii. The committee will review and analyze external resources e.g., Sentinel Events, California Department of Public Health All Facilities Letters (AFLs), and nationally recognized patient safety organizations

iii. The committee will make recommendations to reduce the overall prospect of adverse events based on evidence-based and best practices to improve patient safety

iv. As an integral part of a patient safety and quality improvement the following PS measures will be a focus of the **2022** PS activities**:** ~~but not limited to:~~

1) Medication Safety, Adverse Drug Events/Reactions, Medication Errors, Use of Opioids
~~2) Pressure Injuries~~
~~3) Falls~~
~~4)~~**2)** ~~Restraint~~ **, D~~d~~ocumentation**~~use~~**
~~5)~~**3)** Blood Transfusion **Administration and R**~~r~~**eactions**
~~6)~~**4)** Patient Flow (throughput)
~~7)~~**5)** Pain Management & Assessment **Documentation when Opioids are used**
~~8)~~**6)** Code Blue/Resuscitation **Staff Debriefings**
7) Nursing Quality Indicators
a) Pressure Injuries
b) Falls
~~9)~~**c) Restraint use and documentation of discontinue use**
~~10)~~**8)** Moderate Sedation **Outcome monitoring**
~~11)~~**9)** Critical Results of Test Timeliness
~~12)~~**10)** ~~Hand Hygiene~~
~~13)~~

v. The committee's 2022~~1~~ – 2022**3** PS activities include but are not limited to the following:

1) **Reduce falls with and without injuries by 50% by December 2022**~~Provide Patient Safety education as needed to all employees~~
2) ~~Collaborate with the Infection Preventionist to:~~
3) Update the National Patient Safety Goals (NSPG) 2021**2** Net Learning Module **and monitor staff compliance to the NSPGs**
4) **Provide education on Implicit Bias** ~~Monitor staff compliance to the NSPGs~~
5) ~~Develop and assign the Teach-back Net Learning module~~
6) ~~Improve staff medication management communication with patients on the following:~~
~~7)~~**5) Reinforcing the use of the Teach-Back method to assist with care transition**~~Identify processes to improve Registered Nurses (RN) abilities to explain information to patients understandably~~
~~8)~~**6)** Identify patient safety projects that **are potential** ~~require~~ **risk and required** -Risk Management to conduct **one of the following:** Root Cause Analysis, Performance Improvement (PI), or Failure Mode and Effects Analysis (FEMA~~); minimum of every 18 months~~
~~9)~~**7)** Conduct a Culture of Safety Employee survey at ~~least~~ annually

~~H.~~ ~~**CONFIDENTIALITY**~~

~~1.~~ ~~Any and all documents and records that are part of the patient safety and or risk management process shall be privileged and confidential to the extent provided by state and federal law. Confidentiality protections may include attorney-client privilege, attorney work product, Quality Improvement, and Peer Review protections.~~

~~The organization, to the extent possible, shall avail itself of the protections afforded by the Patient Safety and Quality Improvement Act of 2005 as well as California Evidence Code section 1157. These protections apply to investigation and documentation of patient safety events, data, and reports—referred to in the law as "patient safety work product"—by creating a patient safety evaluation system, through which the organization produces patient safety work product with the intent of analyzing the data for the purpose of improving patient safety and overall care~~.

The signatures below represent an acceptance of the ~~Risk Management and~~ Patient Safety Plan.

_____ Date Approved: _____
Steve Dietlin,
Chief Executive Officer
Tri-City Health Care District

_____ Date Approved: _____
Candice Parras,
Chief **Nurse Executive**~~of Patient Care Services~~

_____ Date Approved: _____
Gene Ma,
Chief Medical Officer

~~_____ Date Approved: _____~~
~~Governing Board~~

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**PRONOUNCEMENT OF DEATH**
Purpose:	To outline the appropriate steps in pronouncement of death.

A. **DEFINITION(S):**

1. Authorized Registered Nurse (RN): The RN who has been instructed on criteria for pronouncement of death who has successfully completed two (2) pronouncements of death in the presence of another authorized RN.
   a. Generally, ~~Assistant Nurse~~ **Nurse Leaders**~~Managers~~ or Administrative Supervisors.
2. Death: Determined by the absence of a patient's neurological, circulatory, and respiratory function.

B. **POLICY:**

1. The primary nurse must notify the patient's attending physician and consulting Physicians (i.e. surgeon) of patient's death.
   a. It is the responsibility of the attending physician or designee to notify the patient's next of kin when the patient has died.
2. An authorized RN may pronounce the patient based on a telephone or written order from the attending physician.
   a. The authorized RN shall not be the patient's primary RN.
3. An authorized RN may pronounce death for patients with a Do Not Resuscitate (DNR) or Allow Natural Death order in all nursing units with the exception of Neonatal Intensive Care Unit (NICU) and the Emergency Department (ED).
   a. NICU patients may only be pronounced by physicians with NICU privileges.
4. The Emergency physician or attending physician shall pronounce full code patients.
   a. ~~After a code, t~~**T**he physician needs to determine when to stop resuscitation measures and pronounce death

C. **PROCEDURE:**

1. Verify written physician order to pronounce.
2. Assess the patient noting the absence of the following:
   a. **Reaction of** ~~P~~**p**upillary response to light
   b. Apical heart sounds/rate by auscultation for one minute
   c. Respirations by visual examination and auscultation for one minute
3. Document the date and time of pronouncement in the ~~"Note upon~~ Pronouncement **Note**~~"~~ **in the electronic health record**~~Power Form in Cerner~~.

D. **FORM(S):**

1. Initial Pronouncement of Death Verification

Department Review	Clinical Policies & Procedures Committee	Nursing Leadership ~~Executive Council~~	Medical Staff Department/ Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
02/12, 10/17, **12/21**	09/12, 05/18, **04/22**	09/12, 05/18, **05/22**	n/a	n/a	10/12, 06/18, **05/22**	**06/22**	11/12, 07/18, **n/a**	12/12, 07/18

Tri-City Medical Center
Pronouncement of Death Verification

Name _____ Employee ID _____

Title _____ Department _____

INITIAL PRONOUNCEMENT OF PATIENTS

1. Medical Record _____

   Date Performed _____

   RN/MD Observer's Signature _____

INITIAL PRONOUNCEMENT OF PATIENTS

2. Medical Record _____

   Date Performed _____

   RN/MD Observer's Signature _____

Revision Date(s): 8/12, 7/18

Tri-City Health Care District
Oceanside, California

~~ADMINISTRATIVE POLICY MANUAL~~
PATIENT CARE Services

ISSUE DATE:	**05/86**	**SUBJECT:**	**Reporting Suspected Dependent Adult / Elder Abuse/Neglect / Exploitation**
REVISION DATE:	**06/91, 09/94, 02/96, 01/97, 07/99, 10/00, 06/03, 12/05, 04/09, 06/11, 07/17, 12/21**	**POLICY NUMBER:**	**8610-309**

Department Approval:	**~~08/21~~03/22**
Clinical Policies and Procedures Committee Approval:	**~~08/21~~04/22**
Nursing Leadership Approval:	**~~10/21~~05/22**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~11/21~~05/22**
Administration Approval:	**~~11/21~~06/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/21**

A. **PURPOSE:**
1. To provide guidelines for the management and reporting of suspected abuse/neglect of elders and dependent adults.

B. **DEFINITIONS:**
1. Abandonment:
   a. Desertion or~~f~~ willful forsaking of an elder or dependent adult by anyone having care or~~f~~ custody of that person under circumstances in which a reasonable person would continue to provide care and custody.
2. Abuse:
   a. Means physical abuse, neglect, financial abuse, abandonment, isolation, abduction, **non-beneficial restraint,** or other treatment resulting in harm, pain or mental suffering or deprivation by a care custodian of goods and services ~~s~~ that are necessary to avoid physical harm or mental suffering.
3. Dependent Adult:
   a. Anyone between the ages of 18 and **59~~64~~** years who has physical or mental limitations or age-diminished physical or mental abilities which restrict that person's ability to carry out normal activities or to protect his/her rights including (but not limited to) persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age. This definition also includes any one between the ages of 18 and **59~~64~~** who is admitted as an inpatient in an acute care hospital or other 24-hour health facility.
4. Elder:
   a. Any person **60~~65~~** years of age or older.
5. Endangered Adult:
   a. Means a dependent or elder adult who is at immediate risk of serious injury or death, due to suspected abuse or neglect and who demonstrates the inability to take action to protect himself or herself from the consequences of remaining in that situation or condition
6. Financial Abuse:

a. Theft, misuse of funds or property, extortion, duress, fraud.

7. Exploitation:
   a. Taking advantage of another for one's own advantage or beni~~e~~fit. An unjust or improper advantage or use of another person or their property for one's own profit or advantage (i.e., using a victim's financial means for another's gain).
8. Imminent Danger:
   a. Substantial probability that elder or dependent adult is in imminent or immediate risk of death or serious physical harm, through either his/her own action or inaction or as a result of the action or inaction of any other person.
9. Isolation:
   a. Acts to intentionally preventing an individual from receiving mail, **email,** telephone calls or visitors. ~~an elder or dependent adult from receiving mail or phone calls.~~
   b. Telling a caller or prospective visitor that an elder or dependent adult is not present, **when**~~does~~:
      i. False
      ii. Contrary to the express wishes of the elder or dependent adult, whether he or she is competent or not; and
      iii. Made for the purpose of preventing the elder or dependent adult from having contact with family, friends or concerned persons
   c. False imprisonment.
   d. Physical Restraint of an elder or dependent adult for the purpose of preventing him or her from meeting with visitors
10. Mandated Reporter:
   a. Professionals or individuals listed under Penal Code required to report by law. Such persons include, but are not limited to, health care providers such as physicians, surgeons, psychiatrists, psychologists, **social workers,** dentists, residents, interns, or licensed nurses.
11. Mental Suffering:
   a. Fear, agitation, confusion, severe depression or other forms of serious emotional distress brought about by threats, harassment, or other forms of intimidating behavior.
   b. False or misleading statements made with malicious intent to agitate, confuse, frighten or cause severe depression or serious emotional distress of the elder or dependent adult
12. Neglect:
   a. Failure to provide food, clothing, shelter, or health care for an individual under~~s~~ one's care when the means to do so are available.
   b. Neglect includes:
      i. Failure to assist in personal hygiene, or in provision of food, clothing or shelter
      ii. Failure to provide medical care for physical and mental health needs (excludes the elder or dependent adult who voluntarily relies on treatment by spiritual means vs. medical treatment, when no other indicators of abuse exist)
      iii. Failure to protect from health and safety hazards
      iv. Failure to prevent malnutrition or dehydration
   c. If a person cannot provide the above for oneself due to poor cognition functioning, mental limitation, substance abuse, or chronic poor health, this also constitutes neglect
13. Physical Abuse: means **any/**all of the following:
   a. Hitting, kicking, burning, and dragging, over or under medicating. Battery
   b. Assault with a deadly weapon or force likely to cause great bodily harm
   c. Unreasonable physical constraint, or prolonged or continual deprivation of food or water
   d. Use of physical or chemical restraint, or psychotropic medication under the following conditions
      i. For punishment
      ii. For a period significantly beyond that for which the restraint or medication is authorized by a physician's licensed in California who is providing medical care to the elder or dependent adult at the time the instructions are given

iii. For any purpose not authorized by the physician

14. Self-Neglect:
    - **a.** Failure to provide food, clothing, shelter or healthcare for oneself.
    - ~~a.~~**b. Self-harming behavior including, but not limited to, suicide attempt.**
15. Sexual Abuse:
    - a. Unwanted sexual contact, sexual exploitation, forced viewing of pornography
    - b. Sexual assault which means any of the following:
        - i. Sexual battery
        - ii. Rape
        - iii. Rape in concert
        - iv. Spousal rape
        - v. Incest
        - vi. Sodomy
        - vii. Oral copulation
        - viii. Sexual penetration
        - ix. Lewd or lascivious act

C. **POLICY:**

1. Sections 15600, et seq., of the California Welfare and Institutions Code requires that a mandated reporter who, in his/her professional capacity, or within the scope of his/her employment that has observed or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse, or neglect, or is told by an elder or dependent adult that he/she has experienced behavior, including the act or omission, constituting acts described above, shall report to an adult protective services agency or local law enforcement agency by telephone immediately or as soon as practicably possible, and by written report within two (2) days.
2. The following may indicate a need for further assessment:
    - a. Injuries inconsistent with what the patient reports to have happened (i.e., burns, welts, bites and scratches)
    - b. Unusual patterns of injury (i.e., hairbrush, rope or belt marks)
    - c. Poor hygiene, malnourishment
    - d. Fear of parent or caregiver, being withdrawn or tearful
    - e. Improper responses to questions such as, "Is anyone misusing your money, food, housing or not allowing you to obtain health care?"
    - f. Inappropriate responses to questions about a safe environment or being threatened at home
3. The code also permits the reporting of suspected intimidation, cruel punishment, or other treatment that endangers an elder or dependent adults' emotional wellbeing.
4. Instances do not have to be reported if a physician, registered nurse, or psychotherapist are unaware of independent evidence of incidents described in 1 above, and the patient has been diagnosed with a mental illness or dementia and mandated reporter does not believe abuse occurred.
5. Abuse of an elder or dependent adult is a criminal act.
6. Welfare and Institutions Code Section 15634 provides that no mandated reporter shall incur any civil or criminal liability as a result of making a report authorized by the law.
7. Any person who knowingly fails to report an instance of elder or dependent adult abuse is guilty of a misdemeanor.
8. The mandated reporter will complete an assessment and report the findings to the attending physician. If abuse is suspected, the mandated reporter will make a telephone report to the appropriate agency immediately or as soon as practically possible.
    - a. If the alleged abuse occurred in a long-term care facility (Skilled Nursing Facility or Board & Care), the report must be made to the local ombudsman (1-800-640-4661; fax 858-694-2568) or the local law enforcement agency where the incident occurred.
    - b. If the alleged abuse occurred anywhere else, the report must be made to the County

Aging and Independence Services (AIS) at 800-510-2020.

c. The mandated reporter will notify by phone, the adult abuse hotline (AIS) at 800-510-2020, or the ombudsman's office 1-800-640-4661 and will complete the elder abuse reporting form SOC 341.

9. The mandated reporter making the telephone report must complete a written report and mail it to the appropriate agency within two (2) days of making the telephone report.
10. All completed SOC 341 forms need to be forwarded to the hospital Social Services Department for mailing and filing. Copies of all completed "Suspected Dependent Adult/Elder Abuse" forms (SOC 341) will be filed and maintained in the Social Services Department at TCHD.
11. The Social Services Department at TCHD has the primary responsibility for coordinating, tracking the reporting of suspected cases of abuse/neglect to the appropriate agency, as well as notification of TCHD Compliance Officer. This applies whether seen in the Emergency Department, or admitted to the Medical Center.
12. Social Services Department will be notified of all cases of suspected elder abuse/neglect by one of the following methods:
    a. Making a Social Service referral through the computer. **Making a Social Service referral does not satisfy the Mandated Reporter's Duty to Report as stated in C.8 of this policy.**
    b. By telephone to the Social Services department or page to a specific Social Worker.
    c. By completing an SOC 341 Elder Abuse Reporting Form and forwarding it to the hospital Social Services Office.
13. Detention of Endangered Adults - Welfare and Institutions Code Section 15703.05 allows a physician treating an adult, if he/she determines that adult is endangered, to delay the release until:
    a. A local law enforcement agency takes custody of the patient
    b. The responding agency determines the adult is not an endangered adult
    c. The responding agency takes other appropriate action to ensure the safety of the endangered adult (This law applies whether or not medical treatment is required)
14. If the patient was a victim of abuse, neglect or domestic violence (except child abuse or neglect), the patient must be promptly informed that a report has been or will be made unless:
    a. The health care provider believes, in the exercise of professional judgement, that the informing the patient would place him or her at risk of serious harm, or
    b. The health care provider would be informing a personal representative , and the provider reasonably believes the personal representative is responsible for the abuse, neglect or other injury and that informing the personal representative would not be in the best interests of the patient
    c. Verbal notification is sufficient. A report must be made even if the patient objects. The health care provider may suggest that the victim go to a protected environment due to the risk of retaliation after the report is made.
15. When appropriate, the Clinical Social Worker shall inform the patient and/or family of what actions have taken place, why they transpired, and what position the District must take in such situations as prescribed by law.
16. The Clinical Social Worker shall serve as liaison between the District and all outside agencies, in compliance with Elder/Dependent Adult Abuse statutes and the regulations and procedures of San Diego County Department of Social Services.
17. The Clinical Social Worker may continue to provide case management including discharge planning to a safe environment.
18. Any problematic cases are reported to the Director/Manager of Social Services and of Risk Management for additional review.
19. When two or more mandated reporters have knowledge or reasonably suspect a reportable incident, they can agree that a single report can be made. This can be coordinated through the Social Services Department.
20. Any person who is not a mandated reporter who knows, or reasonably suspects, that an elder or dependent adult has been the victim of abuse, may report that abuse. Such reports may be

coordinated through the Social Services Department.

D. **REFERENCE(S):**

1. Adult Protective Services (SRS).
2. California Hospital Association. (202020). *California Hospital: Consent Manual*. CHA Publications: Sacramento.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**12/13**	**SUBJECT:**	**Wearable Cardioverter-Defibrillator (LifeVest)**

REVISION DATE~~(S)~~: 12/13, 03/19

Patient Care Services Content Expert Approval:	**~~08/18~~10/21**
Clinical Policies & Procedures Committee Approval:	**~~11/18~~11/21**
Nursinge Leadership~~Executive Committee~~ Approval:	**~~11/18~~12/21**
Division of Cardiology:	**~~12/18~~04/22**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~02/19~~05/22**
Administration Approval:	**~~03/19~~06/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**03/19**

A. **DEFINITIONS:**

1. Life Vest Wearable Cardioverter-Defibrillator (WCD) is a "wearable defibrillator that is worn by patients at risk for sudden cardiac arrest (SCA). It is an optional treatment for SCA designed to detect life-threatening arrhythmias and deliver shock treatment to restore a normal heart rhythm and heart rate.
   a. The WCD (i.e., LifeVest) allows physicians time to assess patient's long-term arrhythmic risk and make appropriate treatment plans.
   b. The LifeVest is a patient interactive device and thus requires a patient is able to respond to alerts.
2. The LifeVestis programmed to perform the following major functions:
   a. Detect life-threating arrhythmias.
   b. Alert asymptomatic patients if a life-threating heart rate/rhythm is detected.
   c. Allow patients to self-administer treatment based on their tolerance to the arrhythmia or initiate treatment i.e., defibrillation.
   d. Deliver shock (defibrillation) treatment to unconscious patients or symptomatic patients that do not halt treatment.

B. **PURPOSE:**

1. To identify the inpatient nursing units that may provide care for patients admitted wearing a LifeVest or have a LifeVest applied during their hospital stay.
2. To identify inpatient Registered Nurse's (RN)'s responsibilities when providing care for patients admitted wearing a LifeVest or when an order is received to apply a LifeVest during a hospital stay.
3. To identify the RN's responsibilities when a patient is transferred to TCMC outpatient rehabilitation unit.

C. **POLICY:**

1. Patient must be alert and oriented to implement the care management routine for the LifeVest and able to identify when LifeVest therapies are not required.
2. Patients should wear the LifeVest at all times, including while sleeping.
3. Ensure patient changes and charges the reserve battery every 24 hours.
4. The LifeVest should only be removed when the patient is showering or bathing with a physician's order. See the patient manual if required to assist patient for additional information.

5. Staff should not intervene or touch patient when the device delivers a treatment. The LifeVest has three types of alerts that the patient must respond to, they are as follows:
   a. Vibration alert – informs the patient "you're about to receive a siren alert". The vibration alert also alarms when the battery is changed.
   b. Siren alert – a high-pitched two-tone sound that means an abnormal rhythm has been detected.
      i. If the patient is alert they must: depress the response buttons to stop the treatment
      ii. If the patient is unconscious or does not response within 60 seconds a treatment will be provided.
         1) Prior to delivering a treatment the siren alert will stop and a voice will prompt bystanders not to touch the patient. The voice also alerts bystanders to call for help after the patient receives the treatment.
   c. Gong alert – low-pitched gong sound that repeats about once a second. The alert is accompanied by a message stating a problem that needs the patient's attention. The patient must read the message to identify the appropriate action.

D. **REHABILIATION UNIT**

1. Patients admitted to Tri-City Medical Center (TCMC) Rehabilitation unit with a LifeVest shall be able to properly manage the alarms and to press the response buttons to stop shock activation.
2. Ensure patient is admitted wearing the LifeVest and has the following supplies (extra garment [vest], electrode belt, battery and battery charger, cell phone with charger, and patient manual)
3. The following shall be implemented by the primary RN in the event a patient:
   a. Receives a shock and is responsive
      i. Assess vital signs (blood pressure, heart rate, respiratory rate, and oxygen saturation percent)
      ii. Call the Rapid Response Team (RRT), if indicated
      iii. Notify physician
   b. Receives a shock and has a change in level of consciousness
      i. Assess vital signs
      ii. Call the RRT
   c. Receives a shock and is unresponsive
      i. Assess vital signs, identify the presence of a pulse and assess breathing.
      ii. Call a Code Blue, if indicated and start basic life support (BLS)
   d. Document events in the medical record

E. **INPATIENT NURSING UNITS**

1. Inpatients requiring a LifeVest shall be admitted or transferred to Telemetry, Progressive Care Unit (PCU) or the Intensive Care Unit (ICU) for continuous cardiac monitoring until discharge.
   a. Patients will have the care provided by a core Telemetry, PCU, or ICU RN
2. RNs shall assess patient's ability to properly manage the alarms and to press the response buttons to stop shock activation. Assess the patient's ability to state or locate the following:
   a. Why they need a LifeVest.
   b. Three types of alarm alerts:
      i. Audible, visual and tactile.
   c. How to stop a shock:
      i. Ask patient to point to the buttons they must depress.
   d. Time of day or night the battery should be changed.
   e. How to change the battery and ensure the spare battery is charging.
   f. How to download the device data.
   g. How they are alerted.
   h. When to change the vest.
   i. When to notify the nurse or when would they call 911 if at home.

3. If the patient is able to properly manage and comply with the LifeVest therapy instructions, do not remove the LifeVest without a physician's order
4. If a patient is unable to properly manage or comply with the LifeVest therapy instructions or requires procedures or test requiring the LifeVest be removed:
    a. Ensure a visible continuous cardiac rhythm is displayed, apply defibrillator pads per hospital procedure, and then remove the LifeVest
    b. After removing the LifeVest perform the following:
        i. Place the device in the patient's closet
        ii. Ensure the battery is charging
        iii. If the family request, give the LifeVest and battery with the charger to family
        iv. Document disposition per Administrative Policy: Valuables, Liability, and Control.
            1) Continuous cardiac monitoring will be implemented during transport to procedures or test with a RN and a monitor capable of defibrillating until the LifeVest is reapplied or an implantable cardioverter defibrillated in implanted
5. See Online Skill: LifeVest Wearable Cardioverter-Defibrillator procedure for instructions on the following:
    a. Overview of the WCD e.g., LifeVest
    b. Patient education
    c. Assessment and preparation for patients with new orders for a LifeVest
    d. Monitoring and care
    e. Expected and unexpected outcomes
    f. General documentation requirements
6. Battery and Garment Management
    a. Ensure patient's battery charger is plugged, reserve battery is charging, patient changes battery per the instruction provided by manufacturer,
    b. Ensures patient has extra LifeVest supplies
7. Discharging a Patient Requiring a LifeVest
    a. Prior to discharge (24-48 hours) ensure patient, if not contraindicated, has ambulated and a cardiac tracing is placed in the medical record. Document patient's tolerance to ambulation in the medical record and complete a focus assessment per the Standards of Care for Adults.
    b. Prior to discharge (24-48 hours) ensure the following is initiated and implemented:
        i. Request patient notify family to bring the LifeVest and battery charger to TCMC if taken home. Once received, update the Valuables and Belongings Checklist in the medical record. Instruct patient to apply the LifeVest. Ensure patient charges the reserve battery.
        ii. RNs will reinforce discharge instructions as outlined by TCMC and suggested by the LifeVest manufacturer for patients admitted wearing a LifeVest. For patients receiving a LifeVest during the current admission, review the instructions provided by the LifeVest technician, and patient is discharged with the LifeVest kit provided by the manufacture
        iii. A physician's order is required to discharge the patient without wearing a LifeVest.

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

1. Patient Care Services (PCS) Policy: Discharge of Patients and Discharge Against Medical Advice Policy
2. PCS Policy: Discharge Planning
3. PCS Policy: Patient and Family Education
4. PCS Policy: Patient Valuables, Liability, and Control

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

1. Online Skill: LifeVest Wearable Cardioverter-Defibrillator Procedure

H. **REFERENCE(S):**

1. Zoll. (n.d.). *LifeVest: Operator Manual LifeVest 4000*
2. Zoll. (n.d.). *LifeVest: Patient Manual LifeVest 4000*

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY
PATIENT CARE

ISSUE DATE: 09/05

SUBJECT: Assignment of Medical Record Numbers and Standard Naming Guidelines

REVISION DATE(S): 05/09, 09/12, 01/18, 01/22

POLICY NUMBER: 8610-390

Administrative Policies & Procedures Content Expert:	~~07/21~~03/22
Administrative Policies & Procedures Committee Approval:	~~08/21~~04/22
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~01/22~~06/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/22

A. **PURPOSE:**

1. A unique medical record number specific to the patient will be assigned to each patient who is admitted or treated at Tri-City Healthcare District (TCHD) as an inpatient, outpatient, or Emergency Department patients. Each patient will be assigned a unique medical record number that will be utilized for every encounter or admission to any area throughout the medical center.

B. **SCOPE:**

1. The policy applies to all personnel who schedule or register patients for admission or treatment at TCHD as Inpatients, Outpatients, or Emergency Department patients. The correction part of this policy also applies to Medical Records/Health Information Management (HIM) Department who are responsible for review/correction of duplicate numbers.

C. **POLICY:**

1. Usage of this unique number will facilitate continuity of patient care through accurate medical record availability, and efficient processing of patients by the various registration locations throughout the hospital, as well as provide for accurate data quality for patient care and billing purposes.
2. Single number for each patient within the Master Patient Index (MPI).
3. Standardized search process to be used.
4. Standardized naming conventions to be utilized.
5. Correction and maintenance of the index is the responsibility of the Medical Records/HIM Department.

D. **PROCESS:**

1. Verification of Patient Identity:
   a. Registration personnel will attempt to obtain the following data when performing the search for medical record number:
      i. Patient's legal name including last, first and middle initial (when applicable)
      ii. Correct spelling of the name by the patient
      iii. Patient's maiden name
      iv. Patient's date of birth
      v. Patient's Gender
      vi. Patient's Social Security Number
   b. All information will be double-checked including spelling of patient's name by reviewing

photo-identification, insurance cards, and/or social security card.

c. Patient will be asked if previously treated at TCHD for inpatient or outpatient services.
d. The name(s) used during previous visit(s) will be verified.
e. When a patient has been treated previously at TCHD and the alias screen displays, the Social Security Number should be used as a tiebreaker to correctly identify the patient.
f. Duplicate Alias Warning Window:
    i. States: "WARNING: This alias is assigned to another person or encounter".
    ii. Appears in any conversation to indicate that the Social Security Number that has been entered is assigned to another individual in Cerner.
    iii. When Alias warning appears: stop. Search for prior MRN by doing an SSN only search.
g. The patient's address is to be included as a tiebreaker when identifying if the patient has been previously assigned a medical record number or treated at TCHD.

2. Patient Naming Conventions:
    a. Order of the name:
        i. Names will be entered in the order that the legal name is stated.
        ii. Foreign names will be entered in the order that the legal name is stated.
    b. Hyphenated Name:
        i. Names containing a hyphen are entered with the hyphen, with no extra spaces before or after.
        ii. The last name is entered in the order of legal name.
    c. Mixed Case Name:
        i. Names will be entered in using the "case" matching the legal name
            1) Example: McDonald, Ronald is entered with a capital "M" and a capital "D"
            2) Example: Smith, John is entered with a capital "S" and lowercase "mith"
    d. Patient Legal Name vs. Nickname:
        i. Patient's legal name including last, first and middle initial (when applicable) will be obtained.
    e. Use of Punctuation:
        i. Names will be entered without the use of punctuation
            1) Exception: Hyphens may be used.
            2) Periods, commas, apostrophes, etc. should not be included in patient's name.
                a) Example: O'Brien, Patrick is entered as "OBrien, Patrick"
    f. Use of Spaces:
        i. Include spaces in the last name if the legal spelling of the name includes a space.
    g. Use of Title and Jr., Sr.:
        i. Titles (e.g. Rev., Mr., Mrs., Jr., Sr., III, etc.) are not to be used for scheduling/registration.
    h. Newborns **delivering at TCMC**:
        i. The naming convention for newborns **will be as follows:**
            1) Last name: Mother's last name
            2) First name: Mother's first name followed by the letter "s" and the gender (boy/girl)~~is the last name of the mother (as the baby's last name) and the gender of the baby (as the baby's first name).~~
                a) Example: DOE, JANESBOY or DOE, JANESGIRL
            3) For the delivery of multiples, the newborns will have the following letters added after the gender:
                a) A (first born), B (second born), C (third born) etc.
                ~~i.~~**b) Example: DOE, JANESBOY A and DOE, JANESBOY B**
        ii. Pre-admitted **newborns**~~baby~~ will be entered as: **Intended Parent(s)**~~Mother's~~ Last Name, and Baby.

~~ii.~~**1) See the WNS policy: Surrogacy**

~~iii. Delivered baby's name will be edited to:~~

~~1) Single Birth:~~

~~a) Last name = Mother's last name~~

~~b) First name = Boy or Girl~~

~~2) Multiple Birth baby will be edited to:~~

~~a) Last name = Mother's last name~~

~~b) First name = Boy or Girl~~

~~c) Middle Initial~~

~~d) A (first born)~~

~~e) B (second born)~~

~~f) C (third born)~~

~~iv.~~**iii.** The Medical Record Birth Certificate Clerk updates the baby's name after the birth certificate information is completed and the newborn is discharged.

3. Search for Medical Record Number:
   a. When a patient match has not occurred after a standard search is performed, a search by Social Security Number will be completed. A standard search includes entry of the following four data elements:
      i. Date of Birth
      ii. Last name
      iii. First name
      iv. Gender
   b. Additional Search may be necessary to clarify correct patient.
      i. Abbreviated Versions of Names:
         1) Jenny vs. Jennifer; Ben vs. Benjamin; Jeff vs. Jeffrey.
         2) Patient's legal name will be used for search.
      ii. Maiden names:
         1) If a female patient was at a TCHD facility previously but is not found during search, patient will be asked for her maiden name and search steps will proceed as above. When record is located, Compass is updated.
      iii. Hyphenated married names:
         1) Both parts of a hyphenated name will be used during the patient search.
         2) Example: Susan SmithJones. Search by SmithJones (with first name, gender, and date of birth).
         3) If the hyphenated name is not found during the search and the patient states they have been here before, search again using the patient's stated Social Security Number only.
      iv. Name Reversals:
         1) Reversed middle and first names
         2) Patient (e.g. William Paul Smith) likes to be referred to as another name (e.g. Paul Smith). Do not register as Paul Smith. Register patient under his/her legal name (e.g. William Smith, middle initial P).
      v. Complex Name (e.g. Thomas Henry).
         1) Initial Search as Henry, Thomas. If search does not reveal a match complete a secondary search.
         2) Secondary Search (e.g. Thomas, Henry). The first name will be reversed with the last name.
4. Medical Record Number Assignment During Times of System Unavailability:
   a. Patients that are admitted and registered during downtime are assigned a downtime encounter number. No medical record number is assigned until the Cerner system is back up.
   b. Downtime procedures direct Registration personnel to the Affinity system to identify a previous medical record number, when necessary.

5. If the patient's identification is unknown (e.g. John or Jane Doe):
   a. Do a patient search for John or Jane Doe
   b. If the search returns no patients enter the name as Doe, John (or Jane), leave a space, then use the letter A (as in Doe, John A)
   c. Subsequent John or Jane Does will use letters B, C, D, etc. to differentiate between patients.
      i. If the search returns other John or Jane Does, look to see the last letter used in the first name (e.g. Doe, Jane C)
      ii. Register the next Jane Doe as: Doe, Jane D
   d. If the date of birth of John or Jane Doe is not known
      i. Use the current day and month as the day and month of Jane/John Doe's birthday
      ii. Example: Today is 2/24/04
         1) John/Jane Doe's birthday to be entered as: 02/24
      iii. The birth year is calculated as follows:
         1) If you think the patient's age is XX, use this birth year

a)	0-10	Year 2000
b)	11-20	Year 1990
c)	21-30	Year 1980
d)	31-40	Year 1970
e)	41-50	Year 1960
f)	51-60	Year 1950
g)	61-70	Year 1940
h)	71-80	Year 1930
i)	81-90	Year 1920
j)	91 and over	Year 1910

   e. A "John Doe" medical record will be generated through the Registration process.
   f. Continuous efforts will be made to establish correct identification throughout the patient's hospitalization.
   g. After the patient's identification has been determined and if the patient has no previous medical record number, the assigned temporary number will remain as the patient's permanent medical record number.
   h. After the patient's identification has been determined and if the patient has a previous medical record number, the individual in charge of the patient will notify the Medical Records or Registration Department.
6. Correction of Duplicate Medical Record Numbers:
   a. The Medical Records/HIM Department is responsible for correcting any duplicate medical record number. This will be implemented in the following manner:
      i. Request for correction of duplicate medical record number will be made in writing to the Medical Records/HIM Department. Submissions may be made by any staff member who identifies possible duplicate medical record numbers.
      ii. The Data Correction sheet is faxed to the Medical Records Department (fax number 3414) or email MPI Specialist.
      iii. The Medical Records/HIM Department follows a Prioritization Matrix to determine which duplicates are combined first.
      iv. The Medical Records/HIM Department reports duplicate assignments by medical service for departmental follow-up.
7. Note: Patient information entered into the Cerner system is passed through to the Affinity Patient Accounting system. When documents are printed from Affinity (i.e. Facesheets, bills, reports) patient name information is displayed in all CAPS without hyphens or spaces.

Tri-City Medical Center
Oceanside, California

EMPLOYEE HEALTH AND WELLNESS ~~MANUAL~~

ISSUE DATE: 05/~~19~~98 **SUBJECT: Immunization Policy**

REVISION DATE(S): 06/02, 09/03, 06/06, 10/06, 07/08, 7/09, 07/12, 04/~~20~~15

Employee Health Department Approval:	03/22
Infection Control Committee Approval:	04/22
Medical Executive Committee Approval:	05/22
Administration Approval:	06/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **INTRODUCTION:**

1. Maintenance of immunity is an essential part of illness prevention. Immunizations provide safeguards to healthcare workers and protect patients from becoming infected through exposure to infected workers.

B. **PURPOSE:**

1. **The health care environment presents risks from communicable diseases to Tri-City Medical Center (TCMC) employees and other healthcare workers. In order to minimize these risks, TCMC requires staff to comply with established vaccination recommendations, guidelines and requirements.** ~~Provide a comprehensive and consistent immunization plan for Tri-City Medical Center employees~~.

C. **DEFINITIONS:**

1. **"Healthcare workers (HCW)" refers to all ~~emloyees~~employees, temporary workers, trainees, volunteers, students, and vendors, regardless of employer. This includes all staff who provide services to or work in patient care or clinical areas.**
2. **Communicable diseases are illnesses resulting from the presence of pathogenic microbial agents, including pathogenic viruses, bacteria, fungi, parasites, and aberrant proteins known as prions.**
3. **Vaccine-preventable diseases are communicable diseases whose transmission can be prevented in whole or in part through vaccinating susceptible staff. In the healthcare environment, the usual vaccine-preventable diseases are the following: influenza, mumps, rubella, rubeola, varicella, diphtheria, pertussis, tetanus and hepatitis B.**

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

1. Hepatitis **B Vaccine:**~~A and B: see separate policies.~~
   a. **New employees with reasonable risk of exposure must show proof of completion of Hepatitis B vaccine series or serology showing immunity. Serologic testing will be performed prior to administering Hepatitis B vaccine in those who state they have received prior vaccination but are unable to show proof. HCWs who have test results that indicate prior immunity will not receive the vaccine.**
   b. **Employees have the option to decline Hepatitis B vaccination and will receive appropriate counseling.**
   c. **Post vaccination screening for immunity to Hepatitis B will be performed within 1 to 2 months after the administration of the third vaccine dose for those personnel who perform tasks involving contact with blood, other body fluids and sharp medical instruments or other sharp objects.**

d. HCWs found to have negative antibody response (defined as <10mIU/mL) after the initial Hepatitis B vaccine series will be revaccinated with a second three-dose vaccine series. If a HCW still does not respond after revaccination, they will be considered a non-responder and susceptible to Hepatitis B infection and referred for evaluation for lack of response.

e. Post-exposure to Hepatitis B (needlestick, percutaneous, or mucous membrane exposure to blood known or suspected to be at high risk of being HBsAg seropositive), susceptible persons will be offered Hepatitis B vaccine series through the Worker's Compensation program.

2. Hepatitis A Vaccine:
   a. Any employee who handles or assists in the preparation of food in the Food & Nutrition department will be offered the vaccine.
   b. Engineering employees who are exposed to raw sewage will be offered the vaccine.
   c. Employees who decline the Hepatitis A vaccine when offered must sign a declination statement.
   d. Post vaccination monitoring is not recommended.
3. Measles, Mumps, and Rubella (MMR) Vaccine:
   a. HCWs must have documented immunity to measles, mumps and rubella.
   b. Documented immunity includes:
      i. Birth before 1957 can considered immune only if they have written documentation of appropriate vaccination or laboratory evidence of immunity.
      ii. HCWs with 2 documented doses of MMR are considered to have presumptive immunity to measles, mumps and rubella
         1) Not recommended to be serologically tested for immunity.
         2) If serological testing is performed and results are negative or equivocal for measles, these HCW should be considered to have presumptive evidence of immunity to measles and do not need additional MMR doses
   c. HCW born in 1957 or later without serologic evidence of immunity or written documentation of prior vaccination (verbal documentation is not acceptable):
      i. Give 2 doses of live 0.5 mL MMR vaccine by subcutaneous route separated by at least 28 days
   d. Personnel without evidence of immunity will be offered MMR vaccine during the employment process unless contraindicated.
   e. Routine serologic screening for measles, mumps, or rubella before administering MMR vaccine to personnel is not performed.
   f. MMR is the vaccine of choice. If the recipient is known to be immune to one or more of the components, monovalent or bivalent vaccine may be used.
4. Tetanus-Diphtheria-acellular Pertussis (Tdap) Vaccine:
   a. Pertussis is highly contagious. Vaccinating HCWs with Tdap will protect them against pertussis and is expected to reduce transmission to patients, other HCWs, household members, and persons in the community.
   b. HCWs who have not received Tdap previously should receive a single dose of Tdap regardless of the time since their last Td (Tetanus-diptheria) dose. Tdap is not licensed for multiple administrations; therefore, after receipt of Tdap, HCWs should receive Td for future booster vaccination (every 10 years) against tetanus and diphtheria.
   c. Pre- and post vaccination testing for antibodies is not recommended.
5. Varicella Vaccine:
   a. HCWs must have documented immunity to varicella. This includes laboratory or

healthcare provider confirmation of prior disease or written documentation of two varicella vaccine doses.

b. Serological testing for varicella will be performed if there is no documentation of immunity.

c. Susceptible personnel who do not have contraindications to immunization should be given two doses of varicella vaccine, at least 30 days apart.

d. Post vaccination testing of personnel for antibodies to varicella will not be performed.

~~a.~~e. Do not vaccinate pregnant women or those planning to become pregnant in the next 4 weeks. If pregnant and susceptible, vaccinate as early in postpartum period as possible.

6. Influenza Vaccine:

a. Influenza vaccine is required annually by November 30 of each year for all TCMC employess, volunteers, and medical staff ~~Mandatory annual vaccination will be offered to Medical Center employees, Auxiliary, and Medical Staff~~

b. Exemptions to influenza vaccination may be granted for documented medical contraindications or sincerely held religious beliefs. Standard criteria for medical exemption will be established based upon recommendations from the Centers for Disease Control and Prevention (CDC).

c. All HCW must either receive vaccine or sign a declination form and wear a face mask during the influenza season typically through March 31 while in patient care areas.

d. All employees, volunteers, and medical staff who begin work at TCMC after November 30 and before April 1 will have 14 days after they begin to sign the Influenza Vaccine Declination Statement or be vaccinated.

e. Failure of compliance will result in progressive disciplinary action, up to and including termination.

7. Other Vaccines (e.g., COVID-19)

a. Additional vaccines will be available free of charge to staff with the issuance of a new applicable public health guideline recommending the additional vaccine, and the vaccine is available.

b. Regulatory requirements for completing vaccine series and reporting will be followed.

~~b.~~c. COVID-19 vaccine requirements will be followed according to the California Department of Public Health (CDPH) order for all facilities (AFL 21-34.3) which requires completion of the vaccination series of either a one-dose regimen or a two-dose regimen as well as a subsequent booster dose according to the schedule defined by the manufacturer.

d. ~~Standard criteria for medical exemption will be established based upon recommendations from the Centers for Disease Control and Prevention (CDC).~~ HCW may be exempt from the COVID-19 vaccination requirements only upon providing a written declination statement, signed by the HCW stating either:

i. The worker is declining vaccination based on religious beliefs; or

ii. The worker is excused from receiving the vaccine due to Qualifying Medical Reasons.

iii. The HCW must also provide a written statement signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician stating that the individual qualifies for the exemption and indicating the probable duration of the worker's inability to receive the vaccine.

e. HCW who have completed their primary vaccination series and provide proof of subsequent COVID-19 infection may defer booster administration for up to 90

days from the date of clinical diagnosis or first positive test.~~who decline a recommended vaccine need to complete a declination form. In the event that a HCW initially declines the vaccine, every effort will be made to make it available to them at a later date.~~

CALIFORNIA IMMUNIZATION REQUIREMENTS FOR COVERED HCP

COVID-19 Vaccine	Primary vaccination series	Vaccine booster dose
Moderna or Pfizer-BionTech	1st and 2nd doses	Booster dose at least 6 months after 2nd dose
Johnson and Johnson [J&J]/Janssen	1st dose	Booster dose at least 2 months after 1st dose
World Health Organization (WHO) emergency use listing COVID-19 vaccine	All recommended doses	Single booster dose of Pfizer-BioNTech COVID-19 vaccine at least 6 months after getting all recommended doses
A mix and match series composed of any combination of FDA-approved, FDA-authorized, or WHO-EUL COVID-19 vaccines	All recommended doses	Single booster dose of Pfizer-BioNTech COVID-19 vaccine at least 6 months after getting all recommended doses

~~2.~~

~~3. Requires all employees, Auxiliary and Medical Staff to either sign the Influenza Vaccine Declination Statement or be vaccinated by November 30 each year, unless the vaccine is unavailable.~~

~~4. All employees, auxiliary, and medical staff who begin work at TCMC after November 30 and before April 1 will have 14 days after they begin to sign the Influenza Vaccine Declination Statement or be vaccinated.~~

~~5. Anyone who does not comply with this requirement is subject to disciplinary action including suspension with intent to terminate.~~

~~6. See IC 11.0 Aerosol Transmissible Diseases and Tuberculosis Control Plan for policy about additional requirements for staff who decline vaccination~~

~~7. Measles, Mumps, Rubella (MMR) vaccine: Required for all employee with patient contact who do not have serological evidence of MMR infection.~~

~~a. Measles and Mumps:~~

~~i. Documented administration of two doses of live MMR vaccine or~~

~~ii. Laboratory evidence of immunity or laboratory confirmation of disease or~~

~~iii. Born before 1957~~

~~b. Rubella:~~

~~i. Documented administration of one dose of live rubella virus vaccine or~~

~~ii. Laboratory evidence of immunity or laboratory confirmation of disease or~~

~~iii. Born before 1957.~~

~~c. Female HCWs may have evidence of Rubella immunity from prenatal testing.~~

~~8. HCWs who have two documented doses of MMR and are inadvertently tested and have negative or equivocal titer results for measles or mumps, it is not recommended that they receive an additional dose of MMR vaccine.~~

~~9. Unvaccinated personnel born before 1957 who lack laboratory evidence of measles, mumps and/or rubella immunity or laboratory confirmation of disease, healthcare facilities should consider vaccinating personnel in routine and outbreak situations with two doses of MMR vaccine at the appropriate interval (for measles and mumps) and one dose of MMR vaccine (for Rubella), respectively.~~

~~10. Tetanus, diphtheria (TD): Administer 1 dose if the person had received the primary series and the last vaccination was 10 years ago.~~

~~11. Tdap Vaccination~~

~~a. Healthcare Workers (HCW) will receive a single dose of Tdap to replace of single dose of Td for active booster vaccination if they have not previously received Tdap. Tdap can be administered regardless of interval since the last tetanus or diphtheria-containing~~

~~vaccine. Only one dose of Tdap is recommended. After receipt of Tdap, HCW should receive Td or TT for booster immunization.~~

~~12. Varicella (Chicken pox) vaccine:~~

~~a. Documented administration of 2 doses of live vaccine or laboratory evidence of immunity. Serologic testing is not recommended if documentation of vaccination is provided. Do not vaccinate pregnant women or those planning to become pregnant in the next 4 weeks. If pregnant and susceptible, vaccinate as early in postpartum period as possible.~~

~~D. **APPROVALS:**~~

~~1. Infection Control Committee~~
~~2. Medical Executive Committee~~
~~3. PAC~~
~~4. Board of Directors~~

E. **REFERENCES:**

~~1. ACIP Provisional Recommendation for Measles-Mumps-Rubella (MMR) 'Evidence of Immunity' for Healthcare Personnel; June 24, 2009~~
~~2. Immunization of Health Care Workers: Recommendation of the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control Practices Advisory Committee (HICPAC),MMR, December 26, 1997/46(RR-18); 1-42~~
~~3. Control of Communicable Diseases Manual, D.L.Heymann, Ed. 18th edition, 2004~~

~~4.~~**1.** APIC Text of Infection Control and Epidemiology, revised edition, ~~2009~~**2014**

2. CDC. Immunization of health-care personnel- Advisory Committee on Immunization Practices (ACIP). MMWR 2014. **CDC: Recommended Vaccines for Healthcare Workers https://www.cdc.gov/vaccines/adults/rec-vac/hcw.html**

~~5.~~**3. CDC Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR, 2011; 60(RR-7)**

Tri-City Medical Cer
Oceanside, California

DELETE – incorporated into Employee Health and Wellness Policy: Immunizations

EMPLOYEE HEALTH AND WELLNESS ~~POLICY MANUAL~~

ISSUE DATE: 01/1999

SUBJECT: Hepatitis A Vaccination

REVISION DATE: 07/06, 05/08

Employee Health Department Approval:	**04/22**
Infection Control Committee Approval:	**04/22**
Medical Executive Committee Approval:	**05/22**
Administration Approval:	**06/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

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

~~1. To provide immunization and prevent the transmission of Hepatitis A.~~
~~2. Any employee who handles or assists in the preparation of food in the Food & Nutrition department are considered eligible and will be offered the vaccine.~~
~~3. Also, employees from Engineering~~ **~~department~~** ~~who are exposed to raw sewage will be offered the Hepatitis A Vaccine.~~
~~4. All other medical center employees are~~ **~~to be determined on a case by case.~~** ~~considered low risk will not be offered the vaccine.~~
~~5. Employees who decline to receive the Hepatitis A Vaccine (HAV) when it is offered must sign a declination stating that the vaccine was offered but refused.~~

~~B.~~ ~~**POST VACCINATION MONITORING**~~

~~1. Post Vaccination Monitoring is not recommended or required.~~

~~C.~~ ~~**APPROVALS**~~

~~1. Infection Control Committee~~
~~2. Medical Executive Committee~~
~~3. PAC~~
~~4. Board of Directors~~

~~D.~~ ~~**REFERENCES**~~~~:~~

~~1. Control of Communicable Diseases Manual, D.L. Heymann, Ed. 19th edition, 2008~~
~~APIC Text of Infection Control and Epidemiology, revised edition, 2014~~**~~02~~**
~~2.~~ ~~**CDC 02/19 ACIP**~~

Tri-City Medical Cent
Oceanside, California

DELETE – incorporated into Employee Health and Wellness Policy: Immunizations

EMPLOYEE HEALTH AND WELLNESS

ISSUE DATE: 01/~~January 1999~~

SUBJECT: ~~Employee Health–~~Hepatitis B Vaccination **(HBV)**

REVISION DATE(S): 10/10, 06/01, 09/04, 10/07, 10/12, 04/~~20~~15

Employee Health Department Approval:	**04/22**
Infection Control Committee Approval:	**04/22**
Medical Executive Committee Approval:	**05/22**
Administration Approval:	**06/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

~~A. **PURPOSE**~~

~~1. To provide immunization for employees and volunteers to reduce risk of exposure to hepatitis B. Any employee **and volunteer** with the potential of an exposure to blood or any body secretions and all volunteers are considered eligible and will be offered the **Hepatitis B Vaccination** (HBV). All other medical center employees are considered low risk due to the lack of exposure to blood or body secretions and will not be routinely offered immunization. Employees who decline to receive the HBV when it is offered must sign a declination stating that the vaccine was offered but declined.~~

~~B. **POST-VACCINATION MONITORING**~~

~~1. Employees who receive the HBV will be tested for successful HBsAB response one – two months after the completion of the HBV series.~~

~~2. Hepatitis B Surface Antibody (HBsAB) Immune (Positive):~~

~~a. No further follow up required.~~

~~b. Vaccine-induced hepatitis B surface antibody (antiHBs) levels may decline over time; however immune memory (anamnestic anti-HGs response) remains intact indefinitely following immunization.~~

~~3. HBsAB Non-Immune (Negative)*~~

~~a. Immune – No further immunization required.~~

~~b. Non-Immune - Administer 1 dose of HBV, post vaccination serologic testing~~

~~4. HBsAB Non-Immune (Negative)*~~

~~a. Immune – No further immunization required.~~

~~b. Non-Immune - Administer 2 more doses of HBV, post vaccination serologic testing~~

~~5. HBsAB Non-Immune (Negative)*~~

~~a. Immune – No further immunization required.~~

~~b. Non-Immune – Healthcare Worker should be treated as non-responder.~~

~~C. **NON-RESPONDER**~~

~~1. A non-responder is defined as a person who is non-immune after 6 doses of HBV.~~

~~a. Non-responders to vaccination should be considered susceptible to hepatitis B virus infection and the need to obtain prophylaxis for any known or probable parenteral exposure to Hepatitis B Surface Antigen (HbsAg) positive blood.~~

~~D. **APPROVALS**~~

~~1. Infection Control Committee~~

~~2. Medical Executive Committee~~

~~3. PAC~~

4. Board of Directors

E. **REFERENCES**:

1. A comprehensive immunization strategy to eliminate transmission of hepatitis B virus infection
2. in the United States: recommendations of the Advisory Committee on Immunization Practices (ACIP).
3. Part II: immunization of adults. MMWR 2006:55 (No. RR-16)
4.

www.cdc.gov/mmwr/preview/mmwrhtml/rr6210a1.htm

F. **CDC Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Postexposure Management**

Recommendations and Reports **December 20, 2013 / 62(RR10); 1-19**

www.cdc.gov/vaccines/adults/rec-vac/hcw.html

Recommended Vaccines for Healthcare Workers

www.immunize.org/catg.d/p2017.pdf

Item #P2017 (3/18)

Tri-City Medical Center
Oceanside, California

FOOD AND NUTRITION SERVICES

ISSUE DATE:	**02/00**	**SUBJECT:**	**Food Safety and Department Cleaning Policy**
REVISION DATE:	**02/12, 02/13**		

Department Approval:	**~~06/20~~06/22**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**06/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/13**

A. **POLICY**:

~~1.~~ All new employees **must complete** ~~attend medical center and individualized~~ departmental **specific** orientation **and follow all regulatory and food safety guidelines**. ~~Topics included in this department specific orientation include~~:

- ~~Safety and You~~
- ~~General Safety Rules~~
- ~~Back strain~~
- ~~Bumps & Bruises~~
- ~~Burns~~
- ~~Cuts~~
- ~~Disaster preparedness procedures~~
- ~~Electrical shock~~
- ~~Procedure for use of safety locks~~
- ~~Slips & Falls~~

B. **PROCEDURE**:

1. **Department Specific Orientation** ~~Orientation to the department is~~ **is** conducted with the employee ~~and the supervisor within 2 days of employment~~ **after attending Tri-City Medical Center New Employee Orientation. Management conducts annual in-services for department safety.**
2. **Employees are scheduled to complete required computer based learning modules within the first 30 days of hire.**
3. **Department employees are expected to follow hospital wide dress and appearance per Administrative Policy: Dress and Appearance Philosophy 415 ~~policy~~. In addition, the following list of requirements must be met by each employee on a daily basis.**
   a. **Employees are responsible for reporting any health problem that might be contagious in nature. This includes respiratory tract infection, boils, infected burns, or sores. The employee is referred to the Employee Health Nurse for evaluation and clearance for work.**
   b. ~~**Employees with long hair must wear it completely contained.**~~ **Hair must ~~also~~ be completely covered with a hairnet or hat~~; bangs should be secured~~.**
      i. **Hats/head covering must be worn by those individuals with short hair.**
   c. **Beards, mustaches, and sideburns are allowed if they are neatly trimmed. When beards are longer than ¼" appropriate covering is required**
   d. **Food & Nutrition services employees are provided with shirts and/or Chef Coats as part of the uniform. Employees may wear a clean white or black washable sweater**

in colder weather. Pants must be black, tan or khaki. No jeans or yoga pants are permitted

e. Closed toe, slip resistant shoes and stockings are required.
f. Aprons will be provided and must be promptly changed when soiled. Aprons should never be worn outside of kitchen
g. Jewelry is limited to the following:
    i. Small pierced earrings, (no loops or dangling earrings allowed).
    ii. Necklaces that are a chain or have a small ornament attached must be tucked in under uniform
    iii. Only simple wedding bands may be worn by employees in food production. No other rings, bracelets, or watches may be worn.
h. Employees must prevent miscellaneous items from falling into food by not carrying items in shirt pockets, behind the ears, stuck in the hair, etc.
i. Smoking is prohibited in all areas of the hospital.
j. Employees are not allowed to chew gum while on duty.

4. Personal protective equipment (PPE) is provided by the department. Examples include pot holders, safety goggles, rubber gloves, heat protective gloves.
5. Cutting Boards
    a. All cutting boards will be constructed of a non-porous material, which may be thoroughly cleaned and sanitized. Sufficient cutting boards will be maintained in each production area to ensure adequate food handling procedures.
6. Can opener
    a. Blades are inspected for cleanliness and maintenance daily.
    b. Receiving Clerk replaces blade monthly or as needed
    c. Can opener base is removed, cleaned, and sanitized monthly
7. Operation of safety locks in the Kitchen Refrigerators and Freezers.
    a. Vegetable and produce walk-in: Turn handle to right of door counter-clockwise as far as it will go, push door open.
    b. Freezer in kitchen: Press white knob on door and push door open as normal.
    c. Freezer in dry goods storeroom:Turn lock on door, Push door open. Door is very difficult to open when door first closes.
    d. Milk and meat walk-ins (light switch located just to right of door, inside: Press white knob on door and push door open as normal.
8. Department Cleanliness and Equipment Maintenance
    a. Regular cleaning assignments are assigned to all positions to assure maintenance of cleanliness of the kitchen and cafeteria.
        i. This includes all refrigerators and freezers within the department.
        ii. Refrigerator shelves are cleaned weekly.
    b. Staff are required to initial cleaning schedule when daily cleaning is completed. If unable to complete, Supervisor must be notified. A Supervisor or designee is required to validate completion for compliance. Task sequences for various positions also outline specific assigned duties for maintenance of kitchen and cafeteria cleanliness.
    c. All surfaces used for food preparation ~~eating~~ are cleaned with an approved disinfectant after each meal period.
    d. Chipped or cracked china or glassware is discarded.
    e. Sanitation buckets are filled with appropriate concentration of disinfectant and ~~by a food service worker and distributed to the production areas. The content of the buckets is~~ changed every 4 hours or when dirty.
    f. Floors in the kitchen and cafeteria are cleaned daily or as needed. ~~mopped with an approved disinfectant~~. Floors are power washed or buffed by EVS staff monthly as available~~.~~
    g. Floor mats are cleaned daily
    h. EVS is responsible for ~~-~~cleanings ~~department~~used mop heads
    i. Rags, aprons, and linen are~~is~~ cleaned by a third party.

j. **Patient food carts and other food carts are cleaned as part of scheduled cleaning assignments.**

k. **Lighting, ventilation, and humidity is controlled to prevent the growth of bacteria/microorganisms.**

l. **All preventive and corrective maintenance on equipment is to be documented by Engineering.**

i. **Preventative Maintenance on the hoods and ice machines are conducted bi-annually or as needed.**

9. **Food- Borne Illness Outbreak**

a. **In the event of a food-borne illness outbreak, the department will:**

i. **Save suspected foods (if able) for culturing by the Public Health.**

ii. **Document departmental conditions at the time of preparation of suspect foods, if possible.**

iii. **Notify Infection Control/Employee Health of any reports of gastrointestinal complaints and suspected time interval.**

~~o~~iv. **Implement and supervise control measures to prevent further occurrence of the illness**

1. ~~In-service education is offered periodically through the year.~~

~~o All employees complete computer based learning modules annually. Topics include:~~

~~• Fire Safety~~

~~• Hazard Communication~~

~~• Electrical Safety~~

~~• Emergency Preparedness~~

~~•~~**a.** ~~Healthcare Security~~

~~2. A departmental risk assessment regarding safety is completed annually by the area safety representative. Any identified risk areas are addressed with appropriate training, provision of personal protective equipment, and review/revision of policies/procedures.~~

~~3. Personal protective equipment (PPE) is provided. Examples include pot holders, safety goggles, rubber gloves, heat protective gloves.~~

~~4. Hot Topics newsletters are posted on the departmental bulletin boards. Other safety information is posted on the main bulletin board near the cafeteria as well as on bulletin boards throughout the department.~~

~~5. A department representative attends Area Safety Representative meetings and reports on appropriate topics at departmental meetings.~~

~~APPROVAL PROCESS~~

~~Clinical Policies & Procedures Committee~~

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

1. **Administrative Policy: Dress and Appearance Philosophy 415**
2. **Infection Control Policy: Hand Hygiene**

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE

ISSUE DATE: 12/02

SUBJECT: Administrative On-Call Supervision

REVISION DATE: 06/04, 01/07, 05/09, 09/11, 06/12, 02/13

Department Approval:	**05/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**06/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/13**

~~ISSUE DATE: 12/02~~ ~~SUBJECT: Administrative On-Call Supervision~~

~~REVISION DATE: 6/04, 12/06~~ ~~POLICY NUMBER: 110~~

~~REVIEW DATE: 6/04, 12/06, 3/09, 6/12~~ ~~APPROVAL: 7/04, 1/07, 5/09, 9/11, 2/13~~

A. **PURPOSE**

1. To define the ~~A~~**a**dministrative ~~S~~**s**upervision of the Home Health Agency.

B. **POLICY**

1. A Registered Nurse, who is part of the ~~L~~**l**eadership ~~T~~**t**eam assumes responsibility of the Home Health department twenty-four hours a day, seven days a week.

~~C. PROCESS~~

~~1.~~**2.** The Director of **Home Health**~~Patient Care Services~~ or **their**~~his/her~~ Registered Nurse **(RN)** designee is available on the premises or immediately accessible by telephone~~/pager~~ during operating hours.

~~2.~~**3.** **During non-operating hours,** ~~S~~**s**upervision of the agency is provided by the administrator on-call**.** The administrator on-call is available via telephone~~ or pager~~.

~~3.~~**4.** Patient's **will be provided information for contacting the on-call RN during non-operating hours**~~may access the administrator on-call via the~~**. Tri-City Medical Center** (TCMC) **) provides phone coverage for the Home Health Agency during non-operating hours and will notify the on-call RN with any patient calls.** ~~Hospital exchange which is provided upon admission.~~

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE

~~Tri-City Home Care~~	~~Distribution: Clinical Staff~~
~~POLICIES:~~	~~UNIT SPECIFIC POLICY MANUAL – HOME HEALTH~~
~~Subject:~~	~~AGENCY EVALUATION~~
~~Policy:~~	~~104~~

ISSUE DATE: 05/04 **SUBJECT: Agency Evaluation**

REVISION DATE: 05/04, 07/06, 07/07, 08/08, 08/09, 10/10, 06/11, 07/13 **POLICY NUMBER: 104**

Home Health Care Approval:	05/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	06/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	07/13

A. **PURPOSE:**
1. To define the Annual Evaluation of the Agency

B. **POLICY:**
1. It is the policy of the Agency to conduct an annual **review of overall agency functioning** ~~Agency Evaluation as outlined in the condition of participation for presentation to the Group of Professional Personnel~~.
2. ~~**Frequency:**~~
   a. ~~An Annual Agency Evaluation will occur to address requirements for Home Health Agencies and will be overseen by the governing body.~~
2. **There shall be an organized, effective and documented evaluation of overall agency functioning at least annually. This evaluation shall include, but need not be limited to, the evaluation of:**
   a. **Administrative policies and procedure.**
   b. **Personnel policies.**
   c. **Infection Control Program.**
   d. **Clinical Program Policies.**
   e. **The adequacy of management and supervision, either on-site or by telecommunications, of support, paraprofessional, and professional personnel based at a minimum on the following considerations:**
      i. **The total patient census.**
      ii. **The numbers, qualifications, experience and current competence of the individuals providing each service.**
      iii. **The level of care/service required.**
      iv. **Service areas covered by the home health agency.**
      v. **The numbers and types of visits conducted.**
      vi. **The primary condition/diagnosis of patients.**
      vii. **Services required which require specialized training.**

viii. **Dissatisfaction expressed by patients regarding the supervision of services.**

f. **The evaluation shall be undertaken by a group which shall include the Administrator, the Director of Patient Care Services, another licensed health care professional employed by the agency, and at least one physician. Results shall be documented and a plan developed, implemented, and documented for correcting deficiencies within specified time frames.**

~~3. **Agency Evaluation Purpose:**~~

~~a. The evaluation assesses the Standards to the extent to which the agency's program is appropriate, adequate, effective, and efficient. (AAEE) defined as follows:~~

~~i. Appropriateness is the assurance that the area being evaluated addresses existing or potential problems. The Agency's assessment of "appropriateness" is determined by review of policies, procedures, protocols, and practice. Leadership reviews policy appropriateness and performs chart audits for appropriateness of care. Clinical Practice reviews all Home Health procedures when needed.~~

~~ii. Adequacy is a determination as to whether the agency has the capacity to overcome or minimize existing or potential problems. The Agency's assessment of "adequacy" will be determined by review of policies, procedures, protocols, and practice.~~

~~iii. Effectiveness determines that the services offered accomplish the objectives of the agency and anticipated patient outcomes. The Agency's assessment of "effectiveness" will be determined by the review of patient satisfaction surveys, physician satisfaction surveys, chart audit data, education, training material and patient infection control data (UTI rate, IV infection rates)~~

~~iv. Efficiency determines whether there is a minimal expenditure of resources by the agency to achieve desired goals and anticipated patient outcomes. The Agency's assessment of "efficiency" will be determined by review of financial analysis of the fiscal year and utilization of resources.~~

~~4. **Agenda:**~~

~~a. The agenda will consist of the following (but not limited to) items to be evaluated:~~

~~i. Previous Meeting Minute Review~~
~~ii. Agency Complaints and Follow-Up via QI review~~
~~iii. Policy and Procedures~~
~~iv. Contract Management~~
~~v. Personnel Management~~
~~vi. Clinical Record Review~~
~~vii. Patient Care~~
~~viii. Achievement of Agency Goals~~
~~ix. Recommendations from the Community including suggested topics for presentation~~
~~x. Involvement or Integration in the Community~~
~~xi. Regulatory Performance~~
~~xii. New Programs Development/Opportunities~~
~~xiii. Policy Review~~
~~xiv. Program Evaluation~~

~~b. Recommendations for the agenda items will be solicited from the GPP.~~

~~5. **Scoring:**~~

~~a. All standards of the Agency such as Safety, Risk Management, Record Review, Human Resources, Education, Group of Professional Personnel (GPP), Administrative Personnel, Fiscal, Quality Management, Patient Rights, Organization and relationship with the Governing Body have subsets and are given a compliance score each quarter totaling an annual score for that particular standard subset.~~

b. The scoring of each subset is based on total compliance set forth in the criteria for that subset. Total compliance for a subset will be ascribed a score of one (1). When any part of subset criteria is not met, the score is zero (0). There is nothing between or beyond a 1 or a 0. The GPP will discuss and direct performance improvement for each subset not achieving a score of one (1). This will be reflected in the minutes of the quarterly meeting of the Group of Professional Personnel and the Leadership of the Agency will follow through with the plan of action. The Plan of Action and results will be reported at the next GPP meeting.

6. **Action & Follow-up:**
   a. The Responsible parties of the Agency will take appropriate action and report the action and results at the next quarterly GPP meeting.
7. **Minutes:**
   a. Minutes will be taken at each meeting and will reflect the membership and attendance, all agenda items, old business, group discussions interaction, and review of previous minutes for completeness and accuracy. Minutes are communicated to the Governing Board by the COO/CNE. The Governing Board is responsible for review, oversight, approval, and any recommendations to be incorporated. The Director or a designee communicates recommendations of the Governing Board to the Group of Professional Personnel for follow up.
8. **Data Collection Process for Annual Evaluation Consideration:**
   a. The GPP committee will be responsible to establish, in writing, the mechanism for the collection of data in assisting the Agency Evaluation process. Sources for data collection may include but are not limited to:
      i. Retrospective and concurrent clinical review. (Quality improvement reports)
      ii. Patient satisfaction surveys
      iii. Policy and Procedure Review
      iv. Recommendations from regulatory surveys. Direct observation
      v. Quality review
      vi. Infection control data
      vii. Equipment safety
      viii. Telephone records
      ix. Case conferences
      x. Supervisory visits
      xi. Quarterly chart review
      xii. National Benchmark
      xiii. Community Liaison
      xiv. Medical Community Survey
      xv. Home Care Agency Survey
      xvi. Community Meetings
      xvii. Agency logs
      xviii. Agency Evaluation Reporting Tool
9. **Chart Review:**
   a. Chart review will be accomplished by peer review. Review will reflect the assessment of (Adequacy, Appropriateness, Effectiveness, and Efficiency) in compliance with the regulatory requirements. The review will represent active and closed records. Review will include representation from all disciplines, which provided services during that quarter.
   b. The GPP committee will establish specific record review criteria. The reviews will focus on:
      i. Compliance with Agency Standards
      ii. Compliance with Agency Policy and Procedure
      iii. Consistency with Community Practice
      iv. Anticipated Client Outcomes

c. Recommendations will be solicited from the committee and reported to the Agency responsible parties. The follow-up action taken in consideration of the recommendations will then be reported at the next quarterly GPP meeting.

C. **REFERENCE(S):**

1. **Title 22 S74742 Quality Management**

Issued:	Reviewed:	Revised:	Approved:
5/04	7/06, 6/07, 5/08, 5/09, 5/10, 3/11	6/07, 5/08, 6/11, 7/13	5/04, 7/06, 7/07, 8/08, 8/09, 10/10, 6/11, 7/13

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE

~~Tri-City Home Health~~	~~Distribution:~~
~~Policies:~~	~~UNIT SPECIFIC POLICY MANUAL – HOME HEALTH~~
~~Subject:~~	~~Budget~~
~~Policy Number:~~	~~108~~

ISSUE DATE: 12/98 **SUBJECT:** Budget

REVISION DATE: 07/04, 05/09, 03/11, 03/13 **POLICY NUMBER:** 108

Home Health Care Approval:	**05/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**06/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

1. The purpose of the budget is to provide a financial framework to assure Home Health delivers cost effective patient care.

B. **POLICY:**

1. The Director / Director of Patient Care Services (DPCS) is responsible for developing and monitoring the budget to assure it is consistent with the strategic plan for Tri-City Health Care District. The Tri-City Healthcare District Board of Directors approves the Budget.

C. **PROCESS:**

1. The budget is broken into components: Capital Equipment, Labor and General Operating Budgets.
2. Accounting and finance provide bi-weekly reports on labor usage. A budget calendar is produced annually by Finance for 3-year planning and budget preparation purposes.
3. Accounting and finance prepares reports, including but not limited to, historical data on costs, past units of service, revenue and staffing patterns.
4. Budget Approval
   a. The Chief Financial Officer provides the final budget for approval through Tri-City Healthcare District Administration and the Tri-City Healthcare District Board of Directors.
5. Budget Monitoring
   a. The Home Health budget is reviewed on an ongoing basis to compare budget to actual dollars expended.
   b. Each component of the budget is monitored monthly. The Manager of Financial Services prepares the Profit and Loss statement. This report includes monthly and year-to-date data.
6. Budgetary Review Mechanisms

a. Retrospective budget review mechanisms are used to evaluate accomplishments for budget purposes. These mechanisms include assessment of staffing, recruitment, retention, educational activities, quality assurance findings, staff, patient, M.D. satisfaction, and use of equipment and supplies.
b. Prospective budget review mechanisms evaluate external influences on the agency and evaluate need for reallocation of resources and which form the basis for planned change. These mechanisms include monitoring of community standards and adjustment for state or federal regulations.
c. The Financial Department prepares reports analyzing the department's performance, which is reviewed with administration.

7. Determination of Costs/Charges for Agency Services
   a. The rates charged for services provided by the agency are determined annually or as needed and are based on the cost of rendering those services.
   b. Mechanisms used by the agency to determine costs are an evaluation of:
      i. Salary cost
      ii. Contracted service cost
      iii. Supply costs
      iv. Retrospective per visit charge
   c. Data is submitted monthly to the Accounting and Finance Department and collated throughout the fiscal year.
8. Mechanisms for Financial Management
   a. Accounts payable are submitted to the Accounting Department by the Manager of Financial Services.
   b. Accounts receivable are processed by the Patient Account Representative and submitted to Tri-City Healthcare District's Accounting and Finance Department.

~~Issued~~	~~Reviewed~~	~~Revised~~	~~Approved~~
~~12/98~~	~~11/07, 3/09, 3/11, 1/13~~	~~5/07, 3/11, 1/13~~	~~7/04, 5/09, 3/11, 3/13~~

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE: 05/04	**SUBJECT:** Certified Home Health Aide (CHHA) ~~Oversight~~ Supervision
REVISION DATE: 05/04, 11/07, 09/11	**POLICY NUMBER:** 310
Home Health Care Approval:	06/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	06/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	09/11

~~ISSUE DATE: 5/04~~
~~REVISION DATE: 6/07~~
~~REVIEW DATE: 6/07, 7/11~~

~~SUBJECT: Certified Home Health Aide (CHHA) Oversight~~
~~POLICY NUMBER: 310~~
~~APPROVAL: 5/04, 11/07, 9/11~~

A. **PURPOSE**:

1. To delineate responsibility regarding the Certified Home Health Aide (CHHA) **patient care supervision requirements and ensure accurate completion of the CHHA assignments and duties as outlined in the Aide Care Plan.** ~~in regards to patient care oversight and completion of the assignment sheet.~~

B. **POLICY**:

1. ~~It is the policy of the Agency that the admitting clinician will develop the assignment sheet for the CHHA when that discipline is ordered on the initial plan of care and that the provision of care by the CHHA is overseen by a Registered Nurse (RN)~~ **The admitting Registered Nurse (RN) or Physical Therapist (PT) will develop the Aide Care Plan for the CHHA when the home health aide service is ordered on the initial plan of care.** ~~for the CHHA when that discipline is ordered on the initial plan of care and that the provision of care by the CHHA is overseen by the clinician per CMS regulations.~~

~~C. PROCEDURE:~~

2. When the RN and the CHHA are the only disciplines **initially** ordered for a patient, the RN will **develop the Aide Care Plan.** ~~write out the assignment sheet for the CHHA. A copy of the assignment sheet will be left in the clinician home chart for the CHHA to follow. The original is filed in the medical records with a copy going to the case manager and scheduler. A supervisory~~ **assessment** ~~visits will be made every two (2) weeks for oversight of the CHHA by a RN.~~

~~1.~~**a.** ~~**When, other disciplines such as Physical Therapist** (PT), or **Occupational Therapist** (OT) **are ordered, PT and OT may complete CHHA supervisory assessment.**~~

~~1.~~**3.** When an RN, PT, **Occupational Therapist** (OT), **Speech-Language Pathologist (ST)** and CHHA are ordered initially for a patient, the admitting RN will develop the **Aide Care Plan.** ~~CHHA assignment sheet and assign a sponge bath in the Personal Care Section of the Assignment sheet.~~ -The **PT** ~~physical therapist~~ or **OT**~~occupational therapist~~ will evaluate **mobility and safety for personal care needs and update the Aide Care Plan as appropriate.** ~~personal care needs of the patient and update the assignment sheet when appropriate. This will also be updated by the clinician in the home chart immediately.~~ **When it is a Rehabilitation (Rehab) only case, PT will develop the Aide Care Plan.**

4. ~~Supervisory visit will continued to be made by the RN unless nursing discharges the patient and PT or OT remains on the case. At the time nursing discharges a patient, rehab services will manage the patient and be responsible for updating the assignment sheet and providing supervisory visits.~~ **The CHHA is assigned to a specific patient by a RN or other appropriate skilled professional (PT, OT, ST) with written patient care instructions for the CHHA prepared by that RN or other appropriate skilled professional. Home Health Aide assignments and duties include, but are not limited to, the following duties:**
   a. **Assisting patients with personal hygiene such as skin, mouth, hair care and bathing.**
      i. **Note: may apply non-prescription topical ointments, creams, lotions and solutions to intact skin surfaces.**
   b. **Assisting patients in and out of bed and assisting with ambulation.**
   c. **Assisting with prescribed exercise which patients and aides have been taught by appropriate health personnel.**
   d. **Preparing meals, including therapeutic diets, and assisting patients with eating.**
   e. **Assisting patients to the bathroom or in using commodes, bedpans or urinals.**
   f. **Performing household services which will facilitate the patient's self-care at home and are necessary to prevent or postpone institutionalization.**
   g. **Assisting patients with medication which are ordinarily self-administered. The home health aide shall not administer medications of any kind.**
   h. **Performing other activities taught by a health professional for a specific patient. This may include such services as changing of non-sterile dressings and non-sterile bowel and bladder hygiene care.**
   i. **Reporting changes in the patient's condition and needs to the supervising nurse or therapist.**
   j. **Completing records regarding services performed.**

~~2.~~5. **Taking of vital signs and changing of colostomy bags is not permitted.**

6. **Home Health aides are members of the interdisciplinary team, and must provide verbal and written report of changes in the patient's condition to the supervising RN or other appropriate skilled professional (PT, OT, ST). If supervising RN, PT, OT, ST is unavailable, CHHA will contact RN Clinical Manager or Rehab Supervisor to provide verbal report. This report will be documented by the CHHA in a coordination narrative note in the electronic medical record.**

7. **A supervisory visit is made every one (1) week for oversight of the CHHA by RN, PT, OT, or ST. The CHHA does not have to be present during this visit.**

8. **The weekly supervisory visits will continue to be made by the RN unless nursing discharges the patient and PT, OT or ST remains on the case. At the time the RN discharges a patient, Rehab services will manage the patient and appropriate skilled professional will be responsible for updating the Aide Care Plan and providing the supervisory visits.**

9. **An annual on-site visit is conducted jointly with the CHHA by a registered nurse or other appropriate skilled professional to the location where the patient is receiving care in order to observe and assess each CHHA while performing care.**

10. **An on-site supervisory visit is conducted jointly with the CHHA if an area of concern in aide services is noted by the supervising registered nurse or other appropriate skilled professional. This on-site supervisory visit to the location where the patient is receiving care is necessary in order to observe and assess the CHHA while performing care.**

11. **If a deficiency in aide services is verified by the registered nurse or other appropriate skilled professional during an on-site visit, then a CHHA competency evaluation will be conducted and validated. The competency evaluation must ensure that the CHHA is furnishing care in a safe and effective manner, including, but not limited to, the following elements:**
    a. **Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional;**

b. Maintaining an open communication process with the patient, representative (if any), caregivers, and family:
c. Demonstrating competency with assigned tasks;
d. Complying with infection prevention and control policies and procedures;
e. Reporting changes in the patient's condition; and
f. Honoring patient rights.

C. REFERENCES:

1. Title 22 Regulations 74709, 74710
2. Medicare Conditions of Participation 484.80
3. California Association for Health Care Services at Home (CAHSAH), Certified Home Health Aide (HHA) Functions, 2007

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE

ISSUE DATE:	**06/04**	**SUBJECT:**	**Contracted Services**
REVISION DATE~~(S)~~:	**07/04, 11/07, 05/09, 09/11 08/20**	**POLICY NUMBER:**	**112**

Home Health Care Approval:	**~~06/20~~05/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~07/20~~06/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/20**

A. **PURPOSE:**
1. To define the use of contracted services within Tri-City Home Health Agency.

B. **POLICY:**
1. It is the policy of Home Health to arrange for another individual or entity to furnish services to the Home Health patient in the event of inadequate staffing or resources not provided by the Agency. Home Health assures the continuity of patient/family care in the home with the use of contracted services. All contracted services must have a legally binding written agreement for the provision of arranged services approved by the legal department of Tri-City Healthcare District.

C. **PROCESS:**
1. All contracts with Tri-City Home Health will be individualized and contain fiscal and service responsibilities and written according to all regulatory agencies. All contracts shall be contained in a binder in the Home Health Care office. Contracted services may encompass supportive and clinician services.
2. It is the responsibility of the contracted individual or agency to adhere to applicable agency policies and personnel qualifications.
3. Home Health is responsible for oversight of all activities performed by the contracted individual or agency to assure quality of care and conformance to regulatory requirements. Home Health retains the professional management responsibility for contracted services and insures that they are furnished in a safe and effective manner and in accordance with the patient plan of care and other state and federal requirements.
4. The Home Health retains financial responsibility for services provided under contract.

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE: 12/98	**SUBJECT:** Dress Code
REVISION DATE: 10/04, 04/07, 02/10, 10/10, 09/11	**POLICY NUMBER:** 201

Home Health Care Approval:	05/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	06/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	09/11

~~ISSUE DATE: 12/98~~	~~SUBJECT: Dress Code~~
~~REVISION DATE: 6/04 , 12/09 , 6/10~~	~~POLICY NUMBER: 201~~
~~REVIEW DATE: 6/04, 2/07, 3/07 1/10, 7/11~~	~~APPROVAL: 10/04, 4/07, 2/10, 10/10, 9/11~~

A. **PURPOSE**:
1. To define the Agency specific dress code policy to assure professionalism and safety in the work place.

B. **POLICY**:
1. All staff will present a professional appearance to the community and maintain safety by following Tri-City Healthcare District and Home Health specific policies for dress code.
2. Employees shall exercise good judgment in personal dress, appearance and the use of fragrances to present a professional appearance appropriate to their job classifications.
3. The Home Care Director or designee shall ensure that employees are dressed appropriately, are groomed, and meet the fragrance control guidelines outlined in the Tri-City Medical Center (TCMC) Dress and Appearance Philosophy policy.
4. The dress code is modified periodically to keep up with changing trends in safety/infection control principles.
~~1.~~**5. Compliance to the dress code is maintained by all members of the Leadership team monitoring the dress code. A member of the Leadership team will discuss non-compliance with individuals. Discipline is according to Tri-City Healthcare District policy.**

~~PROCEDURE~~
~~A. The Leadership Committee determines the dress code specific to Home Health.~~
~~B. The dress code is modified periodically to keep up with changing trends in safety/infection control principles.~~
~~C. Compliance to the dress code is maintained by all members of the Leadership team monitoring the dress code. A member of the Leadership team will discuss non-compliance with individuals. Discipline is according to Tri-City Healthcare District policy.~~
~~D. The District expects staff to use good judgment in determining what is considered acceptable attire and grooming. Blue jeans, shorts, and revealing attire are not to be worn. Facial piercings are not allowed and all tattoos must be covered.~~

~~1.~~**6.** Home Health Specific Policies Include:
a. Scrub uniforms are optional, but encouraged for caregiver staff when making home visits.
b. Caregiver staff that chose to wear business casual attire are highly encouraged to wear

white lab coats or scrub jackets.

c. Shoes:

i. No flip-flops, sandals, open toed shoes or high heels over two inches are to be worn by staff while making home visits.

ii. Open toes shoes may be worn by staff not seeing patients.

~~2.~~**7.** Tri-City I.D. Badges must be worn during all hours on duty and must be above the waist and visible.

8. Hair: long hair should be secured as to not interfere with patient care.

~~3.~~**9.** **Blue jeans, shorts, and revealing attire are not to be worn. Facial piercings are not allowed and all tattoos must be covered**

C. **REFERENCE:**

~~4.~~**1.** **Administrative Policy: Dress and Appearance Philosophy 415.**

Tri-City Health Care District	Home Health Care
PROCEDURE	**ELSEVIER CLINICAL INDEX OF NURSING SKILLS**
Purpose	To review or learn procedures to follow in Home Health
Issue Date:	07/12

A. **PROCEDURE:**

1. Elsevier's Clinical Skills Index is the resource for the Hospital and Home Health Nurses for proper procedure compliance.
2. Home Health has procedures specific to Home Health, but in the event a patient is admitted with a procedure order that is not common, then the Home Health nurses can access Elsevier's for more information.
3. How to access Elsevier's procedures:
   a. Go to the TCMC employee intranet web site.
   b. Click on 'Policies & Procedures'.
   c. Click on the hyperlink in center of page to access Elsevier Online Skills.
   d. Enter name of procedure you are looking for in the search bar.
      i. For Example: If you are looking for a procedure involving Trachs, type in trach, then enter or click on search icon and a list of trach subjects will open up.
      ii. Then you can look for the procedure you need.
4. Staff also have the option to print the procedure if needed.

Department Review	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/20, 05/22	n/a	n/a	07/20, 06/22	n/a	07/12, 08/20

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE

ISSUE DATE:	**04/05**	**SUBJECT:**	**Emergent Care**
REVISION DATE:	**04/05, 04/07, 04/08, 02/09, 02/10, 06/11, 03/13, 07/13**	**POLICY NUMBER:**	**702**

Home Health Care Approval:	**06/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**06/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**07/13**

~~Tri-City Home Health~~	~~Distribution: Clinical Staff~~
~~Policies: UNIT SPECIFIC POLICY MANUAL – HOME HEALTH~~	
~~Subject: EMERGENT CARE~~	
~~Policy Number: 702~~	

A. **PURPOSE:**

1. To clarify the Clinician's role regarding the initiation or advisement of emergent care.

B. **POLICY:**

1. It is the policy of the Agency to consider the safety and well being of all Home Health patients during each home visit. This may result in the initiation of emergency services or the recommendation to seek urgent medical attention when the situation cannot be handled in the home care setting.

C. **PROCESS:**

1. All visiting field staff, i.e. nurses, physical, occupational and speech therapists, medical social workers, registered dietitian and certified home health aides are required to have a current CPR certification upon hire and renewed per standards of practice. CPR is considered in the scope of practice of all visiting staff. The patient's DNR status is communicated to the health care team upon the admission to the Agency or as patient desires change.
2. The initiation or recommendation of emergent care is indicated when the well being of the patient appears to be in jeopardy. The primary physician and nursing supervisor are to be informed of problems and action taken. This may occur after emergent care is initiated due to the severity of the problem. Situations that may put the patient in jeopardy may be, but not limited to: stroke or seizure activity, **cardiac arrest, respiratory arrest,** life threatening blood sugars, drastic changes in vital signs requiring medical intervention, uncontrolled bleeding or pain. Patients always retain the right to refuse emergent care.
3. Documentation of events leading to the initiation or recommendation of emergent services is recorded in the patient's medical record.
4. ~~4.~~ Emergent care, identified on the Quality Review Reports for deteriorating wounds or due to a fall, shall be reviewed for determination of appropriate care **according to Agency risk management and patient safety reporting policy.** ~~by the Manager of Quality and Outcomes. Problem areas discovered will be discussed and acted upon by leadership.~~

~~A Quality Review Report is also completed when a Home Health patient returns to TCMC within twenty four (24) hours of being discharged from the hospital.~~

~~ISSUED~~	~~REVIEWED~~	~~REVISED~~	~~APPROVED~~
~~4/05~~	~~4/05, 5/06,4/07, 4/08,11/08,12/09 10/10, 3/11, 3/13~~	~~4/05, 4/08,11/08,6/13~~	~~4/18/05, 4/23/07,4/29/08,2/09,2/10, 6/11, 3/13, 7/13~~

Tri-City Health Care Dist
Oceanside, California

DELETE – follow Home Care Policy: Agency Evaluation

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE:	**SUBJECT: Group of Professional Personnel**
REVISION DATE:	**POLICY NUMBER:**
Home Health Care Approval:	**05/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**06/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**09/11**

~~ISSUE DATE: 5/10/04~~	~~SUBJECT: GROUP OF PROFESSIONAL PERSONNEL~~
~~REVISION DATE: 9/11,7/12~~	~~POLICY NUMBER: 106~~
~~REVIEW DATE: 11/08, 7/11~~	~~APPROVAL: 5/04, 7/07, 2/09, 9/11~~

~~PURPOSE:~~
~~The Group of Professional Personnel (GPP), often referred to as the Professional Advisory Committee (PAC), will establish, assess, and review agency policies governing the scope of services provided and participate in activities related to all aspects of the operations of the program including the evaluation of the program.~~
~~The focus of direction from the GPP is to assess the extent to which the agency's program is appropriate, adequate, effective and efficient.~~
~~DEFINITIONS:~~
~~Group of Professional Personnel (GPP) or Professional Advisory Council (PAC) are terms that may be interchangeable which will be hereinafter referred to as the GPP.~~
~~The GPP:~~

- ~~Advises the agency on health and financial issues~~
- ~~Participates in the evaluation of the Agency's programs~~
- ~~Assists the Agency in maintaining liaison with other health care providers in the community~~
- ~~Assists in the Agency's total Annual Evaluation of Program~~
- ~~Participates in the Agency's quality assessment and performance improvement program.~~

~~PROCESS:~~
~~The GPP will be responsible for the following:~~

1. ~~Evaluates the professional service program.~~
2. ~~Advises the agency on professional issues.~~
3. ~~Establishes and annually reviews the agency's policies governing:~~
   - a. ~~Scope of Services Offered~~
   - b. ~~Admission and Discharge~~
   - c. ~~Medical Supervision and Plans of Care~~
   - d. ~~Emergency Care~~
   - e. ~~Clinical Records~~
   - f. ~~Personnel Qualifications and Performance~~
   - g. ~~Program Evaluation~~
4. ~~Assists in maintaining liaison with other health care providers in the community.~~
5. ~~Participates in an overall evaluation of the agency's total program at least once a year.~~
6. ~~Assists with agency's community information program.~~
7. ~~Participates in the agency's quality assessment and performance improvement program.~~

~~Membership:~~

1. Membership will include, but is not limited to:
a. Agency leadership staff including the Agency Administrator or representative
b. Staff in a position to address issues reported by the GPP Committee
c. A representative from each professional discipline representing the full scope of service
d. Community Consumers that are not an Agent or Owner of the Agency
e. Community Physician (at least one)
f. Registered Nurse (preferably a Public Health Nurse)
g. Community Liaisons
2. Membership shall be by invitation and shall be for a preferred commitment of one-year minimum.
3. Members shall be asked to participate in quarterly GPP meetings and the annual Agency Evaluation meeting.
4. Part of the Annual Agency Evaluation may include the agenda for recommendation and selection of new GPP committee members.
5. The GPP committee may initiate the selection process to replace a member if at any time a member resigns or otherwise gives notice of their desire to be removed from the committee.
6. At any time the GPP may recommend that invitation for membership be offered to help fulfill the needs of the committee.
7. The Director of the Agency, or designee, will reside as chairperson. The hospital *CEO* or designee shall participate in the committee meetings and maintain liaison among the Tri-City Healthcare District Board of Directors Governing Body, the Group of Professional Personnel, and the Home Care staff.

Frequency/Process:

1. The GPP committee will meet quarterly *or a minimum of three times a year.*
2. The meetings may include, but are not limited to the following agency items:

- Addressing the agency components of direct patient services
- Addressing administration and management of the Home Care Agency
- Agency Complaints and follow up
- Policy and Procedures established, recommends and reviews
- Contract Management
- Clinical Record Review
- Patient Care
- Recommendations from the Community
- Regulatory Performance
- New Programs Development/Opportunities
- Scope of Services Offered
- Admission and Discharge Policies
- Medical Supervision and Plans of Care Emergency Care
- Clinical Records
- Personnel Qualifications
- Program Evaluation

3. The responsible parties of the Agency will take appropriate action and report the action and results at the next GPP meeting.
4. Minutes will be taken at each meeting and will reflect:

- Membership and attendance
- All agenda items
- Old business
- Group discussion/interaction
- Recommendations and review of previous minutes for completeness and accuracy.

5. Minutes will be communicated to the Governing Board by the *CEO* or designee/
6. The Governing Body will be responsible for review, approval and any recommendations to be incorporated into the responsibilities of the GPP and their actions.
7. The *CEO* or designee will communicate recommendation of the Governing Board to the GPP for follow up as necessary.

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE: 12/07	**SUBJECT:** Home Health Advance Beneficiary Notice
REVISION DATE: 04/08, 09/11	**POLICY NUMBER:** 328

Home Health Care Approval:	**05/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**06/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**09/11**

~~ISSUE DATE:12/07~~	~~SUBJECT: Home Health Advance Beneficiary Notice~~
~~REVISION DATE:2/08~~	~~POLICY NUMBER: 328~~
~~REVIEW DATE: 2/08, 7/11~~	~~APPROVAL: 4/08, 9/11~~

A. **PURPOSE**:
1. To explain the CMS ruling regarding the Home Health Advance Beneficiary Notice (HHABN) for Medicare Beneficiaries.

B. **POLICY**:
1. It is the policy of the Agency to provide Medicare beneficiaries with appropriate forms for an efficient appeal process when faced with unanticipated changes in services provided for Medicare beneficiaries.

C. **PROCEDURE**:
1. HHABN Requirements:
   a. The HHABN Option Box Forms must be delivered to all traditional Medicare beneficiaries if the following triggering events occur:
      i. Option Box 1- use when item(s) and/or service(s) may be provided that will not be paid for by Medicare.
      ii. Option Box 2- Use when item(s) and/or service(s) will no longer be provided for financial and/or other reasons.
      iii. Option Box 3- Use when physician's orders reduce certain item(s) and/or services.
   b. The following information is required for the HHABN form:
      i. The beneficiary or authorized representative's signature.
      ii. Beneficiary's name and Medicare number.
      iii. The date Medicare coverage of homecare services ends.
      iv. The triggering event that has determined the appropriate option.

Tri-City Home Healt	Distribution: Clinical Staff
Policies:	UNIT SPECIFIC POLICY MANUAL – HOME HEA
Subject:	Leadership
Policy Number:	103

DELETE- follow Home Care Policy: Agency Evaluation

ISSUE DATE:	SUBJECT:
REVISION DATE:	POLICY NUMBER:
Home Health Care Approval:	05/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	06/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/13

~~A. PURPOSE~~

~~To define the Home Health Leadership members and their roles.~~

~~B. POLICY~~

~~It is the policy of Tri-City Home Health to have an interdisciplinary Leadership team to oversee Agency functions.~~

~~C. DELEGATION OF AUTHORITY~~

~~In the absence of the Director / Director of Patient Care Services, responsibility and decision making authority is delegated as follows:~~

~~1. Operations Manager~~
~~2. Quality & Outcome Manager~~
~~3. Clinical Supervisor~~
~~4. Educator~~

~~D. MEMBERSHIP~~

~~Membership of the Home Health Leadership team consists of, but not limited to:~~

~~1. Director~~
~~2. Director of Patient Care Services~~
~~3. Quality and Outcomes Manager~~
~~4. Clinical Supervisors~~
~~5. Operations Manager~~
~~6. Nursing Educator~~
~~7. Medical Director~~

~~E. FUNCTIONS OF THE LEADERSHIP TEAM~~

~~1. Leadership meets twice per month or when necessary.~~
~~2. Represents professional disciplines at the administrative level in selected meetings and/or~~

~~Issued~~	~~Reviewed~~	~~Revised~~	~~Approved~~
~~12/98~~	~~12/06, 10/08, 8/11, 1/13~~	~~7/04, 12/06, 10/08, 11/08, 8/11, 7/12, 1/13~~	~~7/04, 1/07, 11/08, 2/09, 8/11, 3/13~~

committees.

3. Plans, implements and evaluates solutions to various essential patient care problems, based on identified needs and administrative requests.

4. Assists with planning and monitoring the annual budget, productivity and financial performance.

5. Selects qualified members of the professional staff to participate in decision making for the Agency through committee function.

6. Reviews and approves Policies and Processes in the Agency prior to submission to the Group of Professional Personnel, as well as standards of practice.

7. Participates in performance improvement activities.

8. Implements policies.

9. Participates in survey/accreditation processes.

10. Participates in the development of job descriptions, staff evaluations, performance standards, and annual staff license validation.

11. Receives and acts on reports/recommendations for patient care.

12. Promotes participation in education and attendance at required meetings.

13. Conducts staff meetings.

14. Collaborates to achieve agency goals related to appropriateness, adequacy, efficiency and effectiveness.

F. ROLES

Director / Director of Patient Care Services (DPCS)

A. The DPCS, as appointed by the Governing Body, is responsible for the day-to-day operation, management, development, and evaluation of the Agency.

B. The daily operation of the Agency is vested in the Director to assume the responsibility and authority for programs, staff performance and patient care via the Leadership team.

C. Takes reasonable steps to assure the adequacy, efficiency, effectiveness and appropriateness of services.

Quality and Outcomes Manager

A. Oversees clinical direction of the program and assures compliance with Standards of Care and patient safety.

B. Keeps current with regulatory requirements and acts as a resource for staff.

C. Facilitates and coordinates the Performance Improvement Program for quarterly reporting, tracking, trending and analysis, with recommendations to the general leadership and GPP.

D. Organizes and coordinates the Group of Professional Personnel committee reports and Agency Annual Evaluation.

E. Oversees Performance Improvement activities and survey results.

F. Participates and reports to the Tri-City Infectious Disease Committee, the Patient Safety Committee, and the Quality Outcome Committee.

Operations Manager / Clinical Supervisor

A. Responsible for day to day supervision of clinical staff.

B. Assures appropriate staffing to meet patient needs.

C. Serves as a clinical resource for clinical staff.

Clinical Educator

A. Oversees the new staff orientation process and provides on-going education of the clinical staff.
B. Develops in-services and CEU classes for improved patient care.
C. Evaluates, develops, and provides patient educational materials.

The Medical Director

A. Acts as a resource to the Leadership and Agency as a whole.
B. Renders the necessary medical management, in consultation with the primary physician, consistent with the plan of care and the patient's current needs.
C. Acts as a liaison to interpret Home Health philosophy to other Physicians, and assists with conflict resolution in relation to those physicians.
D. Insures the availability of physician services and the provision of a substitute in the absence of the primary physician, 24 hours a day, 7 days a week.
E. Functions as a member of the UR/QI and Group of Professional Personnel.

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE

ISSUE DATE: 10/09	**SUBJECT:** Mileage Expense Reimbursement
REVISION DATE~~(S)~~: 02/10, 2/10, 9/11, 01/12, 08/20	**POLICY NUMBER:** 204

Home Health Care Approval:	~~06/20~~05/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~07/20~~06/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/20

A. **PURPOSE**:
1. To delineate the reimbursement of auto expenses in regards to the use of personal automobile when providing Tri-City Home Health care to patients.

B. **POLICY**:
1. It is the policy of this Agency to reimburse Tri-City **Health Care** employees for any employment related expenses, which include mileage, in accordance with California law.

C. **PROCEDURE**:
1. Employees keep an accurate tally of mileage used on a daily basis.
   a. The published IRS rate is used.
   b. The mileage needs to be entered in the computer system daily.
   c. The mileage is started from the office and/or the first home visit and recorded for each trip between patients.
   d. Mileage is not paid for personal errands between visits. Document the actual mileage from one patient to another.
   e. Mileage will not be paid from home to work or work to home.
   f. Mileage is not paid from the last visit to home if not returning to office.
2. Emergent after-hours mileage reimbursement.
   a. When an emergent, after hours, visit is necessary Tri-City Health Care will reimburse mileage from staff's home to patient's home **and back to staff's home**.
   ~~b. Tri-City Health Care will not reimburse from the patient's home, back to staff's home, which is considered a commute.~~

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE

ISSUE DATE: 07/05

SUBJECT: Notice of Medicare Non-Coverage for Health Maintenance Organizations (HMO)

REVISION DATE~~(S)~~: 04/08, 06/11, 02/13, 08/20

POLICY NUMBER: 322

Home Health Care Approval:	~~06/20~~05/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~07/20~~06/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/20

A. **PURPOSE:**

1. To explain the CMS ruling, regarding the Notice of Medicare Non-Coverage (HMO).

B. **POLICY:**

1. It is the policy of the Agency to provide Medicare beneficiaries with appropriate forms for an expedited and efficient appeal process when faced with termination of Medicare-covered services.

C. **PROCEDURE:**

1. Notice Of Medicare Non-Coverage (HMO):
   a. For Medicare HMO beneficiaries, the forms are explained to beneficiary and signed, but not dated, on the SOC visit in anticipation that no further visits will be authorized. These forms are then returned to the office medical records for inclusion of date upon termination of service, when determined, and then a copy given to beneficiary at the visit prior to the discharge visit. The copy can also be mailed or faxed to the beneficiary, if no further visits are authorized after SOC.
   b. The beneficiary or authorized representative's signature is required on the Medicare HMO Non-Coverage forms. This may be accomplished by mailing or faxing if the beneficiary is not available.
   c. The following information is required for the form:
      i. Beneficiary's name and medical record number
      ii. The date Medicare HMO coverage of services ends
      iii. The type of coverage that is ending (Home **Health** Care)
   d. If longer services are needed after a form is delivered and signed, and more services are to be given, the clinician must inform the beneficiary of a new effective date of termination, if known. A new form may be signed in person or the clinician may annotate the original form in the medical record. This is accomplished by the following:
      i. Draw a single line though the termination date and write the new termination date above or beside the deleted date.
      ii. Write the words "Notice Amended" on the Generic Notice
      iii. Date and sign the entry
      iv. Verbally notify the beneficiary that the Generic Notice termination date has been amended.
      v. Provide or mail a copy of the amended notice to the beneficiary
      vi. Place a copy of the amended notice in the beneficiary's medical record.

e. A form does not need to be delivered/mailed to a beneficiary when the beneficiary chooses to terminate Home **Health** Care services; the beneficiary is discharged to a higher level of care or in the event of the beneficiary's death.

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE

ISSUE DATE: 07/05

SUBJECT: Notice of Medicare ~~Provider~~ Non-Coverage

REVISION DATE~~(S)~~: 04/08, 02/09, 06/11, 02/13, 08/20

POLICY NUMBER: 321

Home Health Care Approval:	~~06/20~~06/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~07/20~~06/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/20

A. **PURPOSE:**

1. To explain the CMS ruling regarding the Notice of Medicare ~~Provider~~ Non-Coverage for the Medicare beneficiaries.

B. **POLICY:**

1. It is the policy of the Agency to provide Medicare beneficiaries with appropriate forms for an expedited and efficient appeal process when faced with termination of Medicare-covered services.

C. **PROCEDURE:**

1. Notice of Medicare ~~Provider~~ Non-Coverage (Generic form):
   a. The Notice of Medicare ~~Provider~~ Non-Coverage (Generic), must be delivered to all traditional Medicare (Not Medicare/HMO) 2 days prior to the end of the Medicare coverage of All Home **Health** Care services. The day of discharge is considered the effective date of termination of services. This form explains to the beneficiaries their right to an expedited appeal process prior to termination of services. In the event that a beneficiary is advised by their physician that they no longer need Home **Health** Care, the clinician need not make a visit but may instead phone the patient advising of the discharge and mail the Generic notice the same day with documentation indicating verbal discussion with the beneficiary. This would be done the day the clinician would become aware of the ~~MD~~ **physician** discharge.
   b. The beneficiary or authorized representative's signature is required on the Medicare ~~Provider~~ Non-Coverage form. (Generic) This may be accomplished by mailing or faxing if the beneficiary is not available.
   c. The following information is required for the Generic form:
      i. Beneficiary's name and medical record number
      ii. The date Medicare coverage of services ends
      iii. The type of coverage that is ending (Home **Health** Care)
      iv. The name and phone number of the appropriate Quality Improvement Organization
   d. If additional services are needed after a Generic form is delivered and signed, and more services are to be given, the clinician must inform the beneficiary of a new effective date of termination. A new form may be signed in person or the clinician may annotate the original form in the medical record. This is accomplished by the following:
      i. Draw a single line through the termination date and write the new termination date above or beside the deleted date

ii. Write the words "Notice Amended" on the Generic Notice
iii. Date and sign the entry
iv. Verbally notify the beneficiary that the Generic Notice termination date has been amended
v. Provide or mail a copy of the amended notice to the beneficiary
vi. Place a copy of the amended notice in the beneficiary's medical record

e. A Generic form does not need to be delivered/mailed to a beneficiary when the beneficiary chooses to terminate Home Care services; the beneficiary is discharged to a higher level of care or in the event of the beneficiary's death.

f. The 2-day rule prior to termination of services does not apply to patients on service fewer than 2 days or when there are unanticipated changes in coverage. However, the notice still needs to be delivered/mailed even though the 2-day rule does not apply.

g. Although the Generic Notice must be delivered no later than 2 days before the day of discharge, it can be delivered sooner when the day of discharge is identified. If the discharge date of the Generic Notice changes; please refer to the process outlined in #4 **D.i.-vi**.

~~g.~~**h. If the beneficiary refuses to sign the Generic Notice, then annotate the notice to indicate the date that the form was delivered and indicate refusal of beneficiary signature.**

2. Detailed Explanation of Non-Coverage (Detailed Notice):

a. The beneficiary has the option to notify the Quality Improvement Organization when he/she feels services should be continued. If this occurs, the Quality Improvement Organization, (QIO) will notify the Home Care Agency. A Detailed Notice must be delivered on the day the Agency is notified by the QIO of the beneficiary's decision to exercise his/her appeal rights and documented that the Notice was given to the beneficiary. The Detailed Notice is also sent the same day to the QIO by mail, e-mail for fax. If a beneficiary states to a clinician that they are going to appeal when they are given the Notice of Medicare ~~Provider~~ Non-Coverage, the clinician may at that time give the beneficiary the Detailed Notice. The Detailed Notice does not require beneficiary signature.

b. The following are examples of when a Detailed Notice is not required; however, documentation supporting the reason is required for the medical record.

i. Detailed Notice Not Required:

1) Beneficiary requests to discontinue care
2) Unsafe patient situation
3) Unsafe situation for Agency personnel
4) Hospitalization
5) Nursing Home placement
6) Beneficiary relocation
7) Beneficiary non-compliance
8) (Beneficiary non-compliance could include non-compliance with the CMS regulation regarding the physician face to face encounter).

c. The Quality Improvement Organization (QIO) will be available both to receive a

i. Beneficiary's request for an expedited determination and to conduct reviews on weekends.

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE

ISSUE DATE:	**12/98**	**SUBJECT:**	**Orientation / Competency Validation**
REVISION DATE:	**07/04, 05/06, 11/07, 02/08, 05/09, 07/13 05/10, 06/11, 03/13, 07/13**	**POLICY NUMBER:**	**801**

Home Health Care Approval:	**05/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**06/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**07/13**

~~**Tri-City Home Health**~~	~~Distribution:~~
~~**Policies:**~~	~~**UNIT SPECIFIC POLICY MANUAL – HOME HEALTH**~~
~~**Subject:**~~	~~**ORIENTATION / COMPETENCY VALIDATION**~~
~~**Policy Number:**~~	~~**801**~~

A. **PURPOSE**:
1. To define the Home Health Orientation Process for all disciplines.

B. POLICY:
1. All new Home Health employees must attend an individualized, discipline specific orientation~~,~~ organized by the **Director of Home Care or designee.** ~~Clinical Educator. Home Health follows TCMC's Administrative Policy Manual, number 8610-457.~~
2. The Director of Home Care or designee will following the following Tri-City Medical Hospital District policies to organized orientations and competency validation:
- **a. New Hire and Department Specific Orientation**
- **b. Competency**
- **c. Coaching and Counseling for Work Performance**
- **d. Performance Evaluations**

~~**ORIENTATION**~~:
~~1. The general TCHH orientation and competency check lists are processed by the Clinical Educator.~~
~~2. Program Characteristics:~~
~~A. The orientation program includes formalized, structured and individualized instruction.~~
~~B. Staff is assessed for their learning needs, and competency testing is done.~~
~~C. Preceptors are used to facilitate learning.~~
~~3. Methods used in orientation include:~~
~~A. Classroom, didactic instruction.~~
~~B. Programmed instruction where self-learning takes place.~~
~~C. Interactive video instruction.~~
~~D. Supervised clinical experience.~~
~~E. Discipline specific performance standards are used as orientation tools.~~
~~4. Evaluation is an ongoing process, which is done by/through the coordinated efforts of the Orientee, Clinical Educator, Preceptor and/or Supervisor. Issues regarding performance and further education are addressed as needed.~~
~~5. Tools used to determine satisfactory completion of orientation include:~~

A. Orientation Calendars
B. TCMC Department Orientation Checklist
C. TCHH Orientation Checklist
D. Skills Checklist
E. Performance Standards
F. Infection Control Manual
G. TCHH Policies & Procedures
H. Netlearning Modules
I. Quality Performance Manuals

6. Completed orientation documents are included in the employee's personnel file and sent to the centralized employee records unit of the hospital, including the TCMC department orientation checklist and skills checklist.
7. If the new employee fails to meet the objectives of the introductory period, the orientation period can be extended with the agreement of the Educator, Supervisor, Director and orientee. Continuation of the introductory period or termination is enacted according to TCMC administrative policy.
8. Please see TCMC Police #8610-430 on verification and ongoing monitoring of employees licensures.

COMPETENCY VALIDATION:

1. The Agency defines competencies as those activities that the staff and Leadership engage in for the purpose of validating ability to perform the functions of the job. Job Descriptions and Performance Standards define competency. Continuing education, performance appraisal, and supervision maintain competency. Testing tools validate competency.
2. Competency Validations will be completed as follows:
   A. Orientation
   B. Minimum every 3 years
   C. With the introduction of new equipment and/or procedures
   D. Waive testing point of care - competencies are completed every year
   E. New Employees – at Orientation, at 6 months, at 12 months
3. Each individual in the organization is competent in the:
   A. Knowledge and skills required to perform his/her responsibilities
   B. Effective and safe use of all equipment used in his/her activities
   C. Prevention of contamination and transfer of infection
   D. Use of cardiopulmonary resuscitation and other lifesaving interventions
4. All clinical personnel (RN / LVN / PT / PTA / OT / RD / ST / MSW / CHHA) will participate in planned programs to validate competency. Competencies will be validated at a minimum of every three (3) years by review, unit specific testing, and return demonstration. Once the employee's knowledge base and skill level have been validated and completed by a qualified Clinician in their specific discipline, the personnel are certified to continue practicing in their specific clinical area.
5. The Educator documents and tracks mandatory skills, exams, and classes for all individuals in the Education Manual.

6. Unsuccessful validation of competency is reported to the Clinical Supervisor for counseling or disciplinary action as warranted.

ISSUED	REVIEWED	REVISED	APPROVED
12/98	6/04, 97/05, 1/08, 3/09, 4/10, 3/11, 1/13	6/04, 9/26, 1/08, 3/09, 3/10, 7/12, 11/12, 1/13, 7/13	7/04, 5/06, 11/07, 2/08, 5/09, 5/10, 6/11, 3/13, 7/13

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE: 05/04	**SUBJECT:** Outcome and Assessment Data Set Submission (OASIS)
REVISION DATE: 05/04, 01/07, 08/09, 01/12	**POLICY NUMBER:** 501

Home Health Care Approval:	06/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	06/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/12

~~ISSUE DATE: 5/10/04~~
~~REVISION DATE: 1/07~~
~~REVIEW DATE: 11/06, 5/09, 09/11~~

~~SUBJECT: Outcome and Assessment Data Set Submission (OASIS)~~
~~NUMBER: 501~~
~~APPROVAL: 5/04, 1/07, 8/09, 1/12~~

A. **POLICY**:
1. It is the policy of the Agency to comply with the Conditions of Participation regarding submission of the OASIS data set within the guidelines set forth by Department of Health Services/CMS.

B. **PURPOSE**:
1. To delineate the necessary steps required for compliance of OASIS submission.

C. **PROCEDURE**:
1. **The Agency must encode and electronically transmit each completed OASIS assessment to the CMS system, regarding each beneficiary with respect to which information is required to be transmitted (as determined by the Secretary), within 30 days of completing the assessment of the beneficiary.**
2. **The encoded OASIS data must accurately reflect the patient's status at the time of assessment.**
3. **The Agency must encode and transmit data using the software available from CMS or software that conforms to CMS standard electronic record layout, edit specifications, and data dictionary, and that includes the required OASIS data set.**
4. **For all completed assessments, the Agency must transmit OASIS data that includes the CMS-assigned branch identification number in a format that meets the requirements of Section C(3) above and transmit data using electronic communication software that complies with Federal Information Processing Standard, from the Agency or the Agency contractor to the CMS collection site.**
~~1.~~**5.** A corrected OASIS data set will be encoded and locked for future submission to the State agency within thirty (30) days from the -comprehensive patient assessment.
~~2.~~**6.** Submissions are tracked by the Director ~~of Patient Care Services and Operations~~ or designee monthly and the error report reviewed. The Agency will maintain an error percentage below the established thresholds of CMS. The error threshold for thirty (30) day lock is 20%.
~~3.~~**7.** The validation and error survey report is tracked by the Director ~~of Patient Care Services and Operations~~ or designee quarterly. The Agency will maintain an error percentage below the established thresholds of CMS. The error threshold for all validation is 10%.~~.~~
~~4.~~**8.** OASIS data set is not necessary for those patients whose payer source is not Medi-Cal or Medicare as dictated by CMS.

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE
~~UNIT SPECIFIC POLICY MANUAL~~

ISSUE DATE:	**12/98**	**SUBJECT:**	**Patient Complaint/Grievances**
REVISION DATE:	**06/04, 04/05, 11/07, 04/08, 09/11, 02/13**	**POLICY NUMBER:**	**317**

Home Health Care Approval:	**06/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**06/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/13**

~~ISSUE DATE: 12/98~~ ~~SUBJECT: Patient Complaint/Grievances~~
~~REVISION DATE: 6/04, 1/05, 4/08~~ ~~POLICY NUMBER: 317~~
~~REVIEW DATE: 6/04, 4/08, 6/11, 4/12~~ ~~APPROVAL: 4/05, 11/07, 4/08, 9/11, 2/13~~

A. PURPOSE:

1. To define the **expected outcome for investigation, resolution and documentation of patient complaints and grievances**~~mechanism when Tri-City Home Health receives complaints~~.

B. POLICY:

~~2.~~**1.** The Agency will receive, review, investigate, reply and attempt to resolve all complaints in a consistent, expeditious and positive manner.

C. PROCESS:

~~A.~~**1.** All patients or family, upon admission to the Agency, are apprised of their rights to lodge complaints to the Agency, Joint Commission, or to the Department of Health and Human Services. This contact information is documented in the Patient Admission Booklet.

~~B.~~**2.** The Agency allows the patient to voice complaints and recommend changes freely without being subjected to coercion, discrimination, reprisal, or unreasonable interruption of care.

~~C.~~**3.** The Director of Risk Management is to be notified immediately of any legal or potential liability issues with substantiated documentation in RL Solutions.

~~D.~~**4.** Complaints that do not involve Home Health staff will be forwarded to the appropriate department/agency. Tri-City Hospital Complaints are forwarded to Patient Relations Specialist.

~~E.~~**5.** All patient complaints received by any Home Health staff will be reported to the appropriate Supervisor and the resolution process initiated as soon as possible.

~~F.~~**6.** All complaints are considered significant and the nature of the complaint, investigation, action taken and resolution outcome will be documented in RL Solutions. All parties involved in the complaint will be interviewed and this will be documented on the complaint.

~~G.~~**7.** After investigation, the Supervisor, Clinical Manager, or Director will call the patient to review the complaint and offer reasonable resolution. Resolution may include but is not limited to:

- ~~1.~~**a.** Verbal and/or written apology.
- ~~2.~~**b.** Replacement of one staff member with another.
- ~~3.~~**c.** Replacement of broken or damaged item if broken or damaged by staff.

~~H.~~**8.** Unresolved verbal or written complaints are considered grievances and will be handled by TCMC Risk Management and followed-up by letter.

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE: 12/95	**SUBJECT: Patient Education**
REVISION DATE: 07/04, 11/07, 08/09, 01/12	**POLICY NUMBER: 311**

Home Health Care Approval:	**06/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**06/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/12**

~~ISSUE DATE: 12/95~~	~~SUBJECT: Patient Education~~
~~REVISION DATE: 06/04~~	~~POLICY NUMBER: 311~~
~~REVIEW DATE: 06/04, 5/09, 9/11~~	~~APPROVAL: 7/04, 11/07, 8/09, 1/12~~

A. **PURPOSE**:
1. To define the process for a comprehensive patient education program for Home Health.

B. **POLICY**:
1. Home Health educates patients and their caregivers regarding the nature of their illness, care needed, and practices that would promote comfort and optimal quality of life. **The Agency must provide the patient and patient caregiver with a copy of written instructions outlining:**
- **a. Visit schedule, including frequency of visits by personnel and any personnel acting on behalf of the Agency.**
- **b. Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by Agency personnel and personnel acting on behalf of the Agency.**
- **c. Any treatments to be administered by Agency personnel and personnel acting on behalf of the Agency, including therapy services.**
- **d. Any other pertinent instruction related to the patient's care and treatments that the Agency will provide, specific to the patient's care needs.**
- **~~1.~~e. Name and contact information of the Agency Clinical Manager and Director.**

C. **PROCESS**:
1. Mechanisms used to educate patients and caregivers about their care are verbal instruction, printed information, demonstration, and return demonstration techniques.
2. **A ~~M~~m**ultidisciplinary patient education ~~committee, with the Clinical Educator as the Chairperson,~~ **team** is responsible for creating, monitoring and updating educational tools.
3. A variety of teaching tools, such as booklets, video tapes, CDs, are available in the Home Health office for staff usage with patients.
4. Education is documented as an intervention on the plan of care, which is signed by the physician.
5. The disciplines caring for the patient are responsible for identifying the educational needs, including the abilities, motivation, and readiness to learn. Any language and/or cultural barriers are also identified. A teaching plan is established to meet those needs. The educational needs that are identified on the initial visit and subsequent visits are documented on the visit note. At case conferences, patient education issues and learning needs should be discussed by all clinicians involved with the care.
6. Emphasis is placed on patient/family/caregiver involvement in the educational process.

7. Documentation of teaching should consist of what was taught, teaching tools or materials used, patient/family/caregiver response and level of understanding, and the ability to repeat or demonstrate what was taught.
8. Each patient receives a "Patient Admission Booklet" at start of care. The handbook educates all patients regarding emergency preparedness, patient's rights, advance directives, patient safety, and infection control.
9. Community resources will be accessed, as appropriate and available, based on patient/family/caregiver needs.

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE:	12/98	SUBJECT:	Patient's Rights and Responsibilities
REVISION DATE:	11/04, 01/05, 11/07, 06/08, 08/09, 02/10, 03/11, 06/12, 02/13	POLICY NUMBER:	302

Home Health Care Approval:	05/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	06/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/13

~~ISSUE DATE: 12/98~~ ~~SUBJECT: Patient's Rights and Responsibilities~~

~~REVISION DATE: 06/04, 11/04, 6/07, 6/08, 9/09~~ ~~POLICY NUMBER: 302~~
~~REVIEW DATE: 6/04, 1/05, 6/07, 6/08, 4/09~~
~~10/10, 3/11, 6/12~~ ~~APPROVAL: 1/05, 11/07, 8/09, 2/10, 3/11, 2/13~~

A. PURPOSE:
1. The patient and representative (if any), have the right to be informed of the patient's rights in a language and manner the individual understands. The Agency must protect and promote the exercise of these rights.

B. POLICY
1. It is Agency policy to provide necessary Notice of Rights to the patient, and his/her representative (if any), delineating the responsibility of the agency to the patient and defining the patient's responsibility in their own health care.

C. PROCEDURE:
1. Notice of rights.
   a. Provide the patient and the patient's legal representative (if any), the following information during the initial evaluation visit, in advance of furnishing care to the patient:
      i. Written notice of the patient's rights and responsibilities, and transfer and discharge policies. Written notice must be understandable to persons who have limited English proficiency and accessible to individuals with disabilities;
      ii. Contact information for the HHA administrator, including the administrator's name, business address, and business phone number in order to receive complaints.
      iii. An OASIS privacy notice to all patients for whom the OASIS data is collected.
   b. Obtain the patient's or legal representative's signature confirming that he or she has received a copy of the notice of rights and responsibilities.
   c. Provide verbal notice of the patient's rights and responsibilities in the individual's primary or preferred language and in a manner the individual understands, free of

charge, with the use of a competent interpreter if necessary, no later than the completion of the second visit from a skilled professional.

d. Provide written notice of the patient's rights and responsibilities under this rule and the Agency's transfer and discharge policies to a patient-selected representative within 4 business days of the initial evaluation visit.

2. Exercise of rights.
   a. If a patient has been adjudged to lack legal capacity to make health care decisions as established by state law by a court of proper jurisdiction, the rights of the patient may be exercised by the person appointed by the state court to act on the patient's behalf.
   b. If a state court has not adjudged a patient to lack legal capacity to make health care decisions as defined by state law, the patient's representative may exercise the patient's rights.
   c. If a patient has been adjudged to lack legal capacity to make health care decisions under state law by a court of proper jurisdiction, the patient may exercise his or her rights to the extent allowed by court order.
3. *Rights of the patient.* The patient has the right to -
   a. Have his or her property and person treated with respect;
   b. Be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect and misappropriation of property;
   c. Make complaints to the HHA regarding treatment or care that is (or fails to be) furnished, and the lack of respect for property and/or person by anyone who is furnishing services on behalf of the HHA;
   d. Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to -
      i. Completion of all assessments;
      ii. The care to be furnished, based on the comprehensive assessment;
      iii. Establishing and revising the plan of care;
      iv. The disciplines that will furnish the care;
      v. The frequency of visits;
      vi. Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits;
      vii. Any factors that could impact treatment effectiveness; and
      viii. Any changes in the care to be furnished.
   e. Receive all services outlined in the plan of care.
   f. Have a confidential clinical record and access to or release of patient information and clinical records.
   g. Be advised, orally and in writing, of -
      i. The extent to which payment for HHA services may be expected from Medicare, Medicaid, or any other federally-funded or federal aid program known to the Agency,
      ii. The charges for services that may not be covered by Medicare, Medicaid, or any other federally-funded or federal aid program known to the Agency,
      iii. The charges the individual may have to pay before care is initiated; and
      iv. Any changes in the information provided in (i)-(iii) above when they occur. The Agency will advise the patient and representative (if any), of these changes as soon as possible, in advance of the next home health visit but no later than 30 calendar days from the date that the Agency becomes aware of the change.
   h. Receive proper written notice, in advance of a specific service being furnished, if the Agency believes that the service may be non-covered care; or in advance of the Agency reducing or terminating on-going care.

i. **Be advised of the state toll free home health telephone hot line, its contact information, its hours of operation, and that its purpose is to receive complaints or questions about local HHAs.**

j. **Be advised of the names, addresses, and telephone numbers of the following Federally-funded and state-funded entities that serve the area where the patient resides:**
   i. **Agency on Aging,**
   ii. **Center for Independent Living,**
   iii. **Protection and Advocacy Agency,**
   iv. **Aging and Disability Resource Center; and**
   v. **Quality Improvement Organization.**

k. **Be free from any discrimination or reprisal for exercising his or her rights or for voicing grievances to the Agency or an outside entity.**

l. **Be informed of the right to access auxiliary aids and language services, and how to access these services.**

~~To define the Home Health patient's rights and responsibilities for optimal outcomes.~~

~~POLICY~~
~~It is Agency policy to provide necessary information to the patient, and his/her family, delineating the responsibility of the agency to the patient and defining the patient's responsibility in their own health care.~~

~~PROCESS~~
~~2.1 Each patient is provided with a Patient Admissions Booklet upon admission that explains:~~
~~a) Patient's Rights~~
~~b) Responsibilities~~
~~c) Advanced Directive information~~
~~d) Infection control in the home~~
~~e) Medication tips~~
~~f) Equipment safety tips~~
~~g) Safety and comfort in the home~~
~~h) What to do in a disaster~~
~~i) Privacy statement regarding **Outcome and Assessment Data Set Submission** (OASIS)~~
~~j) Pain and symptom management~~
~~k) Fee schedule~~
~~2. Privacy~~
~~a) Home Care makes every effort to assure patient privacy.~~
~~In accordance with **the Health Insurance Portability and Accountability Act** (HIPAA), all patients must receive the Notice of Privacy Practice upon admission or when the content of the Notice has been significantly changed.~~
~~The patient is requested to initial the acknowledgement that the Notice has been received.~~
~~Patient's that have been discharged from TCMC have already signed an acknowledgement.~~
~~i. Verification of the signed acknowledgement is done via data base by Intake Coordinator and checked on the referral sheet as signed.~~
~~3. Patient Admission Consent~~
~~a) The admitting clinician reviews the Patient Admission Consent with the patient prior to signing. The consent covers services provided by the Agency and the acknowledgement that the patient has the right to understand, assist in the development and revision of the plan of care.~~
~~b) Authorization is also given for release of information regarding payment for service and clearly states the patient will be informed of costs incurred.~~
~~c) The consent may be signed by a representative (see Admission Policy) when the patient is unable to sign. The reason for inability to sign is documented on the consent.~~
~~d) The patient's permission for any photography is obtained prior to taking any photos by signing the~~

~~Patient Admission Consent which includes a section pertaining to photographs. *No commercial photos or filming of Home Care patients is allowed unless a separate consent is signed delineating the reason and distribution of the photos or film.*~~

~~e) The patient always has the right to know the name and license/certificate of all clinicians coming to their place of residence.~~

~~f) Verification of all licenses is done by Human Resources. Verification can be done via the internet for the various boards.~~

~~g) The patient always has the right to request termination of services at any time.~~

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE

~~Tri-City Home Health~~	~~Distribution: Clinical Staff~~
~~POLICIES:~~	~~UNIT SPECIFIC POLICY MANUAL – HOME HEALTH~~
~~Subject:~~	~~Philosophy~~
~~Policy Number:~~	~~102~~

ISSUE DATE: 12/98 **SUBJECT:** Philosophy

REVISION DATE: 07/04, 01/07, 07/07, 05/09, 06/11, 03/13 **POLICY NUMBER:** 102

Home Health Care Approval:	05/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	06/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/13

A. **PURPOSE:**

1. A philosophy exists for Tri-City Home Health to define Home Health Care and to articulate the values and beliefs of the management team and the staff.

B. **POLICY:**

1. Assure that the Best Standards of Practice are the central theme in our delivery of health care. The Agency is dedicated to excellence in patient care, teaching, and providing the most effective and efficient home health services.
2. Understand the best utilization of resources and enhance efforts of fiscal responsibility in providing optimal care.
3. Provide continuing staff education and professional growth through a multi-disciplinary, collaborative environment.
4. Assure active participation by all Home Health staff in the **Quality Assurance** Performance Improvement **(QAPI)** program through continuous evaluation of care and services provided.
5. Maintain complete documentation of care, assuring the rights of patient confidentiality, keeping patients informed about all aspects of their health status, and maintaining participation in decisions affecting their care to the fullest extent possible.
6. Provide for the development and annual review of Standards of Practice, which will define acceptable levels of performance. The Standards of Practice is to include a peer review process, standards of patient care and nursing practice, to assure staff competency.
7. Assure compliance to all regulatory standards that pertain to the agency.
8. Work cooperatively with other community organizations and groups to provide comprehensive care and services.

C. **TRI-CITY HOME CARE GUIDING VALUES AND MISSION STATEMENT**

1. The Guiding Values of Tri-City Home Health
   a. We provide highly skilled and innovative services to preserve dignity and enhance quality of life.

b. We deliver ethical care with a team-centered inter-disciplinary approach that is compliant with State and Federal regulations.

c. We are committed to a supportive environment that provides respect and compassion as we care for ourselves and others.

d. We continually expand our knowledge to ensure skilled and optimal delivery of quality patient care.

2. The Mission of Tri-City Home Health

~~i.~~**a.** The purpose of Tri-City Home Health is to provide comprehensive, compassionate and cost effective care to our patients to help optimize their quality of life.

~~b.~~

~~Issued~~	~~Reviewed~~	~~Revised~~	~~Approved~~
~~12/98~~	~~7/04, 1/07, 5/11, 1/13~~	~~6/03, 1/07, 6/11~~	~~7/04, 1/07, 7/07, 5/09, 6/11, 3/13~~

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE: 12/98	**SUBJECT: Policy Development**
REVISION DATE: 07/04, 12/08, 02/09, 11/11, 01/12	**POLICY NUMBER:**
Home Health Care Approval:	**06/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**06/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/12**

~~ISSUE DATE: 12/98~~	~~SUBJECT: Policy Development~~
~~REVISION DATE: 7/04~~	~~POLICY NUMBER: 107~~
~~REVIEW DATE: 12/08, 11/11~~	~~APPROVAL: 7/04, 2/09, 11/11, 1/12~~

A. **PURPOSE**:
1. To define the policy and process for developing and/or revising **written administrative** agency policies.

B. **POLICY**:
~~1.~~ Policies define the conditions and mechanisms needed to operate and control the Agency system. Policies constitute the base of operation and support along with clinical and managerial decision making. They serve to hold members accountable and to provide a basis for negotiating and resolving conflict. **These policies and procedures shall be evaluated ~~reviewed and revised as necessary~~ as part of the annual evaluation of the Agency. The policies and procedures shall be made available upon request to patients or their representatives and to Department representatives.** Policies are established, **reviewed** and approved by **the home health Director** ~~Leadership~~, **Medical Director(s), Hospital Administration,** ~~Group of Professional Personnel~~ and the **Tri-City Healthcare District Board of Directors (BOD).** ~~Governing Body and are an addendum to the Patient Care Services policies of TCMC~~

C. **PROCESS**:
1. The Administrative Policy Manual for Tri-City Healthcare District contains all policies pertaining to all departments of the Hospital.
2. Home Health specific policies are contained in a separate policy manual **in the electronic policy management system**.
~~3.~~ **Administrative** Policies are **established and implemented** ~~developed~~ by the Home Health **Agency ~~and will be reviewed and revised as necessary.~~** ~~team members or Leadership staff and presented to the Group of Professional Personnel for approval.~~
~~4. The Tri-City Healthcare District Governing Board reviews the Home Health policies.~~
~~5. Patient care policies outline the specific care and management of patient care processes.~~
~~6. Policies and Agency processes will not be changed without approval of Leadership, the Group of Professional Personnel, and Governing Board.~~
~~7.~~**4.** Policies are **reviewed, revised, deleted and new policies developed as regulatory requirements and/or organizational policies change.** ~~reviewed annually or as community or regulatory requirements change or as regulations are added or deleted.~~

8. Consideration and need for review or revision of policies are as follows:
    a. Results of continuous performance improvement studies.
    b. Problems/complications/volume indicators occurring with current content/compliance.
    c. Results of satisfaction surveys.
    d. Ethical and legal issues.
    e. Regulatory mandates.
    f. Current Home Health Community Standards of Care.
9. Documentation of policy review and approval is recorded in appropriate committee minutes.

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE: 05/04	**SUBJECT: Recertification**
REVISION DATE: 01/05, 04/07, 03/11, 02/13	**POLICY NUMBER: 306**
Home Health Care Approval:	**06/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**06/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/13**

~~ISSUE DATE: 5/10/04~~	~~SUBJECT: Recertification~~
~~REVISION DATE: 10/04, 9/06, 4/07, 1/08~~	~~POLICY NUMBER: 306~~
~~REVIEW DATE: 1/05, 4/07, 1/08, 12/10, 3/11, 6/12~~	~~APPROVAL: 1/05, 4/07, 3/11, 2/13~~

A. **PURPOSE**:
1. To define the requirements, responsibility and steps necessary for recertification of patients.

B. **POLICY**:
1. The policy of the agency is to recertify all patients when continuing care is indicated beyond the 60-day episode.

C. **PROCEDURE**:
1. Communication occurs and the recertification order is obtained from the primary physician prior to the comprehensive assessment of the patient. Documentation of the communication shall be entered in the ~~McKesson~~ **electronic medical record in a** Clinical Note. The recertification written physician order shall clearly define certification period, disciplines involved, date new frequency and duration is to begin, and applicable components of the prior plan of care.
2. The recertification comprehensive assessment and Plan of Care is completed by each discipline involved in the case within the last five (5) days of the current certification period. Nursing completes the OASIS assessment, as needed, when they are the only discipline involved or if other disciplines are involved. Rehab completes the OASIS assessment, as needed, when nursing is not involved on the case.
3. The recertification process includes completion of the sixty (60) day summary by each discipline active at the time of recertification. **The (60) day summary is sent via fax to the certifying physician, podiatrist or dentist within 5 days of completion.**
4. ~~4.~~ Medications, doses, and frequency are addressed for each certification, including over the counter medications. A new medication **profile** ~~sheet~~ is created and **a written copy is left in home with the patient.** ~~copies are distributed to the patient.~~
5. Items to be completed for a recertification visit by discipline managing the case.
   a. OASIS comprehensive assessment if required (completed by discipline managing the case)
   b. Comprehensive assessment if OASIS not required
   c. New medication list indicating what is new or changed.
   d. Updated profile if changes
   e. If a CHHA continues into the new recertification period, a new CHHA assignment is to be completed.
   f. New **Financial Agreement is signed, if applicable.** ~~funding sheet~~

~~6.~~ The new Plan of Care **will be provided to patient in writing to include the updated visit schedule/frequency, medication schedule/instructions, including medications, dosage and frequency, treatments and any other pertinent instructions related to the patient's care, and treatments that the Agency personnel and personnel acting on behalf of the Agency will provide**~~.shall be delivered to the patient for review~~.

7. See Resumption of Care policy for the process of completing paperwork for a patient that is resumed and due for a recertification during the last five (5) days of the certification period.
   a. If the patient is hospitalized in the last 5 days of the certification period it is a recertification/resumption of care.

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE:	**08/04**	**SUBJECT:**	**Risk Management and Patient Safety Reporting**
REVISION DATE:	**10/04, 11/07, 10/08, 05/10, 12/11, 06/12, 02/13**	**POLICY NUMBER:**	**603**

Home Health Care Approval:	**05/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**06/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/13**

~~ISSUE DATE: 8/04~~
~~REVISION DATE: 8/07, 10/08, 3/10~~
~~REVIEW DATE: 10/08, 3/10, 12/11, 6/12~~

~~SUBJECT: RISK MANAGEMENT and PATIENT SAFETY REPORTING~~
~~POLICY NUMBER: 603~~
~~APPROVAL: 10/04, 11/07, 10/08, 5/10, 12/11, 2/13~~

A. **PURPOSE**:

1. To address areas of potential risk to the patient and agency personnel~~,~~ and to define the reporting and follow-up for incidents.

B. **POLICY**:

1. It is the policy of the Agency to minimize risk to the patient, caregiver, family and personnel. The agency will follow the TCMC process for generating incident reports and follow-up corrective action.

~~1.~~**2.** Home Health staff will not transport patients, caregivers or family members under any circumstance. If an emergency is activated and paramedics transport, Home Health staff may arrange transportation for patients as necessary with appropriate community resources. Home Health staff, if able to do so safely, may assist patients to/from house or vehicle.

~~2.~~**3.** Home Health staff may physically assist in patient transfers if they are able to safely perform this function i.e., bed, chair, toilet.

~~3.~~**4.** Any unexpected variance in the patient status, environment of care or provision of care that results in injury, potential harm or altered outcome to the patient, family, caregiver or staff member is considered an incident. ~~A~~**An incident must be entered in the** ~~Quality Review Report (QRR) must be completed in~~ RL Solutions **reporting system** for review by the **Director of Home Care or Registered Nurse (RN):**~~Manager of Quality and Outcome~~

a. An incident may include, but is not limited to **the following**:

i. Damage or theft of patient's property
ii. Equipment or medical device failure
iii. Endangerment of patient, caregiver, family or staff
iv. Harassment or Abuse
v. Refusal of treatment against the advice of agency personnel
vi. Suspicion of active illegal substance abuse or activities
vii. Any death occurring in the home
viii. Witnessed cardiac or respiratory arrest
ix. Any agency procedure error that results in trauma or injury, untoward outcomes including drug reactions and IV therapy complications

x. Witnessed or unwitnessed patient falls
xi. Medication error made by the patient/caregiver
xii. Motor vehicle accidents involving an employee's vehicle while on Home Health business
xiii. Any reference to legal action by patient, family, or caregiver
xiv. Any staff accidents that require treatment, lost work days or hospitalization or that identify new safety hazards that were previously unrecognized
xv. User errors related to equipment resulting in personal injury from lifting or fallen equipment

~~2.~~**5.** Home Health investigates all reports of accidents, incidents and/or injuries. When an incident occurs, the Home Health staff directly involved or who discover incident will complete a Quality Review Report in RL Solutions as soon as possible, preferably within 24 hours of the incident.[MJT1]

~~4.~~**6.** All significant events (i.e., deaths) will immediately be reported to the **Director of Home Care. Director of Home Care or RN designee will inform the Chief Nurse Executive and Risk Manager.** ~~DPCS, Clinical Supervisor and the Manager of Quality and Outcomes, who reports it to TCMC's Risk Management Department.~~

~~PROCEDURE:~~

~~A. Home Health staff will not transport patients, caregivers or family members under any circumstance. In an emergency EMS is activated and paramedics transport. Home Health staff may arrange transportation for patients as necessary with appropriate community resources. Home Health staff, if able to do so safely, may assist patients to/from house or vehicle.~~

~~B. Home Health staff may physically assist in patient transfers if they are able to safely perform this function. (i.e. bed, chair, toilet).~~

~~C. Any unexpected variance in the patient status, environment of care or provision of care that results in injury, potential harm or altered outcome to the patient, family, caregiver or staff member is considered an incident. A Quality Review Report (QRR) must be completed in RL Solutions for review by the Manager of Quality and Outcomes.~~

~~An incident may include, but is not limited to:~~

~~I. Damage or theft of patient's property~~
~~II. Equipment or medical device failure~~
~~III. Endangerment of patient, caregiver, family or staff~~
~~IV. Harassment or Abuse~~
~~V. Refusal of treatment against the advice of agency personnel~~
~~VI. Suspicion of active illegal substance abuse or activities~~
~~VII. Any death occurring in the home~~
~~VIII. Witnessed cardiac or respiratory arrest~~
~~IX. Any agency procedure error that results in trauma or injury, untoward outcomes including drug reactions and IV therapy complications~~
~~X. Witnessed or unwitnessed patient falls~~
~~XI. Medication error made by the patient/caregiver~~
~~XII. Motor vehicle accidents involving an employee's vehicle while on Home Health business~~
~~XIII. Any reference to legal action by patient, family, or caregiver~~
~~XIV. Any staff accidents that require treatment, lost work days or hospitalization or that identify new safety hazards that were previously unrecognized~~
~~XV. User errors related to equipment resulting in personal injury from lifting or fallen equipment~~

~~D. Home Health investigates all reports of accidents, incidents and/or injuries. When an incident occurs, the Home Health staff directly involved or who discover incident will complete a Quality Review Report in RL Solutions as soon as possible, preferably within 24 hours of the incident.~~

~~F. All significant events (i.e. deaths) will immediately be reported to the DPCS, Clinical Supervisor and the Manager of Quality and Outcomes, who reports it to TCMC's Risk Management Department.~~

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE

ISSUE DATE: 12/98

SUBJECT: Scope of Services / Description of Setting

REVISION DATE~~(S)~~: 07/04, 04/05, 01/07, 11/07, 04/08, 02/09, 02/10, 03/11, 02/13, 07/13, 08/20

POLICY NUMBER: 101

Home Health Care Approval:	~~02/20~~05/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~07/20~~06/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/20

A. **PURPOSE:**
1. To describe Home Health territory, location, and services provided.

B. **POLICY:**
1. Tri-City Home Health is a non-profit, hospital based, program of Tri-City Medical Center. The agency is accredited by the Joint Commission on Accreditation of Healthcare Organizations, licensed by the State of California as a Home Health Agency and Medicare Certified.
2. The offices are located adjacent to Tri-City Medical Center at 2095 West Vista Way, Suite 220, Vista, California, 92083. The physical plant consists of a reception area, offices, office and field staff work areas, medical records storage areas, supply areas and a conference room.
3. Tri-City Home Care services are provided to adult patients (18 years of older) living in the Tri-City service area. The geographic borders range north to Camp Pendleton and east to Fallbrook (excludes north east of the Mission Road exit off I-15 and Rainbow), south to Solana Beach, east to Escondido, west of Valley Center Road and west to the Pacific Coast.

C. **SCOPE OF SERVICES:**
1. Home Health provides skilled intermittent care to individuals with compromised functional abilities and an unstable medical condition requiring interventions of a restorative, rehabilitative or palliative nature at their place of residence. Services are provided by Registered Nurses, Licensed Vocational Nurses, Masters of Social Work, Licensed Clinical Social Workers, Certified Home Health Aides, Physical Therapists, Occupational Therapists, Dietitians and Speech Therapists and Physical Therapy Assistants

D. **DISCIPLINES:**
1. **NURSING**
   a. The role of the Registered Nurse is to assess the total health needs of the patient and develop a plan of care and goals approved and directed by the physician to improve the status of the patient. The plan of care reflects the diagnosis, medications, mental and physical status and environment and may include the need for other members of the health care team. The Licensed Vocational Nurse assists the Registered Nurse in carrying out the plan of care and reports to the Registered Nurse. Nursing services include, but are not limited to, evaluation/assessment, education to the patient and or caregiver and collaboration with the physician and other members of the team.
2. **PHYSICAL THERAPY**
   a. The goals of Physical Therapy are to relieve pain, minimize disability, prevent

deformities, develop, improve and restore functioning to the best ability of the patient. Physical Therapy Services shall include, but are not limited to, evaluation, development of treatment plans /goals approved and directed by the physician, instruction, treatment and education. Physical Therapy Assistants, under the supervision of a physical therapist, may be utilized executing the physical therapy plan of care.

3. **OCCUPATIONAL THERAPY**
   a. The role of Occupational Therapy is to provide assessment, therapy and education for patients who demonstrate deficits in skill required for daily living activities. Services include evaluation and treatment, directed by the physician, for impairments of physical, cognitive and sensory-integrative functioning. The goal of treatment is to improve or restore function, prevent or minimize dysfunction, and or cope with disabling conditions.
4. **SPEECH PATHOLOGY**
   a. Speech Pathology Services include assessment, therapy and education for patients who demonstrate communication or oral-pharyngeal function disorders with direction from the physician. Areas include, but are not limited to, impairment of articulation, language comprehension and expression, cognition, fluency, voice, reading writing and swallowing. Also provided are education and counseling for families of patients exhibiting the aforementioned disorders.
5. **SOCIAL SERVICES**
   a. Social Services include assessment and evaluation of the patient for the functioning and ability of the patient undergoing disruption of their current status. Social Services provide counseling and referral for community resources and assist members of the team and family when a higher level of care needed for the care and safety of the patient. All Social Services are under the direction of the physician.
6. **CERTIFIED HOME HEALTH AIDES**
   a. Personal care is provided to the patient under the supervision of the RN, OT or PT and direction from the physician. These services may include but are not limited to, personal hygiene and assisting with ambulation and or home exercises.
7. **DIETARY**
   a. The Registered Dietitian, under the direction of the physician and in coordination with other team members, evaluates/assesses the dietary needs of the patient and makes recommendations and provides education based on that assessment.

E. **HOURS OF SERVICE:**

1. Office hours are 8:00 am to 5:00 pm Monday through Friday.
2. Nursing services are routinely available 24 hours a day, seven days a week. The on-call RN coordinates this and can be reached for phone contact and/or home visits. Physical Therapy, and CHHA services are available 7 days/week from 8 am to 5 pm. Visits will be scheduled according to the Interdisciplinary Plan of Care, and at the request of the patient, family, or caregiver.
3. Occupational and Speech Therapies, and Medical Social Workers, are available Monday through Friday from 8:00 am to 5:00 pm and other hours by arrangement or as patient/family and staff deem appropriate.

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE:	**12/98**	**SUBJECT:**	**Staff Development**
REVISION DATE:	**06/04, 07/05, 11/06, 11/07, 08/09, 10/11, 01/12**	**POLICY NUMBER:**	**802**

Home Health Care Approval:	**06/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**06/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/12**

~~ISSUE DATE: 12/98~~	~~SUBJECT: Staff Development~~
~~REVISION DATE: 06/04, 7/05, 9/06~~	~~POLICY NUMBER: 802~~
~~REVIEW DATE: 06/04, 4/06, 5/09, 10/11~~	~~APPROVAL: 7/05, 11/6, 11/07, 8/09, 1/12~~

A. **PURPOSE**:
1. To define provision of education for all Home Health staff.

B. **POLICY**:
1. Education is provided to all Home Health staff on an ongoing basis. Education is based on assessed needs and advances of the industry.

C. **PROCESS**:
1. The ~~Clinical Educator~~ **Director, Clinical Manager or RN designee** is responsible for coordinating staff development for all disciplines.
2. The **Director, Clinical Manager or RN designee** ~~Clinical Educator~~ works with ~~the Leadership team,~~ Home Health staff, and the Education Department of TCMC in a collaborative effort. ~~He/she~~ **The in-service program is developed and implemented with focus to** ~~coordinates the in-service program~~ meeting the individual education needs of the staff by utilizing interdisciplinary presenters.
~~3. The Clinical Educator reports to the DPCS.~~
~~4~~**3.** The mechanisms for identifying learning needs as the basis for program development at both staff and management levels include, but are not limited to, staff surveys, in-service evaluations, education, open time at staff meetings for comments, suggestions, and the results of quality improvement studies. Education needs can be identified by yearly performance appraisals and through orientation of new employees.
~~5.~~**4.** Mechanisms are used to plan and coordinate learning events **and education opportunities are provided and distributed to all staff. Attendance at classes is documented and maintained in the department.** ~~Monthly calendars with education opportunities are distributed to all staff. Staff and supervisors can request special information or classes in writing or verbally.~~
~~6. Documentation related to staff education is kept in manuals maintained by the Clinical Educator and located in her office.~~
~~7. The educational manuals are organized by calendar year.~~
~~8. Attendance at classes provided by the agency is documented.~~
~~9~~**5.** CEUs will be given for appropriate classes and issued by TCMC education department.

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE

ISSUE DATE:	**08/04**	**SUBJECT:**	**Staff Safety**
REVISION DATE~~(S)~~:	**10/04, 07/07, 02/09, 10/10, 01/12, 03/12, 02/13, 08/20**	**POLICY NUMBER:**	**203**

Home Health Care Approval:	**~~06/20~~05/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~07/20~~06/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/20**

A. **PURPOSE:**
1. To outline safety concerns for Home Health Staff.

B. **POLICY:**
1. It is the Policy of Tri-City Home Health to clearly define safety in the workplace for field staff. TCMC Security will assist the clinician when requested.

C. **GENERAL FIELD SAFETY:**
1. When a staff member enters any area or situation they perceive to be unsafe, their first responsibility is to leave the area or situation. They are to be alert and aware of their surroundings and if something doesn't feel right, they should leave the premises. This action must be reported to the supervisor **and/**or ~~supervisor~~ Administrator **on-call**.
2. Staff members are to immediately leave any situation if a patient or caregiver becomes physically or verbally abusive. This must be reported to the supervisor **and/**or ~~Administrative Supervisor~~ Administrator **on-call** immediately. Physician notification will also be made. The supervisor **and/or clinical manager** will investigate all incidents and determine the appropriate follow up. This follow up may include but is not limited to: reports to local law enforcement, telephone contact with the patient or caregiver, reassessment by other agency personnel or discharge from the Agency.
3. Cellular phones are available to all visiting staff for communication and safety.

D. **VISITING STAFF ARE ADVISED TO:**
1. Be familiar with the destination prior to leaving office/home.
2. Carry identification at all times
3. Avoid lingering groups of people on corners or around doors.
4. Carry keys in hand and keep jewelry to a minimum.
5. Never knock on unmarked doors or doors other than the patient's.
6. Never enter a vacant or what appears to be an abandoned house.
7. If necessary, discuss with supervisor the use of an escort.
8. Always be aware of exits and do not allow your access to an exit to be blocked while in the patient's home.

E. **FIREARMS SAFETY:**
1. The Agency recognizes the significant potential danger that firearms present to the Home Health clinician. If firearms are identified to be in the patient's home, the following apply:

a. The patient/family/caregiver is instructed that the weapon must be removed and not be present during clinician visits or Home Health service to the patient will be discontinued.
b. It is mandatory that the supervisor or the **Administrator** on-call ~~Administrative supervisor~~ be called when firearms are identified.
c. The DPCS or designee will contact the patient, family/ caregiver and reiterate the policy on weapons within the next working day.
d. If weapons are identified on subsequent visits demonstrating non-compliance, the following individuals must be notified immediately:
   i. DPCS or designee, primary physician and administrator on call
e. The patient will be discharged from service after the primary physician has been notified.
f. Threatening behaviors involving firearms and other weapons require immediate staff removal, police notification and discharge of patient from Home Health service.

F. **PET SAFETY:**

1. Approach pets in a calm and cautious manner. Ask the owner to secure the pet while making the home visit.
2. If an animal appears aggressive or if you feel uncomfortable, ask that the animal be leashed, caged, or put in another room.

G. **ILLEGAL DRUG USE/MEDICINAL MARIJUANA:**

1. A patient visit will not proceed if medicinal marijuana is being smoked in the clinician's presence. The patient will be asked to not smoke medicinal marijuana just prior to the visit to avoid the presence of second hand smoke.
2. Any evidence of illegal drug use, drug paraphernalia, or methamphetamine production, should be reported to your Supervisor. Do not confront or question anyone in the home, just conclude the visit and leave the area immediately.

H. **AUTOMOBILE SAFETY:**

1. It is recommended that clinicians in the field keep a half a tank of gas or more in their automobiles at all times. This becomes very important in the event of a disaster.
2. Do not talk on cell phones while driving. Use a hands free device or pull over to the side of the road if deemed safe.
3. Follow all the California rules of the road and wear a seat belt.
4. Use an automobile that is in good working order.
5. Lock valuables in the car trunk prior to the first visit.
6. Park as close to the destination as possible in a well lighted area

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE:	**12/98**	**SUBJECT:**	**Staffing**
REVISION DATE:	**07/04, 04/07, 11/08, 09/09, 02/10, 01/12**	**POLICY NUMBER:**	**109**

Home Health Care Approval:	**05/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**06/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/12**

~~ISSUE DATE: 12/98~~
~~REVISION DATE: 7/04, 2/07, 11/08, 9/09~~
~~REVIEW DATE: 2/07, 11/08, 10/11~~
~~SUBJECT: Staffing~~
~~POLICY NUMBER: 109~~
~~APPROVAL: 7/04, 4/07, 2/10, 1/12~~

A. **PURPOSE**:
1. To define staffing needs.

B. **POLICY**:
1. Home Health will maintain adequate staffing to meet the needs in providing quality patient care.
~~PROCEDURE:~~
2. Staffing will be sufficient at all times to ensure that:
   a. All care is provided to patients at the level and intensity required by patient needs and physician orders.
   b. All Agency and regulatory standards are maintained.
   c. Professional staff is available to all patients served by the Agency.
   d. Staff members are able to participate in committees/meetings, quality improvement and educational activities.
3. The staffing plan will be reviewed and adjusted to assure that a sufficient number of qualified Home Health staff is available to meet the defined patient care needs and/or any unusual occurrences.
   a. Historical data is used to project numbers of visits for all disciplines.
   b. Staffing patterns are evaluated by leadership to determine the success of the staffing plan.
   c. Staffing needs are evaluated daily and weekly by the **Clinical Manager and Rehab** Supervisor.
   ~~c.~~**d.** Adequacy of staff is monitored by utilizing productivity statistics, patient census data and by constant communication with the case managers and field staff assessing the team's caseload.
4. The Case Managers, in coordination with the Director, addresses inadequate staffing needs by performing the following:
   a. Monitors agency's ability to accept patients based on available staff.
   b. Reassigns staff where possible.
   c. Authorizes overtime.
   d. Informs referral sources when unable to accept patients on a particular day.
   e. Informs referral sources of other days of availability to accept patient referrals.

5. Scheduling is done by the Case Managers **(CM)** and/or designee, the **Registered Nurse** (RN) **CM**~~case manager,~~ **Scheduling and Lead Therapist.** ~~Scheduling and Lead Therapist.~~
6. Scheduling practices for Home Health services are developed in consideration of the unique needs of each Home Health patient.
7. Nursing students are not allowed to perform direct patient care in this Agency. Students, with prior approval of the Agency and of the patient, are only allowed to observe care given by the Agency staff.

Tri-City Health Care District
Oceanside, California

HOME HEALTH CAR
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~~UNIT SPECIFIC POLICY MANUAL~~
~~HOME HEALTH~~

DELETE – follow Administrative Policy: Paid Time Off 433

ISSUE DATE: 01/03	**SUBJECT:** Vacations
REVISION DATE: 07/05, 10/10, 01/12	**POLICY NUMBER:** 202
Home Health Care Approval:	05/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	06/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/12

~~ISSUE DATE: 1/03~~	~~SUBJECT: Vacations~~
~~REVISION DATE: 9/03~~	~~Policy Number: 202~~
~~REVIEW DATE: 7/05, 6/10, 11/11~~	~~APPROVAL: 7/05, 10/10, 1/12~~

~~POLICY:~~

~~It is the policy of the agency to allow for time off in a fair and consistent manner in accordance with the law. (Please refer to Tri-City Medical Center's Employee Handbook for further information on PTO.)~~

~~PROCEDURE:~~

~~**Vacations:**~~

~~The leadership committee determines the number of vacations that may be granted concurrently throughout the year. Employees requesting vacation must have the appropriate amount of PTO to cover the request. Those with PTO hours will have priority over those who do not have or do not qualify for PTO. Leadership, when approving vacations, will consider the following:~~

~~1) When the request was submitted~~
~~2) Previous time taken off~~
~~3) Seniority~~
~~4) Special circumstances~~

~~**Winter Holiday PTO:**~~

~~The winter holiday period runs from the Sunday before Thanksgiving until the Sunday following New Year's Day.~~

~~1) Requests for vacation will be accepted after June 1 of each year.~~
~~2) Requests for vacation will be approved or denied in writing by July 31.~~
~~3) A maximum of 14 calendar days will be approved. The request may only include the week of Christmas or the week of New Year's, but not both. (Christmas week will be from the Monday before Christmas through the Sunday after Christmas. New Year's week will be from the Monday before New Year's through the Sunday after New Year's. If the two holidays fall on the Monday~~

that will be the beginning of the week). Longer periods of time will be considered on an individual basis, and provided you did not have more than the allowed time off at the same time the last year.

4) Requests for PTO during the winter holiday will not be granted two years in a row. Exceptions may be made if no one else requests this time off.
5) Each nurse and CHHA will need to work one of the three winter holidays (Thanksgiving, Christmas, New Year's). We will make this a rotation process year to year. Requests for PTO will not be approved during the holiday it is your turn to work.
6) PTO will be limited to two nurses (including case managers and field RN/LVN) and one CHHA off at any one time. This may be changed at the discretion of leadership.

Non Holiday PTO:

1) Spring vacation period will begin Monday after New Year's and end on the Sunday following Memorial Day.
2) PTO requests for spring vacation period will be accepted after July 1 of the preceding year and will be approved or denied by Aug. 31.
3) Summer/Fall vacation period will begin Monday after the Spring Vacation period ends and ends on Saturday before Thanksgiving.
4) PTO requests for summer/fall vacation period will be accepted after December 1 of the preceding year and will be approved or denied by January 31.
5) A maximum of 14 calendar days will be approved. Longer periods of time will be considered on an individual basis, other staff members requesting vacation, and provided you did not have more than the allowed time off at the same time the last year.
6) Each nurse and CHHA will need to work 2 out of the 4 non-winter holidays (Presidents Day, Memorial Day, Independence Day, and Labor Day). Vacation over one of the holidays becomes part of your two holidays off.
7) Requests for PTO will not be granted 2 years in a row for the same time frame. Exceptions may be made if no one else requests this time off.
8) PTO will be limited to two nurses (including case managers and field RN/LVN) and one CHHA off at any one time. This may be changed at the discretion of leadership.

If you find it necessary to cancel approved PTO, please notify the supervisor immediately to allow someone else the opportunity to use your slot.

It may become apparent that that the Agency does not need the number of nurses or CHHAs signed up to work on a particular holiday. Those nurses or CHHAs scheduled who would like the holiday off, may submit their name to a drawing to be off that day. This will not change your ability to take the holiday off the next year.

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 08/12

SUBJECT: Automatic Dose Rounding

REVISION DATE~~(S)~~: 09/15, 01/18

Department Approval:	~~10/17~~12/21
Pharmacy and Therapeutics Approval:	~~11/17~~03/22
Medical Executive Committee Approval:	~~11/17~~05/22
Administration Approval:	06/22
Professional Affairs Committee Approval:	~~01/18~~ n/a
Board of Directors Approval:	01/18

A. **PURPOSE:**

1. To provide a procedure for rounding medication dosages to deliver high-quality, cost-effective pharmaceutical care while minimizing charge errors and medication waste.

B. **PROCEDURE:**

1. It is preferred that the prescriber round the dose of a medication to the nearest available package size or closest measurable dose.
2. If the prescriber does not round to the nearest available package size or closest measurable dose, the pharmacist will round a dose to the nearest available package size or closest measurable dose providing the following criteria are met:
   a. Doses may be adjusted by the pharmacist for approved medications listed below or pursuant to an approved protocol (for example enoxaparin and heparin per the Pharmacy Procedure: Anticoagulation Dosing and Monitoring).
      i. Approved Medications:
         1) Chemotherapy
         2) Immune globulin
         3) G-CSF: granulocyte colony-stimulating factors (i.e., filgrastim)
         4) Erythropoetin stimulating factors (i.e. Epogen)
         5) Coagulation factors (VII, VIII, IX, Prothrombin Complex Concentrate)
         6) Alpha-proteinase inhibitors (i.e. Zemaira, Aralast)
         7) Antimicrobials, antifungals, and antivirals
         8) Tranexamic acid
         9) Monoclonal Antibodies
   b. Doses of non-chemotherapeutic agents will be adjusted within 10% (plus or minus) of the calculated prescribed dose.
   c. Chemotherapeutic agents may be adjusted pursuant to Pharmacy Policy: Chemotherapy, Prescribing, Processing, and Preparation.
   d. The dose for the ordered medication is within the normal dosing range based upon the indication, age, weight, and clinical status.
3. The pharmacist shall contact the prescriber prior to rounding the dose of an unapproved medication.
4. Dose-rounding for patients on an investigational protocol will occur based on protocol specifications only.
5. The prescriber shall be notified of potential rounding of doses greater than 10% for non-chemotherapeutic agents and shall approve the new dose prior to any changes made by the pharmacist. For Chemotherapeutic agents, the prescriber will be notified pursuant to Pharmacy Policy: Chemotherapy, Prescribing, Processing, and Preparation.

6. The pharmacist shall round the dose and complete the order "per protocol" in the patient medical record.

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

1. Pharmacy Policy: Chemotherapy, Prescribing, Processing, and Preparation
2. Pharmacy Procedure: Anticoagulation Dosing and Monitoring

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 05/92

SUBJECT: Clinical Intervention/Activity Documentation Program

REVISION DATE: 05/97, 01/97, 08/00, 02/03, 06/05, 07/06, 07/09, 01/12, 07/15, 01/18

Department Approval:	~~10/17~~12/21
Pharmacy & Therapeutics Committee Approval:	~~11/17~~03/22
Medical Executive Committee Approval:	~~11/17~~05/22
Administration Approval:	06/22
Professional Affairs Committee Approval:	~~01/18~~ n/a
Board of Directors Approval:	01/18

A. **PURPOSE**:

1. To provide a process for documentation of daily clinical pharmacy activities and programs, implemented for patient safety and cost-saving initiatives.
2. To provide a process for tracking and reporting of clinical intervention documentation activities for financial and quality improvement purposes and medication error reduction.

B. **PROCEDURE:**

1. During each pharmacy shift, the clinical pharmacist will document clinical pharmacy activities in a designated documentation/tracking system to record all patient related clinical activities.
2. The pharmacist will select the appropriate section and document the details of any cost savings interventions or therapeutic interventions that have a significant impact on patient care. Common interventions include but are not limited to:
   a. Antibiotic Stewardship
   b. Renal Dose Adjustment
   c. Therapeutic Substitution
   d. IV to PO Conversion
   e. Therapeutic Duplication
   f. Drug-Disease Interaction
   g. Drug-Drug Interaction
   h. Physician Near Miss
   i. Dose, Duration, Frequency Optimization
   j. Adverse Drug Event
   k. Anticoagulation, Vancomycin, Aminoglycoside, TPN Consults
   l. Drug Information Question
3. Pharmacy Clinical Interventions shall be reviewed monthly by the Clinical Manager and reported to the Pharmacy and Therapeutics Committee.

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 03/00 **SUBJECT: Decreasing Medication Errors**

REVISION DATE~~(S)~~: ~~06/05, 07/06, 07/09, 01/12, 09/15~~ 07/18

Department Approval:	**~~02/18~~12/21**
~~Medical Staff Department/Division Approval:~~	**~~n/a~~**
Pharmacy & Therapeutics Committee Approval:	**~~05/18~~03/22**
Medical Executive Committee Approval:	**~~06/18~~05/22**
Administration Approval:	**06/22**
Professional Affairs Committee Approval:	**~~07/18~~ n/a**
Board of Directors Approval:	**07/18**

A. **POLICY**:

1. It is the policy of Tri-City Healthcare District (TCHD) to take a proactive approach by focusing performance improvement activities toward reducing medication errors. Staff is reminded that errors can occur at any step of the process: prescribing, ordering, dispensing, administering or monitoring the effects of the medication.
2. The Institute for Safe Medication Practices (ISMP) has identified some common sources of errors:
   a. Unavailable patient information prior to dispensing or administering a drug (lab values, allergies, etc.)
   b. Unavailable drug information (written resources)
   c. Miscommunication of drug orders (similar names, use of zeros, inappropriate abbreviations, poor handwriting)
   d. Problems with labeling, packaging
   e. Drug Standardization, storage (stocking multiple concentrations of the same drug, look-alike containers)
   f. Drug device use and monitoring (lack of standardization in drug delivery devices, unsafe equipment)
   g. Environmental stress (distractions, noise during transcription or dispensing, long work hours)
   h. Limited staff education
   i. Limited patient education
3. The Institute of Safe Medication Practices also determined that a majority of medication errors resulting in death or serious injury were caused by "high alert medications":
   a. Insulin
   b. Opiates and narcotics
   c. Injectable potassium chloride (or phosphate) concentrate
   d. Intravenous heparin
   e. Sodium chloride solutions above 0.9%
4. TCHD has adopted the following strategies to decrease the incidence of medication errors:
   a. A unit dose system of medication distribution has been implemented.
   b. Information on ordered medications will be produced on the nursing units and provided, in writing, for the patient/family on discharge. The Pharmacist will be available to counsel patients on complex drug therapies.
   c. The Pharmacy and Therapeutics Committee has developed standardized practices for prescribing medications:
      i. All drug orders must be written in the metric system. Units must be spelled out.
      ii. Medication orders must include the name of the drug, dosage amount and form.

iii. A leading zero (0) must always precede a decimal point for a dose less than one (1); a trailing zero (0) is never to be used after a decimal.
iv. The use of unapproved abbreviations (see Patient Care Services Policy: Use of Abbreviations) will be avoided.

d. Storage of medications will assist in distinguishing similar products from one another.
e. There will be special awareness with appropriate safeguard policies followed in the ordering, storage and administration of the identified "high-risk drugs".
f. Staff are encouraged to report medication errors which are then reviewed, trended, and reported to the Pharmacy and Therapeutics Committee.
g. Medication event reporting shall be done according to Administrative Policy Incident Report - Quality Review Report (QRR) RL Solutions 396.
h. The physician shall be notified of all medication errors upon discovery. If there was no harmful outcome from the error, the notification may take place during the next business day.

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

1. Patient Care Services Policy: Use of Abbreviations
2. Administrative Policy: **Event**~~Incident~~ Report**ing**~~ Quality Review Report (QRR) RL Solutions~~ 396

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE:	**06/80**	**SUBJECT:**	**Medication Preparation**
REVISION DATE:	**06/05, 07/06, 07/09, 01/12, 07/15 03/18**		
Department Approval:		**~~12/17~~12/21**	
Pharmacy & Therapeutics Committee Approval:		**~~01/18~~03/22**	
Medical Executive Committee Approval:		**~~02/18~~05/22**	
Administration Approval:		**06/22**	
Professional Affairs Committee Approval:		**~~03/18~~ n/a**	
Board of Directors Approval:		**03/18**	

A. **POLICY**:
1. Whenever possible, only those medications which are commercially available and/or in single-unit packages and in ready-to-administer form will be used.
2. For medications not commercially available in unit dose form, medications will be repackaged from bulk containers into single unit packages so that they may be used in a unit dose system whenever possible.
3. All medications are prepared in a safe manner.

B. **PROCEDURE**:
1. To prevent contamination of medications prepared by the Pharmacy Department and medication errors, the following guidelines will be followed in the preparation of medications:
   a. The medication preparation and packaging operation will be isolated, to the extent possible, from other pharmacy activities.
   b. The preparation area will be maintained in a clean and uncluttered manner, functionally separate area for product preparation to minimize the possibility of contamination.
   c. Pharmacists and technicians will prepare only one (1) drug product at a time. No drug products other than the one being repackaged or prepared will be present in the immediate preparation area. No labels other than for the product being repackaged should be present in the area.
   d. Pharmacists and technicians shall use clean or sterile techniques as appropriate to the medication being prepared. For injectable products, see Pharmacy Policy: Sterile Product Preparation.
   e. All unused labels (if separate labels are used) should be removed from the immediate preparation area.
   f. The integrity of the product being prepared and medications ready to dispense will be examined for evidence of damage, contamination, or other deleterious effects.
   g. The Pharmacist will be readily accessible to Pharmacy Technician staff during medication preparation.
   h. Unit dose packages and labels will comply with law and regulation standards. See Pharmacy Policy: Labeling Standards.
   i. Expiration dates will be checked and verified on all products prior to dispensing.
   j. High-risk medications will be stocked and stored in a way that minimizes the likelihood of an error occurring during preparation and distribution.
   k. All medications will be packaged and stored in a temperature-and humidity-controlled environment to minimize degradation caused by heat and moisture. Packaging materials

should be stored in accordance with the manufacturer's instructions and any applicable regulations.

l. Applicable Federal Drug Administration (FDA) and United State Pharmacopeia (USP) requirements concerning the type of package required for specific drug products will be followed.

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

1. Pharmacy Policy: Sterile Products Preparation
2. Pharmacy Policy: Labeling Standards

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE:	**01/80**	**POLICY: Pharmacy and Therapeutics Committee**
REVISION DATE:	**01/94, 01/97, 09/00, 02/03, 06/05, 07/06, 07/09, 01/12, 04/14, 07/18**	

Department Approval:	**~~04/18~~03/22**
~~Medical Staff Department/Division Approval:~~	**~~n/a~~**
Pharmacy & Therapeutics Committee Approval:	**~~05/18~~03/22**
Medical Executive Committee Approval:	**~~06/18~~05/22**
Administration Approval:	**06/22**
Professional Affairs Committee Approval:	**~~07/18~~ n/a**
Board of Directors Approval:	**07/18**

A. **POLICY**:

1. The Pharmacy and Therapeutics Committee exists as part of the hospital medical staff and is responsible for managing the formulary system. P&T committee members are appointed by medical staff to serve in an evaluative, educational, and advisory capacity to the medical staff and organizational administration in all matters pertaining to the use of medications (including investigational medications). The P&T committee is responsible for overseeing policies and procedures related to all aspects of medication use within an institution. The P&T committee is responsible to the medical staff as a whole, and its recommendations are subject to approval by the organized medical staff as well as the administrative approval process.
2. Other responsibilities of the P&T committee include medication- use evaluation (MUE), adverse-drug-event monitoring and reporting, medication-error prevention, and development of clinical care plans and guidelines.

B. **ORGANIZATION:** As defined in Section 10.18-1 of the Medical Staff Bylaws.

C. **FUNCTIONS AND SCOPE**: As defined in Section 10.18-2 of the Medical Staff Bylaws.

D. **CONFLICT OF INTEREST:**

1. To assure decisions made by the Pharmacy and Therapeutics Committee are of the highest ethical quality and not influenced by any associations with outside sources with respect to an alternate agenda the following is required:
   a. Pharmacy and Therapeutics Committee members in order to serve are required to complete and sign a Conflict of Interest Disclosure Statement. See Attachment 1: Conflict of Interest Disclosure Form below.
   b. Anyone who provides information or recommendations to the committee related to medication use is required to sign a Conflict of Interest Disclosure Statement.
   c. Any practitioner submitting a request for formulary revision is required to provide a Conflict of Interest Disclosure Statement. This statement may be included within the Formulary Revision Request Form document. See Attachment 2. Formulary Request Form.
   d. Conflict of Interest Disclosure Statement forms are submitted to the Pharmacy and Therapeutics Committee Chairperson or the Director of Pharmacy and are reviewed by the committee. Any actual or potential conflicts identified will attempt to be resolved. In the absence of resolution, the matter shall be in accordance with the Medical Staff Conflict of Interest Policy. Conflict of Interest Disclosure Statements are retained on file by the Director of Pharmacy Services.

e. Any member of the hospital committee who perceives a conflict of interest for himself/herself is required to take the following action:
   i. Declare the conflict of interest prior to discussions or debate
   ii. Refrain from voting on an issue in which the conflict of interest exists
   iii. Refrain from influencing other members' votes for an issue in which a conflict of interest exists

f. Any member that perceives or suspects another member of a potential conflict of interest is required to request tabling the discussion until the suspicions and conflicts are resolved.

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 03/06

SUBJECT: **Receiving and Tracking Narcotic Pump Refills Prepared by Outside Vendors**

REVISION DATE~~(S)~~: 03/06, 07/09, 01/12, 09/15, 03/18

Department Approval:	~~12/17~~12/21
Pharmacy & Therapeutics Committee Approval:	~~01/18~~03/22
Medical Executive Committee Approval:	~~02/18~~05/22
Administration Approval:	06/22
Professional Affairs Committee Approval:	~~03/18~~ n/a
Board of Directors Approval:	03/18

A. **PROCEDURE**:

1. Narcotic pump refills for Tri-City Healthcare District (TCHD) patients will be processed in the following manner:
   a. The outside vendor will be instructed to always deliver the medication to TCHD inpatient pharmacy.
   b. All medications will be signed in on the sheet located on the C-II safe.
   c. All medication will then be received into the Pyxis C-II safe in the following manner:
      i. Go to 'increase meds'
      ii. Go to 'receive meds'
      iii. Type 'narcotic pump refill outside RX'
      iv. Type quantity under 'acq. qty' field
      v. Under 'Vendor' box, hit drop down arrow and select appropriate vendor
      vi. Enter the RX # in the invoice field
      vii. In the DEA-222 field, type patient's name
      viii. Hit the '+' (plus sign)
      ix. Select Save
      x. Place the vendor invoice (or the Pyxis load receipt if invoice not available) on the pharmacy buyer's desk
         1) Write patient's full name on C-II safe printout
         2) Write drug and dose on C-II safe printout
2. Medication sent to stations will be signed out in the following manner:
   a. Go to 'Decrease Meds'
   b. Go to 'Send Meds'
   c. Select location or floor med will be delivered to
   d. Select 'narcotic pump refill outside RX'
   e. Type the quantity of med being sent
   f. Select the '+' (plus) sign
   g. Check the 'print on save' box
   h. Hit the save key
      i. Write patient's full name on C-II safe printout
      ii. Write drug and dose on C-II safe printout
      iii. Return sheet to Pharmacy Buyer's desk

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

May 26, 2022 – 3:00 o'clock p.m.
Via Teleconference

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held via teleconference at 3:00 p.m. on May 26, 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 Mizell
Director Adela Sanchez
Director Tracy Younger

Also present via teleconference were:

Steve Dietlin, Chief Executive Officer
Gene Ma, M.D., Chief Medical Officer
Candice Parras, Chief Patient Care Services
Jeremy Raimo, SVP, Business Development
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant

1. The Board Chairperson, Director Chavez, called the meeting to order at 3:00 p.m. via teleconference with attendance as listed above.

2. Approval of agenda

   It was moved by Director Chaya to approve the agenda as presented. Director Gleason seconded the motion. The motion passed unanimously.

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

   Board Counsel Jeff Scott made an oral announcement of the item listed on the May 26, 2022 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Hearing on Reports of the Hospital Medical Audit or Quality Assurance Committees.

5. Motion to go into Closed Session

   It was moved by Director Younger and seconded by Director Coulter to go into Closed Session at 3:05 p.m. The motion passed unanimously.

6. At 3:15 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 involving Hospital Quality Assurance matters and took no action.

8. Adjournment

It was moved by Director Coulter and seconded by Director Younger to adjourn the meeting at 3:20 p.m. The motion passed unanimously.

_____
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	71.7	69.5			68.1	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	90.2	87.3			94.5	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	98.6	

TCHD EROE $ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY22	($900)	($1,011)	($733)	$132	($1,441)	($1,358)	($1,172)	$275	($2,318)	($2,149)			($10,674)	($908)
FY21	($1,489)	($923)	($930)	$508	($175)	($881)	$1,109	($245)	$210	($554)	$4,682	$4,774	($3,371)	

TCHD EROE % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY22	-3.24%	-3.67%	-2.55%	0.43%	-5.23%	-4.87%	-3.99%	0.95%	-7.66%	-7.51%			-3.71%	-0.32%
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%	-1.25%	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

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

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY22	$190	$76	$340	$1,190	($359)	($277)	($105)	$1,343	($1,264)	($1,085)			$49	$10,863
FY21	($191)	$291	$302	$1,738	$879	$332	$2,344	$935	$1,383	$422	$5,782	$5,855	$8,436	

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%	-4.18%	-3.79%			0.02%	3.87%
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	4.72	5.09			5.10	5.27
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	5.63	

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	$49.2	$49.3			
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	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending May 31, 2022

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	LeaseTerm Beginning	LeaseTerm 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)	36,299.35	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	03/31/23	**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	Appox 4,508	$1.75	(a)	14,183.15	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)	12,553.62	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	05/31/22	**Pulmonary Specialists of NC** 3231 Waring Court Suit D Oceanside, CA 92056	7088
Total				**212,895.08**				

(a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending May 2022

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
7400	LACTACTION COUNSLER RECERT	52322EDU	126.00	82528	BRENDA BENEDETTI
7420	CHEMO ONS/ONCC	51822 EDU	458.00	84098	JOSHUA SMILEY
8381	CERTIFICATION EXAM	41122 EDU	125.00	84094	CEJA OMAR
8710	CME ACREDIDATION	51622 EDU	150.00	84096	JOHNSON TRACY
8740	PEDS LIFE SUPPORT	51222 EDU	200.00	83881	MARTIN NORIEGA
8740	FETAL HEART MONORITERING	42822 EDU	200.00	84093	SHERMAN JOANNA
8740	AWHONN	51222 EDU	167.55	21621	DAMSKY, GWEN
8740	OB WORKSHOP	51222 EDU	110.00	46518	NANCE, LAUREN
8740	AWHONN	50522EDU	167.55	78106	WARSOFF DEBORAH
8740	RN to MSN	32922EDU	5,000.00	82179	RABOLD,RYAN
8740	NCC CERT	51222 EDU	200.00	82988	DONALSON, ELEATA

**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.