TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
March 31, 2023 – 3:30 o'clock p.m.
Assembly Rooms 2 & 3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

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

	Agenda Item	Time Allotted	Requestor
1	Call to Order	3 min.	Standard
2	Roll Call / Pledge of Allegiance		
3	Approval of Agenda	2 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	Reports – Information Only a) Auxiliary Report – Linda Wolfe, President b) Labor & Delivery Update – Dr. Gene Ma	 10 min. 30 min.	 Auxiliary President Interim CEO
6	February 2023 Financial Statement Results	10 min.	CFO
7	New Business a) Consideration to cast the ballot for the Regular and Alternate Special District Member on the LAFCO Commission	 5 min.	 Chair
	b) Consideration to cast the ballot for the San Diego County Consolidated Redevelopment Oversight Board	5 min.	Chair
8	Old Business – None	-	-
9	Chief of Staff - a) Consideration of March 2023 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on March 27, 2023.	 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
	b) Consideration of Clinical Privilege Request Form	2 min.	COS
10	Consent Calendar – a) Approval of an agreement with 3M Health Information Systems, Inc. for software licenses and support for a term of 36 months, beginning May 11, 2023 and ending May 10, 2025, for an annual cost of $256,471.20 and a total cost for the erm of $769,414.20. b) Approval of an agreement with Henry Showah, M.D. as the Coverage Physician for Inpatient Wound Care for a term of 24 months, beginning May 1, 2023 and ending April 30, 2025, not to exceed an average of 20 hours per month, at an hourly rate of $180 for a total term cost of $86,400. c) Approval of an agreement with Sharon Slowik, M.D. as the Coverage Physician for Inpatient Wound Care for a term of 24 months, beginning May 1, 2023 and ending April 30, 2025, not to exceed an average of 20 hours per month, at an hourly rate of $180 for a total term cost of $86,400. d) Approval of an agreement with Henry Showah, M.D. as the Coverage Physician for Outpatient Wound Care for a term of 24 months, beginning May 1, 2023 and ending April 30, 2025, not to exceed an average of 20 hours per month, at an hourly rate of $180 for a total term cost of $86,400. e) Approval of an agreement with Sharon Slowik, M.D., as the Coverage Physician for Outpatient Wound Care for a term of 24 months, beginning May 1, 2023 and ending April 30, 2025, not to exceed an average of 20 hours per month, at an hourly rate of $180 for a total term cost of $86,400. f) Approval of the renewal of the Purchase Agreement with Edwards Lifesciences, LLC for a term of 24 months, beginning April 1, 2023 and ending March 31, 2025, for an annual cost of $1.350M and a total cost for the term of $2.7M. g) Approval of the addition of Robert Shapiro, M.D. to the Emergency Department On-Call Coverage Panel for Urology, for a term of 12 months, beginning March 1, 2023 and ending February 29, 2024, at a shared panel total term cost not to exceed $255,000. h) Approval of the Third Amendment Lease Renewal with 3907 Waring Road MOB, LLC for an additional 24-month term, beginning April 1, 2023, ending March 31, 2025 for a monthly expense of $7,158.60, for a total expense for the 24-month term of $171,806.40. i) Approval of an agreement with Nandan Prasad, M.D., as the Medical Director of Quality/Chairperson of Medical Quality Peer Review Committee for a term of 12 months, beginning May 1, 2023 and ending April 30, 2024, not to exceed a total term cost of $51,500.00. j) Administrative committees **A. Policies** **1. Patient Care Services Policies & Procedures** a) Advanced Care Technicians (ACT) Assignments and Shift Routines for Telemetry and Acute Care Services (ACS) b) Antimicrobial Stewardship Policy c) Blood Products Administration Procedure d) Growth Chart Documentation for Pediatrics, Adolescents and Neonates Policy (RETIRE)		

	Agenda Item	Time Allotted	Requestor
	e) Intravenous Solution, Storage & Warming of Procedure f) Lift Team Policy g) Massive Transfusion Protocol h) Sitter Policy i) Telephone Service for Patient Rooms Policy j) Therapeutic Anticoagulation Management Policy **2. Administrative 200** a) Assault and Battery Reporting Process 241 (RETIRE) b) Code Gray 283 (RETIRE) c) Disposal of Drugs and Drug Paraphernalia 217 d) Dr. Strong 221 **3. Administrative 400 and Pay Practice** a) Compensation for Education – 474 b) Compensation for Mandatory Education – 474.01 c) Compensation for Professional-Personal Education Activities – 474.03 (RETIRE) d) Press and Appearance Philosophy – 415 e) Paid Time-Off Program – 433 f) PTO Buy-Back – 433.01 g) Use of PTO Hours for Hardship – 433.02 h) Timekeeping and Break Policy i) Workplace Violence Policy – 463 **4. Emergency Operation Procedure (EOP) Manual** a) 4008 Disaster Procedure for VIP Hospital Wide b) 4027 E.R. Base Hospital Disaster (RETIRE) c) 4080 Registration Department Specific d) Code Silver Person with Weapon or Active Shooter **5. Employee Health and Wellness** a) Light Duty **6. Infection Control** a) Infection Prevention Risk Assessment **7. Medical Staff** a) Audit Criteria for Blood UR 8710-540 b) Standard for Endovascular Therapy (Catheter Based) 8710-530 **8. Outpatient Behavioral Health Services** a) Co-treatment of Patients Policy b) Speech Pathology Services Department Policy **9. Rehabilitation** a) Ethical Code of Conduct b) Interdisciplinary Plan of Care c) Interdisciplinary Team Conference d) Mission Statement, Goals and Objectives e) Patient/Family Conferences f) Policies and Procedures g) Pre-Admission Screening h) Provision of Services Not Provided by Tri-City Rehabilitation Center i) Scope of Services		

	Agenda Item	Time Allotted	Requestor
	10. Staffing a) Monitoring Registry Files Policy b) Registry Badge Process Policy c) Registry Contracts, Rate Addendums, Orientation Packet and Audits k) Minutes 1) February 23, 2023 – Special Meeting 2) February 23, 2023 – Regular Meeting 3) March 13, 2023, Special Meeting l) Meetings and Conferences – None m) Dues and Memberships – None n) Reports – (Discussion by exception only) 1) Lease Report – (February, 2023) 2) Reimbursement Disclosure Report – (February, 2023)		
11	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
12	Comments by Members of the Public NOTE: Per Board Policy 19-018, members of the public may have three (3) minutes, individually and 15 minutes per subject, to address the Board on any item not on the agenda.	5-10 minutes	Standard
13	Comments by Chief Executive Officer	5 min.	Standard
14	Board Communications (three minutes per Board member)	18 min.	Standard
15	Report from Chairperson	3 min.	Standard
16	Total Time Budgeted for Open Session	2 hours	
17	Adjournment		

Tri-City Medical Center

DATE: March 31, 2018

TO: Board of Directors

FROM: Gene Ma, M.D., Interim CEO

RE: Labor & Delivery Services Update

As a result of significant declines in utilization rates of women and newborn services at the hospital, staff will be providing an update to the Board and public for discussion and information purposes.

The decision earlier this month by the San Diego Local Formation Commission (LAFCO) to retrospectively grant Palomar Health permission to continue to encroach into the Tri-City Healthcare District boundaries and redirect women and newborn patients to Palomar Medical Center in Escondido has significantly impacted the ability of Tri-City Medical Center to continue to provide women and newborn service lines.

The staff presentation will outline the financial challenges facing these service lines along with potential options for future Board consideration.

San Diego County
Local Agency Formation Commission

Regional Service Planning | Subdivision of the State of California

CORRECTED
BALLOT AND VOTE CERTIFICATION FORM

March 8, 2023

TO: Independent Special Districts in San Diego County

FROM: Tamaron Luckett, Commission Clerk

SUBJECT: **Ballot and Vote Certification Form | Election to Regular and Alternate Special District on LAFCO Commission**

On December 19, 2022, the San Diego Local Agency Formation Commission (LAFCO) solicited nominations for (a) one regular and (b) one alternate special district member to serve on the LAFCO Commission. A total of five nominations were received following a 60-day filing period: (a) three regular members; and (b) two alternate members. The term is four years and commences on May 1, 2023. Note there was a correction to the alternate nominee Jeff Griffith he is with Palomar Healthcare District.

San Diego LAFCO is now issuing ballots to all 57 independent special districts in San Diego County and inviting each district to cast a ballot. Write-in candidates are permitted, and spaces have been provided for that purpose. **Only cast one vote for each nominee on the ballot and vote certification form; a ballot that is cast for more than indicated number of positions the vote will be disregarded.** The ballot and vote certification form along with nominee resumes provided by the candidates are attached.

State Law specifies a district's vote is to be cast by its presiding officer, or an alternate member designated by the board and a valid signature is required on the ballot. **A ballot received without a signature will be voided.** A minimum of **29** ballots must be received to certify that a legal election was conducted. A candidate for a special district LAFCO Commission member must receive at least a majority of the votes cast to be elected. The ballots will be kept on file in this office and will be made available upon request.

Ballots may be submitted by mail, courier, hand delivered, FAX or via email to tamaron.luckett@sdcounty.ca.gov, include **"Special District LAFCO Ballot"** and your **"District Name"** in the subject title, if necessary to meet the submission deadline, but the original for must be submitted. The deadline for receipts of the ballots by LAFCO is **Friday, April 14, 2023,** any ballots received after the deadline will be voided. All election materials will be available on the website: www.sdlafco.org. Should you have any questions, please contact me at 619-321-3380.

Tamaron Luckett. Commission Clerk

Administration:
Keene Simonds, Executive Officer
2550 Fifth Avenue, Suite 725
San Diego, California 92103
T 619.321.3380
E lafco@sdcounty.ca.gov
www.sdlafco.org

Chair Jim Desmond
County of San Diego
Joel Anderson
County of San Diego
Nora Vargas, Alt
County of San Diego
Kristi Becker
City of Solana Beach
Dane White
City of Escondido
John McCann, Alt
City of Chula Vista
Vice Chair Stephen Whitburn
City of San Diego
Marni von Wilpert, Alt
City of San Diego
Jo MacKenzie
Vista Irrigation
Barry Willis
Alpine Fire Protection
David A. Drake, Alt
Rincon del Diablo
Andy Vanderlaan
General Public
Harry Mathis, Alt
General Public

ATTACHMENT ONE

CORRECTED
2023 SPECIAL DISTRICTS ELECTION
BALLOT and VOTE CERTIFICATION
FOR REGULAR LAFCO SPECIAL DISTRICT MEMBER

VOTE FOR ONLY ONE

James Pennock [ ]
(Vallecitos Water District)

Ross Pike [ ]
(North County Fire Protection District)

Barry Willis[1] [ ]
(Alpine Fire Protection District)

Write-Ins

________________ [ ]

________________ [ ]

As presiding officer or his/her delegated alternate as provided by the governing board, I hereby certify that I cast the votes of the ____________________________
(Name of Independent Special District)
at the 2023 Special Districts Selection Committee Election.

____
(Signature)

____________________ ________________
(Print Name) (Date)

____
(Print Title)

Please note: The order in which the candidates' names are listed was determined by random selection.

The Ballot and Vote Certification form can be submitted electronically to: ***tamaron.luckett@sdcounty.ca.gov.***

1 Incumbent member

Corrected March 8, 2023

CORRECTED
2023 SPECIAL DISTRICTS ELECTION
BALLOT and VOTE CERTIFICATION
FOR ALTERNATE LAFCO SPECIAL DISTRICT MEMBER

__VOTE FOR ONLY ONE__

David Drake[1] [ ]
(Rincon del Diablo Municipal Water District)

Jeff Griffith [ ]
(Palomar Healthcare District)

__Write-Ins__

______________________ [ ]

______________________ [ ]

As presiding officer or his/her delegated alternate as provided by the governing board, I hereby certify that I cast the votes of the ______________________________
(Name of Independent Special District)
at the 2023 Special Districts Selection Committee Election.

____
(Signature)

____
(Print Name)

____
(Date)

____
(Print Title)

Please note: The order in which the candidates' names are listed was determined by random selection.

The Ballot and Vote Certification form can be submitted electronically to: tamaron.luckett@sdcounty.ca.gov.

[1] Incumbent member

Corrected March 8, 2023

ATTACHMENT A

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

The Vallecitos Water Distrtict (Name of Independent Special District) is pleased to nominate James Pennock (Name of Candidate) as a Candidate for the San Diego Local Agency Formation Commission as a regular special district member with a term expiring 2027.

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

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

(Presiding Officer Signature)

Glenn Pruim
(Print name)

General Manager
(Print Title)

2/7/23
(Date)

PLEASE ATTACH RESUME FOR NOMINEE

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

RECEIVED
FEB 07 2023
SAN DIEGO LAFCO

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Jim Pennock
jpennock@sbcglobal.net
760-815-4402

I look to utilize the interpersonal relationship skills and knowledge obtained through running my own business for the past 30 years to help propel public agencies to be more effective and efficient. I hope to increase moral and attitude within human resources and increase financial responsivity through effective planning and budgeting. Found to be Hardworking, honest and innovative in my approaches to helping others succeed.

EXPERIENCE

Pennock Insurance Agency
01-Aug-2020 - Present
Sales and service of Insurance contracts

Select Quote Home/Auto and Commercial
01-Jan-2019 – 01-June 2020
Received incoming calls for Sales of Policies

Wawanesa Insurance
01-Mar-2017 – 01-Jan 2019
Focused on Retention of Policies within Company

Farmers Insurance Group
01-Aug-1991 - 11-Aug-2016 – Insurance Agency Owner
I enjoyed a long career as an Insurance agent with Farmers Insurance.
Operated my own agency for 25 years - growing from 0 to 2900 policies and generating millions of dollars in annual premium.
Director of Sales – Recruited, trained and mentored producers: helped them meet their income goals
Focused on all lines of business - Home / Auto / Life / Health and Commercial.
Managed day to day sales, service, claims, underwriting of personal and commercial lines policies.
Managed accounting, finance, human resource.
Oversaw all Financial Management of agency, including auditing and reporting

EDUCATION

Brigham Young University / United States International University -
Graduated in 1991 with BS in International Business Administration

Other Skills and Experience
* **Fluent in English and Spanish**
* **Teacher in San Marcos Unified School District**
* **Provided consulting for Public Administration policies**
* **Served on Student and Neighborhood relations committee for City of San Marcos**
* **Served on the Budget Review committee for City of San Marcos 2009-2011**
* **Served on the Planning Commission for City of San Marcos 2013-2015**
* **Served as Chairman of Kit Carson District for Boy Scouts of America**
* **Coached multiple youth sports teams for last 30 years**
* **Served on multiple boards with non-profits over last 30 years**

*** Board Member for Hope Legacy 2017 to Present: assist youth to become self-reliant in area of education and finances.**
***Petco Park Customer service agent for San Diego Padres games**
***Board Member for Vallecitos Water District in San Marcos 2020 – Present**
***Board Member for Encina Waste Water 2023**

ATTACHMENT A

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

The North County Fire Protection District is pleased to nominate Ross Pike as a
(Name of Independent Special District) (Name of Candidate)

Candidate for the San Diego Local Agency Formation Commission as a regular special district member with a term expiring 2027.

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

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

Cindy Acosta
(Presiding Officer Signature)

Cindy Acosta
(Print name)

Board President NCFPD
(Print Title)

01/30/2023
(Date)

PLEASE ATTACH RESUME FOR NOMINEE

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

RECEIVED
FEB 21 2023
SAN DIEGO LAFCO

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ROSS PIKE

NORTH COUNTY FIRE PROTECTION DISTRICT

February 21, 2023

Dear San Diego County Special Districts,

I've had the pleasure of traveling around San Diego County over the past few weeks to meet many of you and it has been enlightening to hear about the experiences your districts are facing and how you interact with SDLAFCO. Thank you for your time and for sharing your stories!

SDLAFCO encourages orderly growth, promotes the logical formation and determination of local agency boundaries, discourages urban sprawl, and preserves open space and prime agricultural lands. From there, our Special Districts provide essential services to constituents, ratepayers, and community residents to achieve the goals of their unique agencies. Our SDLAFCO Commissioners present as one of the few outlets for representation and it's important that our Commissioners work to provide better collaboration between SDLAFCO and our Special Districts. As Directors, Trustees, and Board members, we understand that our agencies must adapt to the changing world we live in and our Special Districts must have a voice in the process that impacts them.

I am uniquely qualified and have been fortunate to be nominated by North County Fire Protection District and received support from Mission Resource Conservation District where I serve as a new Board Member. Also, serving on a Community Planning Group has provided me an education in land use experience where I serve on subcommittees advising on roads, traffic, and public facilities. All these roles require close attention to detail, commitment to the community, and dedication. That experience provides critical perspectives when voting on matters before SDLAFCO.

As a leader in the recent redistricting efforts, I attended every redistricting commission meeting which often would go on until nearly midnight and was able to activate our Community Planning Group in the process. Fallbrook was the first Planning Group to send a letter to the Redistricting Commission and the two letters I authored were well-received which resulted in bipartisan support and unanimous votes by my colleagues. I also led the community to submit comments with 397 comments mentioning Fallbrook compared to 470 comments for Oceanside, a city more than triple our size. Our efforts were successful and the input we submitted helped shape the final map of Supervisor District 5.

Local control matters. We represent the communities we live in and serve. We know what is best for our neighbors because we live in the same community as them. Serving as an alternate and attending the meetings for the North County Dispatch Joint Powers Authority has allowed for me to see how both Special Districts and cities were able to band together to provide essential services at healthy savings to our taxpayers by each district and city bringing their own independent perspectives and skills/services to the table, all while still maintaining all of our own local autonomy.

Please reach out to me if you have any questions or want to talk about anything. I always tell my constituents that they elect me to do a job, which means to get things done effectively and thoughtfully. I not only welcome your input, but I ask for it. As your Special District Representative to SDLAFCO, I would represent you and ensure that the voice of the Special Districts in San Diego County is heard.

Thank you for your time and consideration. I respectfully ask for your Board's vote to represent you and all our special districts as the Special Districts Representative on the San Diego Local Agency Formation Commission.

Respectfully,

Ross Pike
Director
North County Fire Protection District
rpike@ncfire.org

ROSS PIKE

NORTH COUNTY FIRE PROTECTION DISTRICT

PERSONAL

760-723-2012 (office)

rpike@ncfire.org

ncfire.org/board-director-ross-pike

EDUCATION

Grand Rapids Community College
Communications

Bellevue University
Business Management

CERTIFICATIONS

Leading Diverse Teams
University of California-Irvine

People & Business Leadership
Bellevue University

Successful Negotiation
University of Michigan

MEMBERSHIPS & AFFILIATIONS

- Fallbrook Chamber of Commerce
- California Special Districts Association (CSDA)
- Society for Human Resource Management (SHRM)
- American Management Association
- American Association of Political Consultants (AAPC)
- Young Elected Officials Network

AWARDS & RECOGNITION

"Awesome Award" on behalf of Rady Children's Hospital for Children's Miracle Network fundraising (2021)

"Benham Service & Civic Engagement Award" for civic engagement and community outreach (2012)

ELECTED & APPOINTED LEADERSHIP

ELECTED DIRECTOR, BOARD OF DIRECTORS

NORTH COUNTY FIRE PROTECTION DISTRICT | Jul 2022 - present

- North County Fire serves a 90 square-mile area including Fallbrook, Bonsall, De Luz, and Rainbow
- Through labor negotiations, secured the highest bilingual incentive pay in San Diego County to ensure the district, serving our 50% Latino community ensuring culturally-competent care
- Use pre-established relationships in order to build coalitions connecting NCFPD leadership with potential grants, funding, and lobbying opportunities
- Partner with community organizations and nonprofits to ensure we are providing the highest level of care and services are reaching as many community members as possible

ALTERNATE, BOARD OF DIRECTORS

NORTH COUNTY DISPATCH JOINT POWERS AUTHORITY (JPA) | Jul 2022 - present

North County Dispatch Joint Powers Authority, or North Comm, provides fire and medical emergency dispatch services to most city fire departments and fire district agencies in North San Diego County and private security dispatch to the Rancho Santa Fe Patrol.

ELECTED BOARD MEMBER

FALLBROOK COMMUNITY PLANNING GROUP | Jan 2021 - present

- Advise San Diego County, County Supervisors, and SANDAG on Fallbrook land use matters
- Led community redistricting efforts by drafting public statements and organizing strategic initiatives, including two letters sent by the Fallbrook Planning Group that inspired other planning groups to send letters
- Serve on the Circulation (roads, traffic circulation, and sidewalks) and Public Facilities Committees (utility-related projects)
- Member of the Ad-Hoc Social Media Committee to establish social media guidelines for the Fallbrook Planning Group and its members
- As Board Secretary, drafted board and committee agendas, issued information to the local newspaper, and disseminated information through social media reaching an average of 1,800-2,800 people per post
- Write speeches and prepares talking points for weekly public engagements

APPOINTED DIRECTOR, BOARD OF DIRECTORS

MISSION RESOURCE CONSERVATION DISTRICT | Jan 2023 - present

MRCD works to promote the conservation of soil, water, and other natural resources in the San Luis Rey and Santa Margarita watersheds through effective planning that ensures a healthy ecosystem and provides economic benefits and quality of life for landowners/land occupants and the general public. Through partnerships with water agencies, MRCD works with ratepayers to assist with conservation and savings on water bills

RELEVANT WORK EXPERIENCE

CHIEF OF STAFF/CAMPAIGN MANAGER

COUNTY SUPERVISOR CAMPAIGN | Feb 2022 - Dec 2022

- Managed daily campaign operations
- Supervised staff in various roles including communications, field operations, and volunteer recruitment
- Drafted and disseminated campaign messaging through media, surrogates, and digital outlets
- Coordinated calendar for speaking engagements, fundraisers, and community appearances
- Interfaced with community groups, elected officials, partnering campaigns, and political organizations
- Coordinated with 23 overlapping campaigns (school board, city council, special districts) in the 2,200 square-mile district

LOCAL COMMUNITY SERVICE & LEADERSHIP

Member, Fallbrook Chamber of Commerce

Advisor, Board of Directors, Fallbrook Village Association
which promotes and supports the economic, physical and cultural revitalization of the Fallbrook area

Strategic Steering Committee Chair, Fallbrook Village Association
led the committee to establish the organization's first strategic plan

Member, Friends of the Fallbrook Library

Member & Fundraiser, Fallbrook Land Conservancy

Fundraiser, Fallbrook Animal Sanctuary

ATTACHMENT A

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

The ALPINE FIRE PROTECTION DISTRICT (Name of Independent Special District) is pleased to nominate BARRY WILLIS (Name of Candidate) as a Candidate for the San Diego Local Agency Formation Commission as a regular special district member with a term expiring 2027.

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

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

[signature]
(Presiding Officer Signature)

Stephen R. Taylor
(Print name)

PRESIDENT
(Print Title)

1/17/23
(Date)

RECEIVED
JAN 25 2023
SAN DIEGO LAFCO

PLEASE ATTACH RESUME FOR NOMINEE

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

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Baron T. Willis
btwillis9@gmail.com

EDUCATION

U.C. Berkeley/ University of California, San Diego
Major: Pre-Law Program/Bachelor of Arts in Political Science
Minor: Psychology

College for Financial Planning
Chartered Retirement Planning Counselor Designation
2017-2023

Kaplan Financial Education
Series 7 Stock Broker License

Chelsea Financial Services Broker Training Programs
Life Insurance and Financial Planning, (Multi-State)

COMMUNITY INVOLVEMENT:

Commissioner- San Diego LAFCO 2019- Present
2550 Fifth Avenue Suite 725
San Diego, CA 92103
619.321.3380

Alpine Fire Protection District Board
Vice President 2023 - 2027
Board Member - 2018 - 2022

Alpine Kiwanis
Member - 2018 - Present
Board Member 2019- Present

East County Federal Credit Union
President 2019-2023 Supervisory Board Committee

Santee Chamber of Commerce
Executive Board Member - 1996-1998
Elected to handle budgetary and Administrative issues at the local Santee Chamber

Relevant Skills and Strengths:

- Owner/Operator of successful insurance company
- Office Administrator of success Counseling Business in East County
- Over 10 years in Senior Management position
- Excellent Mediation and Negotiation Skills
- Active in Alpine and surrounding communities helping seniors, homeless and special needs groups
- Strong supporter of our military, public safety and homeless populations

- Excellent Customer Service Skills
- Committed to the safety and future of our community and surrounding communities
- Actively involved in community organizations
- Working knowledge of vocational rehabilitation and clinical procedures in counseling office that specializes in Worker's Compensation and Expert Testimony.
- HIPAA trained and compliant; ensuring confidentiality of sensitive medical, mental health and personal information; reviewed confidential and sensitive med/legal files.
- Experience with Workers-Compensation and assisting injured workers with re-employment/return to work benefits; identifying suitable employment opportunities after reviewing physical disabilities and permanent restrictions. Assisted government employees in return-to-work with suitable and gainful employment.
- Heavy interaction with injured workers, physicians, attorneys, insurance carriers and claims adjusters, psychologists, government entities, schools and employers.
- Performed client intake
- Conducted Labor Market research, and Labor Market reports
- Reviewed and analyzed Sub Rosa tapes
- Excellent Microsoft Office, PC and Mac experience; managed electronic client data files
- Exceptional interpersonal and organizational skills, reliable and personable

PROFESSIONAL EXPERIENCE

Hartley Cylke Pacific Insurance Agency, San Diego, CA
Insurance Broker - 2003 – Present - (FT)
Responsible for Group Medical, Life and Health Insurance and various Fix Annuities, Retirement Planning and assisting clients with their insurance needs.

Chelsea Advisory Services , San Diego, CA
Insurance Broker - 1997 - Present - (PT)
Investment Advisor Representative that specializes in Retirement Planning, Series 7 Stock Broker license. Life Insurance and Financial Planning with clients.

Jeannette S. Clark & Associates Inc.
Office Administrator 10/1/2009 - Present - (PT), El Cajon, CA
Office Administrator and Logistics Manager for Certified Department of Labor Counseling/Vocational Rehabilitation and Personal Counseling Office: Responsible for Drafting and editing legal documents and correspondence, assisted Worker's Compensation clientele (injured Department of Labor, veterans and other government workers) with re-employment/ return to work benefits. Working knowledge of clinical procedures in vocational rehabilitation in a Counseling office. Heavy interaction with physicians, attorneys, psychologists, government entities, insurance carriers and claims adjusters, schools and employers. Performed client intake. Review confidential and sensitive medical files and brief attorneys; conduct labor market research surveys; reviewed, analyzed Sub Rosa tapes; generate legal and general correspondence including drafting expert witness statements; cash handling experience. Troubleshooting of PC/Mac and

software. Electronic data management and filing. Excellent client relations. Greet clients, provide assistance in person and via phone. Answer telephones, respond to e-mails, schedule client appointments, and coordinate travel arrangements.

Denny's Restaurants
Restaurant Manager - 1981 - 1983, Pacific Beach, CA
Responsible for managing, marketing, scheduling, interviewing, hiring and termination of employees, teaching employees how to maintain a safe work place, food orders, front and back staff, cost of sales, budgets, cash handling, working with vendors and customer service.

COMMUNITY INVOLVEMENT:

Alpine Fire Protection District Board
Board Member - 2018

Alpine Kiwanis
Member - 2018

Santee Chamber of Commerce
Executive Board Member - 1996-1998
Elected to handle budgetary and Administrative issues at the local Santee Chamber

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ATTACHMENT B

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

The Rincon del Diablo MWD is pleased to nominate David Drake as a
(Name of Independent Special District) (Name of Candidate)

Candidate for the San Diego Local Agency Formation Commission as an alternate special district member with a term expiring 2027.

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

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

[signature]
(Presiding Officer Signature)

Jim Murtland
(Print name)

President
(Print Title)

1/26/2023
(Date)

PLEASE ATTACH RESUME FOR NOMINEE

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

RECEIVED
FEB 14 2023
SAN DIEGO LAFCO

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David A. Drake

Escondido, CA
daviddrake@cox.net

David Drake is one of the original inventors and co-founder of SmartCover Systems. He served as the initial head of engineering and wrote the formative software. He currently is a member of the Board of Directors of SmartCover. In 2020, he was named as the Industry Icon by Water and Wastes Digest.

David Drake was elected as Vice President of the Association of California Water Agencies Joint Powers Insurance Authority in September of 2022. He was subsequently appointed to the ACWA Board of Directors.

Mr. Drake was elected as an Alternate Commissioner for Special Districts to the San Diego County Local Area Formation Commission (LAFCO) in July, 2022.

Mr. Drake was appointed to the Board of Directors in January of 2006 as the Division II representative of Rincon del Diablo Municipal Water District's Parent District and Improvement District "E."

Mr. Drake has served in engineering and management roles since 1974. He was a Member of the Technical Staff at the Jet Propulsion Laboratory, Manager of Engineering at Oak Industries, Software Unit Manager at Digital Equipment Corporation, CIO and VP at Mitchell International, Internet Service Architect at SAIC, and Co-founder and Enterprise Architect of SmartCover Systems in Escondido, CA. He holds 15 US and five foreign patents and has three pending patents. He graduated from Caltech in Engineering and is a Life Member of the Caltech Alumni Association. In 2017 he was named a Life Member of Institute of Electrical and Electronics Engineers (IEEE) and was awarded his Masters Degree in Electrical Engineering from USC.

Mr. Drake has lived in Escondido since 1979.

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ATTACHMENT B

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

The Palomar Health is pleased to nominate Jeff Griffith as a
(Name of Independent Special District) (Name of Candidate)

Candidate for the San Diego Local Agency Formation Commission as an alternate special district member with a term expiring 2027.

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

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

Linda Greer Chair
(Presiding Officer Signature)

Linda Greer RN Chair
(Printed Name)

2/ 19 / 23
Date

PLEASE ATTACH RESUME FOR NOMINEE
Limit t [illegible]
Must be submitted with Nomination Form

RECEIVED
FEB 20 2023
SAN DIEGO LAFCO

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Jeff Damon Griffith

EDUCATION:

Butte College, Oroville, California
Associates Degree-1994
Certificate of Achievement-Paramedic
Enterprise High, Redding, California

LICENSES:

State of California:
Paramedic
Commercial Driver License "A"

WORK EXPERIENCE:

10/01/2021 – Present

Palomar College
Part-Time Faculty
Emergency Medical Education
1140 W Mission Rd.
San Marcos, CA 92069
(760) 744-1150

02/29/2006 – 12/21/2021

Cal Fire/Riverside Unit
Glen Oaks Station #96
Temecula Division/Battalion 15
(951) 302-7502
Fire Captain – Schedule "A"

11/06/2012 – Present

Palomar Health District
2185 Citracado Parkway
Escondido, CA 92029
Phone: (442) 281-5000
Board of Directors, Vice Chair

10/23/1988 -09/11/2006

CDF/Ramona Fire Department
Battalion 8
829 San Vicente Road
Ramona, CA 92065
(760) 788-2222
Position: Fire Apparatus Engineer/Paramedic
Schedule "A" Proctor/Field Training Officer

Additional Information:

As of November 6, 2012, I have been elected to the Board of Directors for Palomar Health. It is a seven-member board with a term of four years. The responsibility of the Board Member is to develop and ensure that the organization's mission and vision statements are carried out in an effective and ethical manner. To that end, the member is accountable for oversight and implementation of policies and monitoring of the organizations performance in establishment of strategic direction, financial stewardship, quality outcomes and leadership of the Healthcare District.

Palomar Health is the largest public health district in the State of California serving communities in an 850-square mile area and a trauma center that covers more than 2,200 square miles of South Riverside and North San Diego Counties.

Currently, I am Vice Chair and Chair the Governance Committee and I have been re-elected to another four-year term as of November 8, 2016.

I have also been certified in Essentials of Healthcare Governance.

As of September 24, 2013, I have been appointed to the San Diego County Health Services Advisory Board (HSAB) to represent District 3. I continued until 2016.

As of April 21, 2017, I have been appointed to San Diego County Medical Reserve Corps as a "Disaster Service Worker" The San Diego Medical Reserve Corps (MRC) is a community-based group of local medical and health workers who can serve as volunteers during a local health emergency. The mission of the San Diego County Medical Reserve Corps (MRC) is to enhance San Diego County's ability to respond to public health emergencies or disasters with a team of trained health professionals. The MRC accomplishes this by:

- Involving volunteers in response drills and exercises
- Linking MRC members with local public health initiatives and education campaigns for ongoing community engagement

In 2021, I was appointed to the Association of California Healthcare Districts (ACHD) to serve as a member of the Board of Directors. ACHD works with numerous state and local entities to promote the role of Healthcare Districts play in the responding to the specialized health needs of tens of millions of California while also have direct accountability to the communities that Districts serve. I have been assigned to the Advocacy and Governance committees.

If you have any questions, please give me a call.

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

CALL FOR BALLOTS

March 20, 2023

TO: Independent Special Districts in San Diego County

FROM: Tamaron Luckett, Commission Clerk
San Diego Local Agency Formation Commission

SUBJECT: Call for Ballots |
San Diego County Consolidated Redevelopment Oversight Board

This notice serves as a call for ballots pursuant to California Government Code 56332(f) with respect to electing one special district representative among the two nominated candidates (attached resumes) to serve on the San Diego Consolidated Redevelopment Oversight Board. **All independent special districts** in San Diego County are eligible to cast one vote through their presiding officers or their alternates as designed by the governing bodies.

The official ballot is attached (Attachment A). Ballots must be signed by the presiding officers or their designees and returned to San Diego LAFCO no later than **Monday, May 1, 2023.** A ballot received without a signature will not be counted. Should LAFCO review a quorum of 29 ballots by the May 1st deadline the nominee with the most votes will be appointed. Ballots received after this date will be invalid. Should LAFCO not receive a quorum of ballots by the deadline an automatic 60-day extension to July 1st is required.

Ballots can be mailed to San Diego LAFCO Office at 2550 Fifth Avenue, Suite 725, San Diego CA 92103-6624 or via email to tamaron.luckett@sdcounty.ca.gov, include **"District Name"** and **"Redevelopment Oversight Board Ballot"** in the subject title, if necessary to meet the deadline, but the original form must be submitted.

Should you have any questions, please contact me at 619-321-3380.

Attachments
1) Candidates Resumes
2) Attachment A: Election Ballot and Vote Certification form

Administration:
Keene Simonds, Executive Officer
2550 Fifth Avenue, Suite 725
San Diego, California 92103
T 619.321.3380
E lafco@sdcounty.ca.gov
www.sdlafco.org

Chair Jim Desmond, County of San Diego
Joel Anderson, County of San Diego
Nora Vargas, Alt, County of San Diego
Kristi Becker, City of Solana Beach
Dane White, City of Escondido
John McCann, Alt, City of Chula Vista
Vice Chair Stephen Whitburn, City of San Diego
Marni von Wilpert, Alt, City of San Diego
Jo MacKenzie, Vista Irrigation
Barry Willis, Alpine Fire Protection
David A. Drake, Alt, Rincon del Diablo
Andy Vanderlaan, General Public
Harry Mathis, Alt, General Public

ATTACHMENT A

SAN DIEGO COUNTY CONSOLIDATED REDEVELOPMENT OVERSIGHT BOARD ELECTION BALLOT and VOTE CERTIFICATION

VOTE FOR ONLY ONE

Timothy Robles [ ]
(Lakeside Fire Protection District)

Patrick Sanchez [ ]
(Vista Irrigation District)

As presiding officer or his/her delegated alternate as provided by the governing board, I hereby certify that I cast the votes of the ______________________
(Name of Independent Special District)

for the San Diego County Consolidated Redevelopment Oversight Board Election as:

[ ] the presiding officer, or
[ ] the duly-appointed alternate board member.

____
(Signature)

____
(Print Name)

____
(Print Title)

____
(Date)

Return Ballot and Vote Certification Form to:
San Diego LAFCO
Tamaron Luckett
2550 Fifth Avenue, Suite 725
San Diego, CA 92103-6624
Email: tamaron.luckett@sdcounty.ca.gov

CANDIDATE STATEMENT

COUNTY OF SAN DIEGO

COUNTYWIDE REDEVELOPMENT SUCCESSOR AGENCY OVERSIGHT BOARD

TIMOTHY ROBLES

I believe that government should be serving its citizens to create a better standard of living. My career experience consists of being a Fire Captain/Paramedic with the City of San Diego Fire and Rescue Department (1998-present) and additionally having been elected twice (2018-present) as a Board Director for the Lakeside Fire Protection District.

I am honored that my fellow Lakeside Fire Protection District Board members have decided to nominate me for this opportunity. This nomination comes strongly from a fellow Lakeside Board member, Mark Baker, who recently vacated his seat on the San Diego Countywide Redevelopment Successor Agency Board. Having this Former Board Member at the same agency as me creates a unique opportunity for legacy information to be shared creating a seamless transition of a new member to the Redevelopment Successor Agency Board. I look forward to continuing looking out for the interest of Special Districts here in San Diego County that are affected by the continuing disillusionment of the Redevelopment Agencies throughout the County.

During my career I have been involved in many processes requiring diligent financial oversight and have been involved in other professional Boards and Commissions as you will see listed below.

San Diego Fire and Rescue:

Development of a Fire Management Assistance Grant,
FEMA Grant Reimbursements,
San Diego Fire-Rescue Foundation (Secretary, 2006-present),
Local 145 Union Board Member (2009 – 2015)

Lakeside Fire District:

District's Budget Development Committee (2019-present),
Employment contract and agreement District Representative Negotiator (2019-present),
Heartland Communications Facility Authority Commissioner (2019-present),
Santee-Lakeside EMS Authority JPA Commissioner, 2022

As an Oversight Board Member of the San Diego County Countywide Redevelopment Successor Agency, I will work diligently to assist and ensure that each Successor Agency remains on track for their timely disillusionment and that property tax revenues are appropriately redistributed to the originating agencies including Special Districts.

Timothy E. Robles

EMPOLYMENT HISTORY:

- Fire Captain/Paramedic, San Diego Fire-Rescue Department (1998-Present)
  600 B Street, Suite 1300, San Diego, CA 92101

OPERATIONAL EXPERIENCE:

- Special Operations Captain (2018-Present)
  -TRT, HIRT, USAR, Operational Support, Peer Support
- Special Assignments
  -Logistics Section Chief (COVID-19 Response IMT)
  -COVID-19 Testing Group Manager
  -Logistics (Telestaff Outage)
  - Dignitary Protection for President Trump
  -EMS CE Paramedic Instructor
  -IST Instructor
  -Academy Instructor (82nd,83rd,84th)
- Specialty Station Assignments:
  - Station 8 - Aircraft Rescue and Fire Fighting
  - Station 45 – HAZMAT, full-time and relief
  - Station 2/41 – TRT, relief
- CA-TF8 USAR (Urban Search and Rescue)
  - Logistics Team Manager
  - Medical Specialist
  - HazMat Technician
  - Rescue Specialist

EDUCATION:

- Associate Degree, Miramar College

OTHER RELEVANT ACHIEVEMENTS AND QUALIFICATIONS:

- Elected Lakeside Fire Protection District Board Member (President),
- Santee-Lakeside EMS Authority Commissioner
- San Diego Fireman's Relief Association, Member (1998-Present)
- Local 145 Union Board Member (2009-2015)

Patrick Sanchez

Vista Irrigation District
Board of Directors

NOMINEE:

Special District Representative
to the San Diego County
Consolidated Redevelopment Oversight Board

Interests and Qualifications:

- I have worked closely with Regional Planning Agencies, including the San Diego Association of Governments, the Southern California Association of Governments, and the Orange County Council of Governments on various projects.
- I have worked diligently with all outside service extensions to consolidate service levels for cities and counties.
- I possess a clear understanding of my special district's interaction with other agencies to meet current and future community needs.
- I provided leadership with regard to improving agency oversight and transparency.
- With respect to Redevelopment Funding Consolidation, I have experience helping streamline government services.
- I serve as member of the Board of Directors of the Vista Irrigation District; our Board strives to develop partnerships and consortiums with other agencies to efficiently deliver services to our customers.
- My professional experience has provided me with in-depth knowledge of capital projects, recycled water systems, aging infrastructure and water and park bond act projects.
- I have worked closely with other governmental agencies to insure coordination of joint projects; I acted as agency liaison for the Orange County National Pollution Discharge Elimination System program, and prepared and administered extensive landscape and water conservation programs for parks, medians, and street tree projects.
- I have worked collegially with staff and other members of boards on developing community outreach, public policy, and public information programs.
- I have 34½ years of experience working for municipal and county agencies as a Director of Community and Public Services and Director of Parks and Recreation for various public agencies, including the cities of Santa Fe Springs, Oceanside, Tustin, Glendora and Yucaipa and the County of San Mateo.

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
March 8, 2023

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 3/31/2023 – 2/28/2025)

Any items of concern will be "red" flagged in this report. Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 3/31/2023 through 2/28/2025:

- ANDRY, James MD/Orthopedic Surgery(Ortho 1)
- FLORES, Bruno MD/Neurosurgery (C & E Neurosurgery)
- FRANKE, Mark MD/Teleradiology (Imaging Healthcare)
- HARDI, Umar MD/Internal Medicine – Internal Medicine (Sound)
- JACOBS, David MD/Teleradiology (StatRad)
- PASHA, Sabiha MD/Internal Medicine (Salutogenesis)
- REICH, Phillip MD/Teleradiology (Imaging Healthcare)
- SANTA MARIA, Amanda MD/Emergency Medicine (TeamHealth)
- VU, Quin MD/Anesthesiology (Sound)
- WILLIAMS, Solomon MD/Telepsychiatry (Array)

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 1 of 3
March 08, 2023

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 04/01/2023 –03/31/2025)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 04/01/2023 through 03/31/2025, 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:

- **ALTER, Mark, MD/Telepsychiatry/Provisional**
- **ANSARI, Rashad, MD/Rheumatology/Active Affiliate**
- **BODDU, Navneet, MD/Anesthesiology/Active**
- **BRAHMBHATT, Hetal, MD/Telepsychiatry/Provisional**
- **BRAR, Karanbir, MD/Internal Medicine/Active**
- **CARPINELLO, Matthew, MD/Telepsychiatry/Provisional**
- **CASTRO, Jorge, MD/Pediatrics/Active**
- **DAY, Richard, MD/Internal Medicine/Active**
- **DSOUZA, Gehaan, MD/Plastic Surgery/Active**
- **FARHOOMAND, Kaveh, DO/Internal Medicine/Active**
- **HARTMAN, Andrew, MD/Orthopedic Surgery/Active**
- **JACOBS, Robert, MD/Otolaryngology/Active**
- **KARP, Michael, MD/Pediatrics/Active**
- **LORENTS, Evelyn, MD/Teleradiology/Active Affiliate**
- **MADHAV, Kinjal MD/Sleep Medicine/Refer and Follow**
- **ORDAS, Dennis, MD/Psychiatry/Active**
- **PADUGA, Remia, MD/Neurology/Active**
- **RYPINS, Eric, MD/General Surgery/Active**

- **STRIDIRON, Marissa, MD/Telepsychiatry/Provisional**
- **WANG, Anchi, MD/Neurology/Active**

SPECIALTY CHANGE:

- **SHOWAH, Henry, MD/Emergency Medicine/Active**

RESIGNATIONS:

Voluntary:

- **BERNHARDT, Chad, MD/Emergency Medicine**
  Voluntary resignation as requested by the practitioner effective 03/31/2023.
- **DAUGHETY, Jason, DO/Anesthesiology**
  Voluntary resignation as requested by the practitioner effective 03/01/2023.
- **DOUGLASS, Alan, MD/Endocrinology, Diabetes & Metabolism**
  Voluntary resignation as requested by the practitioner effective 04/01/2022.
- **HELGAGER, James, MD/Orthopedic Surgery**
  Voluntary resignation as requested by the practitioner effective 03/21/2023.
- **REISMAN, Bruce, MD/Otolaryngology**
  Voluntary resignation as requested by the practitioner effective 06/30/2022.

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
March 08, 2023

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 **March 31, 2023**

- **COFFLER, Eliane , MD** — **Internal Medicine**
- **RUIZ, Lizette, MD** — **Emergency Medicine**

ADDITIONAL PRIVILEGE REQUEST (Effective 3/31/2023)

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

- **AFRA, Robert, MD** — **Orthopedic Surgery**
- **AMORY, David, MD** — **Orthopedic Surgery**
- **BHALLA-REGEV, Sandhya, MD** — **Internal Medicine**
- **COOPERMAN, Andrew, MD** — **Orthopedic Surgery**

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
March 08, 2023

PROCTORING RECOMMENDATIONS

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

- **BEJKO, Etleva, MD** — **Rheumatology**
- **CARDOZA-FAVARATO, Gabriella , MD** — **Pathology**
- **GARRISON, David , MD** — **Critical Care**
- **YUNG, Siyi , MD** — **Pediatric**

Clinical Privilege Request Form

Radiology - (Revised 2/19)

Provider Name:

Request	Privilege

BASIC QUALIFICATIONS: The Department of Radiology consists of physicians who have a contractual relationship with the hospital to practice Radiology and are board certified, or board eligible and actively progressing towards certification, in Diagnostic Radiology and/or Nuclear Medicine by the American Board of Radiology.

SITES:

All privileges may be performed at:

- 4002 Vista Way, Oceanside, CA
- 2095 W. Vista Way, Suite 111, Vista
- 2095 W. Vista Way, Suite 101, Vista

Privileges annotated with (F) may be performed at 3925 Waring Road, Suite C, Oceanside CA 92056.

___ Admit Patients

___ Consultation, including via telemedicine (F)

___ History and physical examination, including via telemedicine (F)
Proctoring: Six (6) cases

___

General Diagnostic Radiology and Fluoroscopy (All Diagnostic Radiologists may remotely interpret (teleradiology) diagnostic images.) - By selecting this privilege, you are requesting the core privileges listed immediately below. If you do not want any of the core privileges below, strikethrough and initial the privilege(s) you do not want.
Initial - Board certification or board eligible and actively progressing towards certification
Proctoring - Twenty-five (25) representative blend of cases
Reappointment - Fifty (50) representative blend of cases

Arthrography/Arthrocentesis/Injection

Breast biopsy

Computed tomography

General diagnostic/fluoroscopy

Hysterosalpingography

Lymphocintigraphy

Magnetic resonance imaging/spectroscopy

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

Radiology - (Revised 2/19)

Provider Name:

Request	Privilege

Mammography

Nuclear medicine (all routine)

Positron Emission Tomography (PET)

Radionuclide cysternography and shunt studies

Sialography

Ultrasonography/hysterosonography

Vascular duplex ultrasound

Venography

Lumbar or C1-2 puncture/myelography

___ **Special Nuclear Medicine Procedures:**
Initial - Board certification or board eligible and actively progressing towards certification
Proctoring - Three (3) representative blend of cases
Reappointment - Five (5) representative blend of cases

___ I-131 Therapy for tyroid cancer or for hyperthyroidism

___ Radionuclide therapy low dose < 33 mCi

___ Radionuclide therapy high dose > 33 mCi

___ P-32 Intravenous or intracavitary

___ Immune imaging (Zevalin, etc.)

| ___ **Teleradiology** ~~(for Stat-Rad only; all non-Stat-Rad practitioners use General Diagnostic Radiology and Fluoroscopy privileges.)~~
- By selecting this privilege, you are requesting the core privileges listed immediately below. If you do not want any of the core privileges below, strikethrough and initial the privilege(s) you do not want.

Initial - Twenty-five (25) cases General Radiology and ten (10) ultrasound, ten (10) tomography, ten (10) MRI, and ten (10) nuclear medicine.
Proctoring - Twenty-five (25) representative blend of cases
Reappointment - Fifty (50) representative blend of cases

Computed tomography

General radiology

General nuclear medicine

Provider Name:

Request	Privilege

Magnetic resonance imaging

Ultrasound

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

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

Carotid

Cerebral

Extremity

Pulmonary

Thoracic

Visceral

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

Angioplasty

Chemoembolization

Drug infusion

Embolization

Stent graft

Stent placement

Thrombolysis

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

IVC filter

Stent

Tissue plasminogen activator (tPA)

Clinical Privilege Request Form

Radiology - (Revised 2/19)

Provider Name:

Request	Privilege
	Transjugular Intrahepatic Portosystemic Shunt (TIPS)
	Venous Access Procedures (Ports, Tunneled Lines, Midline catheters)
	Venous Sampling
	Venous Thrombolysis
	INTERVENTIONAL PROCEDURES: Unless specified by policy, the following criteria shall apply for the following interventional procedures: **Initial** - Completed fellowship training in interventional radiology or diagnostic radiology with appropriate experience and acceptable outcomes. **Proctoring** - See below **Reappointment** - Twenty (20) representative blend of cases
___	Endovascular AAA Repair (Refer to Medical Staff Policy # 8710-503 for Initial, Proctoring, and Reappointment Criteria)
___	Vertebral Augmentation (Refer to Medical Staff Policy # 8710-534 for Initial, Proctoring, and Reappointment Criteria)
___	Endovascular (Catheter Based) Therapy for Cerebrovascular Disorders (including: Coil Occlusion of intracranial aneurysms, treatment of AV Malformation or Fistulas) (Refer to Medical Staff Policy # 8710-530 for Initial, Proctoring, and Reappointment Criteria)
___	Genito-Urinary Intervention (includes Nephrostomy, Ureteral Stent, Stone Removal, Tract Dilation, Endopyelotomy, etc.) **Proctoring:** Two (2) cases
___	GI/Biliary Intervention (includes Gastrostomy/Enterostomy, GI Stent, Biliary Drain/Stone removal, Dilation, Stent, etc.) **Proctoring:** Two (2) cases
___	Biopsy/Drainage Intervention (includes all biopsy, aspiration and drainage procedures) **Proctoring:** Two (2) cases from either this privilege or Tumor Ablation Intervention
___	Tumor Ablation Intervention (includes ablation by injection or Rediofrequency probe, Brachytherapy with implantable seeds) **Proctoring:** Two (2) cases from either this privilege or Biopsy/Drainage Intervention
___	**PAIN MANAGEMENT CORE PRIVILEGES** - Per Medical Staff "Criteria for Pain Management Privileges" Policy 8710-541 By selecting this privilege, you are requesting the core privileges listed immediately below. If you do not want any of the core privileges below, strikethrough and initial the privilege(s) you do not want.
	Epidural Procedures (i.e. Translaminar and transforaminal epidural injections (cervical, thoracic, lumbar), and epidural blood patch)
	Joint injections (i.e. Facets, SI joint)
	Sympathetic blocks

Clinical Privilege Request Form

Radiology - (Revised 2/19)

Provider Name:

Request	Privilege
	Chemo denervation (i.e. Stellate Ganglion block, peripheral nerve block, Botox injections, Intra-muscular phenol injections)
	Discograms
___	**PAIN MANAGEMENT SPECIAL PROCEDURES** - Per Medical Staff "Criteria for Pain Management Privileges" Policy 8710-541
___	Implantables
___	Intradiscal Electrothermal Annuloplasty
___	Radiofrequency Thermocoagulation Lesion Ablation (RFTC)
___	**SEDATION PRIVILEGES:** (Per Medical Staff policy #8710-517 for all initial, proctoring, and reappontment credentialing criteria)
___	Moderate Sedation

____

Print Applicant Name

____

Applicant Signature

____

Date

____

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

____

Date

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: March 31, 2023
Software Licenses & Support Renewal

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

Vendor's Name: 3M Health Information Systems, Inc.

Area of Service: Medical Records

Term of Agreement: 36 months, Beginning, May 11, 2023 – Ending, May 10, 2026

Maximum Totals:

Term	Annual Cost	Total Term Cost
36 months	$256,471.40	**$769,414.20**

Description of Services/Supplies:

- Renewal of medical records coding and reimbursement calculation software licenses and support.
- This product will continue to be used with the Cerner Community Works EMR.
- This is a 3 year agreement at $256,471.40 per year for a total spend of $769,414.20.
- This represents an annual increase of $30,072.42 and $90,217.26 for the term.

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

Person responsible for oversight of agreement: Mark Albright, VP Information Technology / Ray Rivas, Chief Financial Officer

Motion:

I move that the TCHD Board of Directors authorize the agreement with 3M Health Information Systems, Inc. for software licenses and support for a term of 36 months, beginning May 11, 2023 and ending May 10, 2025 for an annual cost of $256,471.40, and a total cost for the term of $769,414.20.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: March 31, 2023
PHYSICIAN AGREEMENT FOR COVERING PHYSICIAN – INPATIENT WOUND CARE

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

Vendor's Name: Henry Showah, M.D.

Area of Service: Inpatient Wound Care

Term of Agreement: 24 months, Beginning May 1, 2023 – April 30, 2025

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

Rate/Hour	Hours per Month	Hours per Year	Cost per Month	24 Month (Term) Cost
$180	20	240	$3,600	$86,400

Description of Services/Supplies:

- Provide supervision for the clinical operation of the Inpatient Wound Care Team
- Provide staff education to improve outcome of care
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention
- Ensure that services provided are in compliance with regulatory standards
- Participate in Quality Assurance and Performance Improvement activities
- Timely communication with primary care physicians and/or other community health resources
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions
- Utilization Review, Quality Improvement: Actively participate in hospital and Medical Staff utilization review, quality, performance improvement and risk programs

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: Candice Parras, Chief Nurse Executive

Motion:

I move that the TCHD Board of Directors approve the agreement with Henry Showah, M.D. as the Coverage Physician for Inpatient Wound Care for a term of 24 months, beginning May 1, 2023 and ending April 30, 2025, not to exceed an average of 20 hours per month, at an hourly rate of $180 for a total term cost of $86,400.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: March 31, 2023
PHYSICIAN AGREEMENT FOR COVERING PHYSICIAN – INPATIENT WOUND CARE

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

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

Area of Service: Inpatient Wound Care

Term of Agreement: 24 months, Beginning May 1, 2023 – April 30, 2025

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

Rate/Hour	Hours per Month	Hours per Year	Cost per Month	24 Month (Term) Cost
$180	20	240	$3,600	$86,400

Description of Services/Supplies:

- Provide supervision for the clinical operation of the Inpatient Wound Care Team
- Provide staff education to improve outcome of care
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention
- Ensure that services provided are in compliance with regulatory standards
- Participate in Quality Assurance and Performance Improvement activities
- Timely communication with primary care physicians and/or other community health resources
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions
- Utilization Review, Quality Improvement: Actively participate in hospital and Medical Staff utilization review, quality, performance improvement and risk programs

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: Candice Parras, Chief Nurse Executive

Motion:

I move that the TCHD Board of Directors approve the agreement with Sharon Slowik, M.D. as the Coverage Physician for Inpatient Wound Care for a term of 24 months, beginning May 1, 2023 and ending April 30, 2025, not to exceed an average of 20 hours per month, at an hourly rate of $180 for a total term cost of $86,400.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: March 31, 2023
PHYSICIAN AGREEMENT FOR COVERING PHYSICIAN – OUTPATIENT WOUND CARE

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

Vendor's Name: Henry Showah, M.D.

Area of Service: Outpatient Wound Care

Term of Agreement: 24 months, Beginning May 1, 2023 – April 30, 2025

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

Rate/Hour	Hours per Month	Hours per Year	Cost per Month	24 Month (Term) Cost
$180	20	240	$3,600	$86,400

Description of Services/Supplies:

- Provide supervision for the clinical operation of the Outpatient Wound Care Team
- Provide staff education to improve outcome of care
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention
- Ensure that services provided are in compliance with regulatory standards
- Participate in Quality Assurance and Performance Improvement activities
- Timely communication with primary care physicians and/or other community health resources
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions
- Utilization Review, Quality Improvement: Actively participate in hospital and Medical Staff utilization review, quality, performance improvement and risk programs

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: Candice Parras, Chief Nurse Executive

Motion:

I move that the TCHD Board of Directors approve the agreement with Henry Showah, M.D. as the Coverage Physician for Outpatient Wound Care for a term of 24 months, beginning May 1, 2023 and ending April 30, 2025, not to exceed an average of 20 hours per month, at an hourly rate of $180 for a total term cost of $86,400.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: March 31, 2023
PHYSICIAN AGREEMENT FOR COVERING PHYSICIAN – OUTPATIENT WOUND CARE

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

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

Area of Service: Outpatient Wound Care

Term of Agreement: 24 months, Beginning May 1, 2023 – April 30, 2025

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

Rate/Hour	Hours per Month	Hours per Year	Cost per Month	24 Month (Term) Cost
$180	20	240	$3,600	$86,400

Description of Services/Supplies:

- Provide supervision for the clinical operation of the Outpatient Wound Care Team
- Provide staff education to improve outcome of care
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention
- Ensure that services provided are in compliance with regulatory standards
- Participate in Quality Assurance and Performance Improvement activities
- Timely communication with primary care physicians and/or other community health resources
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions
- Utilization Review, Quality Improvement: Actively participate in hospital and Medical Staff utilization review, quality, performance improvement and risk programs

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: Candice Parras, Chief Nurse Executive

Motion:

I move that the TCHD Board of Directors approve the agreement with Sharon Slowik M.D. as the Coverage Physician for Outpatient Wound Care for a term of 24 months, beginning May 1, 2023 and ending April 30, 2025, not to exceed an average of 20 hours per month, at an hourly rate of $180 for a total term cost of $86,400.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: March 31, 2023
TISSUE VALVE PURCHASE AGREEMENT RENEWAL

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

Vendor's Name: Edwards Lifesciences, LLC (CN# 1498)

Area of Service: Surgery / Operating Room

Term of Agreement: 24 months, Beginning, April 1, 2023 – Ending, March 31, 2025

Bid Process Requirement:

Yes		**No**	X

Maximum Totals:

Monthly Cost	**Annual Cost**	**Total Term Cost**
$112,500	$1.350M	$2.7M

Description of Services/Supplies:

- Purchase Agreement for Tissue Valves (Heart valves and rings):

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-Director, Surgery/OR / Candice Parras, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee recommend that the TCHD Board of Directors renew the Purchase Agreement with Edwards Lifesciences, LLC for a term of 24 months, beginning April 1, 2023 and ending March 31, 2025 for an annual cost of $1.350M+ and a total cost for the term of $2.7M.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: March 31, 2023
ED ON-CALL COVERAGE - UROLOGY

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

Physician's Names: Robert Shapiro, M.D.

Area of Service: Emergency Department On-Call: Urology

Term of Agreement: 12 months, Beginning, March 1, 2023 – Ending, February 29, 2024

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
No change in rate; addition of new physician to current, shared call panel; no additional cost to the district

Rate/Day	Total Shared Annual Cost	Maximum Total Term Cost
$700	$255,500	**$255,500**

Description of Services:

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

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

Person responsible for oversight of agreement: Jonathan Gonzalez, Director-Medical Staff Services / Gene Ma, M.D., Chief Medical Officer

Motion:

I move that the TCHD Board of Directors authorize the addition of Robert Shapiro, M.D., to the Emergency Department On-Call Coverage Panel for Urology, for a term of 12 months, beginning March 1, 2023 and ending February 29, 2024, at a shared panel total term cost not to exceed $255,500.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: March 30, 2023
Third Lease Amendment Proposal – 3907 Waring Rd MOB, LLC.

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

Practice Name: Urology San Diego (TCMC 1206b practice)

Premises: 3907 Waring Rd, Ste. #4, Oceanside, CA 92056 (2,460 sq. ft.)

Term of Agreement: 2 year, Beginning, April 1, 2023 – Ending, March 31, 2025

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

Rental Rate:	**Monthly Expense**
Rental Rate of $2.21 per square foot, per month, (2,460 rentable sq. ft.)	$5,436.60
Common Area Maintenance Fees – $0.70 SF	$1,722.00
Total 2 Yr. Term Expense Amount:	**$171,806.40**

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: Jeremy Raimo, Sr. Director Business Development / Dr. Gene Ma, Interim CEO

Motion:

I move that the TCHD Board of Directors authorize the Third Amendment Lease Renewal with 3907 Waring Rd MOB, LLC for an additional 24-month term beginning April 1, 2023, ending March 31, 2025. This proposal remains within the current fair market value rental rate of $2.21 per square foot, plus monthly CAM fees of $0.70 for a monthly expense of $7,158.60, for a total expense for the 24-month term of $171,806.40.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: March 31, 2023
Medical Quality Peer Review Committee Chair and Quality Medical Director Agreement Proposal

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

Physician's Name: Nandan Prasad, M.D.

Area of Service: Medical Quality Peer Review Committee and Medical Director of Quality

Term of Agreement: 12 months, Beginning, May 1, 2023 – Ending, April 30, 2023

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

Transition of services to new Medical Director, same rates, no increase in cost

Rate/Hour	Maximum Hours per Month	Hours per Year Not to Exceed	Monthly Cost Not to Exceed	Annual / Term Cost Not to Exceed
$155	25	300	$3,875	$46,500
Education allowance – Annual Maximum Not to Exceed				$5,000
			Total Term Cost:	**$51,500**

Description of Services/Supplies:

- Promote initiatives for improving quality of patient care and services within TCHD
- Lead MQPR as Physician Chairperson
- Provides Medical oversight for Quality/Performance Improvement regarding patient care
- Works collaboratively with QAPI chair to develop QA/PI initiatives
- Makes recommendations to advance the quality of care and outcomes at TCMC
- Identify opportunities for improvement based on national best practices in Quality
- Makes recommendations to develop processes to address potential systems related vulnerabilities
- Attends nationally recognized healthcare quality conference annually, when able, to bring best practice recommendations to the MQPR membership;

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: Jonathan Gonzalez, Director-Medical Staff Services / Gene Ma, M.D., Chief Medical Officer

Motion:
I move that the TCHD Board of Directors authorize Nandan Prasad, M.D., as the Medical Director of Quality/Chairperson of Medical Quality Peer Review Committee for a term of 12 months, beginning May 1, 2023 and ending April 30, 2024, not to exceed a total term cost of $51,500.00

Tri-City Medical Center

ADMINISTRATION CONSENT AGENDA

March 20th, 2023

CONTACT: Candice Parras, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Advanced Care Technicians (ACT) Assignments and Shift Routines for Telemetry and Acute Care Services (ACS)	3 year review, practice change	Forward to BOD for Approval
2. Antimicrobial Stewardship Policy	3 year review	Forward to BOD for Approval
3. Blood Products Administration Procedure	3 year review, practice change	Forward to BOD for Approval
4. Growth Chart Documentation for Pediatrics, Adolescents and Neonates Policy	RETIRE	Forward to BOD for Approval
5. Intravenous Solution, Storage & Warming of Procedure	3 year review, practice change	Forward to BOD for Approval
6. Lift Team Policy	3 year review, practice change	Forward to BOD for Approval
7. Massive Transfusion Protocol	3 year review, practice change	Forward to BOD for Approval
8. Sitter Policy	3 year review, practice change	Forward to BOD for Approval
9. Telephone Service for Patient Rooms Policy	3 year review, practice change	Forward to BOD for Approval
10. Therapeutic Anticoagulation Management Policy	3 year review, practice change	Forward to BOD for Approval
Administrative 200		
1. Assault and Battery Reporting Process 241	RETIRE	Forward to BOD for Approval
2. Code Gray 283	RETIRE	Forward to BOD for Approval
3. Disposal of Drugs and Drug Paraphernalia 217	3 year review, practice change	Forward to BOD for Approval
4. Doctor Strong 221	3 year review, practice change	Forward to BOD for Approval
Administrative 400 and Pay Practice		
1. Compensation for Education - 474	3 year review, practice change	Forward to BOD for Approval
2. Compensation for Mandatory Education - 474.01	3 year review, practice change	Forward to BOD for Approval
3. Compensation for Professional-Personal Education Activities - 474.03	RETIRE	Forward to BOD for Approval
4. Tuition Reimbursement Loan Program - 474.04	3 year review, practice change	Forward to BOD for Approval
5. Dress and Appearance Philosophy - 415	3 year review, practice change	Forward to BOD for Approval
6. Paid Time-Off Program - 433	3 year review, practice change	Forward to BOD for Approval
7. PTO Buy-Back - 433.01	3 year review, practice change	Forward to BOD for Approval
8. Use of PTO Hours for Hardship - 433.02	3 year review, practice change	Forward to BOD for Approval
9. Timekeeping and Break Policy	NEW	Forward to BOD for Approval

Tri-City Medical Center

ADMINISTRATION CONSENT AGENDA
March 20th, 2023
CONTACT: Candice Parras, CNE

Policies and Procedures	Reason	Recommendations
10. Workplace Violence Policy - 463	3 year review, practice change	Forward to BOD for Approval
Emergency Operation Procedure (EOP) Manual		
1. 4008 Disaster Procedure for VIP Hospital Wide	3 year review, practice change	Forward to BOD for Approval
2. 4027 E.R. Base Hospital Disaster	RETIRE	Forward to BOD for Approval
3. 4080 ED Registration Department Specific	3 year review, practice change	Forward to BOD for Approval
4. Code Silver Person with Weapon or Active Shooter	3 year review, practice change	Forward to BOD for Approval
Employee Health and Wellness		
1. Light Duty	3 year review, practice change	Forward to BOD for Approval
Infection Control		
1. Infection Prevention Risk Assessment	3 year review, practice change	Forward to BOD for Approval
Medical Staff		
1. Audit Criteria for Blood UR 8710-540	3 year review	Forward to BOD for Approval
2. Standard for Endovascular Therapy (Catheter Based) 8710-530	3 year review	Forward to BOD for Approval
Outpatient Behavioral Health Services		
1. Co-treatment of Patients Policy	3 year review	Forward to BOD for Approval
2. Psychiatric Evaluation for Higher Level of Care	3 year review, practice change	Forward to BOD for Approval
Rehabilitation		
1. Audiology Services	3 year review	Forward to BOD for Approval
2. Speech Pathology Services Department Policy	3 year review	Forward to BOD for Approval
Rehabilitation Center		
1. Ethical Code of Conduct	3 year review	Forward to BOD for Approval
2. Interdisciplinary Plan of Care	3 year review	Forward to BOD for Approval
3. Interdisciplinary Team Conference	3 year review, practice change	Forward to BOD for Approval
4. Mission Statement, Goals and Objectives	3 year review	Forward to BOD for Approval
5. Patient/Family Conferences	3 year review	Forward to BOD for Approval
6. Policies and Procedures	3 year review	Forward to BOD for Approval
7. Pre-Admission Screening	3 year review	Forward to BOD for Approval

ADMINISTRATION CONSENT AGENDA
March 20th, 2023

CONTACT: Candice Parras, CNE

Policies and Procedures	Reason	Recommendations
8. Provision of Services Not Provided by Tri-City Rehabilitation Center	3 year review	Forward to BOD for Approval
9. Scope of Services	3 year review	Forward to BOD for Approval
Staffing		
1. Monitoring Registry Files Policy	3 year review, practice change	Forward to BOD for Approval
2. Registry Badge Process Policy	3 year review, practice change	Forward to BOD for Approval
3. Registry Contracts, Rate Addendums, Orientation Packet and Audits	3 year review, practice change	Forward to BOD for Approval

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES
POLICY

ISSUE DATE:	**04/14**	**SUBJECT:**	**Advanced Care Technicians (ACT) Assignments and Shift Routines ~~Telemetry and Acute Care Services (ACS)~~**
REVISION DATE(S): 04/14, 06/17			

Department Approval:	**~~07/16~~10/20**
Clinical Policies & Procedures Committee Approval:	**~~12/16~~~~10/20~~08/21**
Nurse Executive Council Approval:	**~~01/17~~10/21**
Division of Psychiatry Approval:	**n/a**
Pharmacy & Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~05/17~~11/21**
Administration Approval:	**03/23**
Professional Affairs Committee Approval:	**~~06/17~~ n/a**
Board of Directors Approval:	**06/17**

A. **PURPOSE:**
1. To outline the Advanced Care Technician **(ACT)**'s shift assignments, routines, tasks, vital sign, intake and output, and weight assignment **for ACTs in the following areas including but not limited to:**~~.~~
   a. Acute Care Services (ACS)~~-ACT's,~~
   b. Telemetry~~-ACTs,~~
   c. **Progressive Care Unit**
   d. ~~r~~Resource **Network**
2. ACTs~~,~~ and registry Certified Nursing Assistants (CNA) shall use the Handoff Tool for their assigned unit to communicate shift handoff.

B. **POLICY:**
1. ACTs report to Registered Nurses (RNs)
2. ACTs shall assist with patient care needs of all patients~~'~~ on their assigned units as delegated by the RN and the **Nursing Leader**~~Assistant Nurse Manager (ANM)/relief c~~/**C**harge ~~n~~**N**urse.
3. Assignments shall be made every shift by the **Nursing Leader**~~ANM or relief~~ ~~c~~/**C**harge ~~n~~**N**urse.
4. Assignments may not be changed without the approval of the **Nursing Leader**~~ANM/relief~~ ~~c~~**C**harge ~~n~~**N**urse
5. Breaks Telemetry & ACS
   a. One ACT shall be available on each unit at all times
   b. ACTs shall sign up for break times at the beginning of their shift.
   c. Break times will be determined by the management team and listed on the break sheet.
      i. Sitter break coverage shall be arranged by the ACTs assigned to the unit or **Nursing Leader**~~ANM~~**/Charge Nurse**
   d. The ACT break sheet will be posted on every unit to inform RNs of the ACT break times.
   e. ACTs are expected to take the allotted time for breaks.
      i. ACT's must initial on the break form to confirm break time.
6. Hand-off
   a. Shift handoff is mandatory and shall be conducted **at the beginning of the shift** for a maximum of 10 minutes**, recommended** from 0700-0710 and 1900-1910.

i. After reviewing the ACT/CNA Report Sheet, start answering call lights and phones, pass or pick up meal trays, and start A.M. or P.M. care while the nurses are completing report.

b. Hand Off Tool
   ~~i. Telemetry Hand Off Tool - The Nursing Unit Census shall be used as the Telemetry ACT Hand-off tool.~~
   ~~ii.~~**i.** ~~Acute Care Services Hand Off Tool (ACT Report) -~~ The ~~ACS~~ ACT Hand Off Tool shall be used when giving and receiving report
   ~~iii. Progressive Care Unit (PCU) - ACTs will use PCU identified hand-off tool~~

c. Shift hand-off shall consist of a verbal hand-off and rounds on assigned patients

d. The following information shall be **reviewed during hand-off** ~~documented on the~~ **(see** ACT Hand-off tool):
   i. Code Status
   ii. Isolation Status
   iii. Patient's orientation i.e. alert, confused
   iv. Oxygen requirements i.e. nasal cannula, number of liters
   v. Mobility i.e., with assist, ~~lift team~~**patient mobility technician** assist, turn every 2 hours
   vi. Toileting needs i.e., voids, **indwelling urinary**~~foley~~ catheter, rectal tube, incontinent
   vii. Hygiene needs i.e., (shower bed bath, or minimum assistance)
   viii. Oral care
   ix. Tubes, drains, and other patient care equipment
   x. Daily weight
   xi. Daily bath
   xii. Diet
      1) Aspiration precautions
      2) Level of assistance required during meals
   xiii. Intravenous (IV) type and location [i.e. peripheral (saline lock) vs. central venous catheter (CVP), or peripherally inserted central catheter (PICC)].
   xiv. Special considerations
      1) Hard of Hearing
      2) Legally Blind
      3) No Blood Pressure (BP) on Left or Right Arm
      4) Restraints
      5) Dialysis fistula/graft
      6) Mastectomy
   xv. Admitting diagnosis
   xvi. Safety Falls Risk status
   xvii. Braden Scale

e. ~~Note e~~**Ensure** tasks not completed on previous shift, and ensure incomplete tasks are completed, prior to the end of the shift. Task not completed shall be communicated to RN and oncoming ACT.

f. After the RN (s) complete their bedside report, check for any additional patient information or changes in patient care for assigned patients.

g. Discuss with the ~~lift team~~**patient mobility technician** member patients needing their assistance.

7. Vitals Signs

a. Vital signs shall be taken on all patients per unit policy and as directed by the RN
   i. Telemetry **and Medically Monitored** vital~~s~~ signs every 4 hours while patient is awake and as needed
   ii. ACS vital signs every 8 hours and as needed
   iii. PCU - vital signs will be obtained as outlined for ACS and Telemetry level of care and as ordered

b. Neutropenic patients - if available a vital signs machine is to remain at the patient's bedside. Ensure stethoscopes are cleaned in between patient use.

c. Vital signs shall be taken on all patients scheduled for discharge at least one hour prior to discharge per Patient Care Services Discharge of Patients – Discharge AMA Policy.

d. Heart rate/pulse will be obtained as follows:

i. Telemetry and PCU staff ACTs will use a function within the Cardiac Monitor to obtain heart rate values for patients with orders for Telemetry monitoring.

1) The heart rate values will be documented as Heart Rate Monitored

ii. ACTs floating to Telemetry or PCU and Registry Certified Nurse Assistants (CNA) and Nurse Assistants (NA) will:

1) Contact a Monitor Technician (MT) or the primary RN to obtain heart rate values.

a) Document the heart rate values in Cerner as "Heart Rate Monitored"

e. **Ensure** ~~V~~vital signs ~~shall be initially~~**are** documented ~~on the Vital Signs Worksheet and then charted~~ in the electronic health record (EHR)~~ after they are reviewed by the primary RN~~.

~~f. After obtaining vital signs complete the following:~~

~~i. Make copies of the Vital Signs Worksheet for each RN~~

~~ii. Give each RN a copy of the Vital Signs Worksheet~~

~~iii. Document the results of the vital signs in the EHR after the primary RN reviews the results and provides instructions to document~~

~~g.~~**f.** Report the following findings to the primary RN immediately or as instructed by the primary RN:

i. Temperature greater than 38.6 or less than 36

ii. Heart Rate (HR) greater than 100 or less than 60

iii. Systolic Blood Pressure (SBP) greater than 150 and less than 100

iv. Diastolic Blood Pressure (DBP) greater than 90

v. Respiratory Rate (RR) greater than 24 and less than 10 breaths per minute

1) Post-op patients RR less than 14 breaths per minute

vi. SPO2 less than 92%

8. Intake and Output (I & O)

a. Intake

i. ACTs are responsible for measuring and documenting oral intake on all patients on their assigned unit in a timely manner

ii. ACTs are responsible for refilling the water pitchers every 8 hours or as directed by the primary RN.

b. Output

i. ACTs are responsible for measuring and discarding urine and stool for all patients on their assigned unit, and documenting the results in a timely manner.

1) Check urine output every 4 hours and notify the primary RN if low or no output. Notify the primary RN if less than 240 mLs of urine is obtained within 8 hours or patient has not voided.

2) Check stool output once a shift and notify the primary RN of any complaints of constipation or diarrhea

ii. Output from tubes and drain is limited to **indwelling urinary**~~Foley~~ catheters, ileostomies, urostomies, rectal tubes, and colostomies canisters and will be measured and discarded at the end of the shift or as directed by RN.

iii. Tubes and Drains

1) ACT/CNAs/NAs are responsible for measuring and discarding the output from the following throughout a shift:

a) Urinary catheters i.e., Foley

b) Female and male urinary device collection containers or bags (examples include but are not limited to Purewick and condom catheters)

c) Rectal Tubes
d) Ostomy collection bags
   i) ACTs, CNAs, and NAs may not change an ostomy appliance (wafer)

2) ACTs/CNAs/NAs may not empty or document the output for the following. RNs only may empty the tubes and drains listed below:
   a) Nephrostomy tubes attached to any collection device or bag
   b) Jackson Pratt (JP)
   c) T-Tubes
   d) Add marking to a chest tube collection device
   e) Add markings to a nasogastric or gastric suction collection container

3) Suction Canisters attached to a tube or drain may be ~~be~~ emptied as directed by RN after the RNs has obtained the drainage output.

c. Intake and output will be completed and documented in a timely manner and prior to the end of each shift.

d. Intake and outputs not completed by the end of the shift shall be communicated to the oncoming ACT/CNA and primary RN.

9. Weights
   a. Admission
      i. All patients shall be weighed on admission **and recorded in kilograms per Patient Care Services: Standards of Care Adult**
         1) All patients transferred to Telemetry shall be weighed as directed by the RN **per Telemetry Procedure: Weighing Telemetry Patients**.
      ii. The patient's weight and the type of scale used to weigh the patient shall be documented in the EHR.
   b. Daily
      i. Nightshift ACTs shall receive a daily weight assignment from the RNs on their assigned units.
      ii. All daily weights shall be completed and documented by nightshift ACTs
      iii. Weights not completed shall be communicated to the RN and the oncoming shift ACT.
         1) The oncoming shift ACT shall weigh the patient(s) and document the weight
   ~~c. Please review Patient Care Services Weighing Patients for additional information~~

10. Bath Assignments
   a. ACTs are responsible for documenting completion of the baths in the EHR.
   b. Dayshift ACTs are responsible for complete assist baths or ensuring showers are taken, if ordered, on their assigned patients.
      i. Baths not completed on the dayshift shall be communicated during shift hand-off and completed by the nightshift ACT.
   c. Nightshift: Each ACT is responsible to complete up to 4 baths on confused or total care patients. If these patients are not on the unit, ask each primary RN for at least two patient bath assignments.
      i. Baths not completed on the nightshift shall be communicated during shift hand-off and completed by the dayshift ACT
   ~~d. Electrodes shall be replaced with each bath if needed and PRN.~~
   ~~e.~~ **d.** Ventilator patients (Core Telemetry ACTs only may be assigned to these patients:
      i. Ventilator patients that are not weaning shall receive a bath daily on nightshift and as directed by the RN.
      ii. Ventilator patients and patients with artificial airways that are weaning shall receive their baths on the nightshift between 1800 and midnight or as directed by the primary RN.
   ~~f.~~ **e.** Confused, disoriented, or patients that are awake shall be offered a bath during the PM and night time frames or as directed by the RN

11. Meals
    a. Patients shall sit in chair for all meals unless instructed to remain in bed by the primary RN
    b. Diabetic patients should not receive their trays until checking with primary RN to ensure the point of care blood glucose (finger stick) is completed
    c. Distribute bedtime snacks as directed by the RN
        i. Restock refrigerator when supplies are received for dietary
    d. Document percentage of meal intake in the EHR.
    e. Ensure trays are removed from patient's room after completion of the meal
12. Infection Control
    a. Infection control **practices**~~manual~~ must be followed at all times.
    b. Always check with the RN **to verify**~~if unsure of~~ the patient's isolation status or **clarify**~~if unclear on~~ what isolation precautions need to be taken.
    c. Infection Control Caddys or baskets must be kept stocked throughout the shift by both the day and night shift ACTs.
    d. ~~Gloves and masks must be disposed of when exiting the room of a patient that is on isolation precautions~~.
    e. Perform hand hygiene and clean equipment use**d** for ~~all~~**direct** patient~~s~~ **care** prior to leaving patient's room.
    ~~f. Do not use masks multiple times. Masks are one time use only.~~
13. **Indwelling Urinary Catheter**~~Foley~~ Care
    a. **Indwelling urinary catheter** ~~Foley C~~care will be done on all patients with a**n indwelling urinary** ~~Foley~~ catheter once a shift, PRN and after every bowel movement~~ using the Foley wipes~~.
    b. **Indwelling urinary catheter**~~Foley C~~care will be documented by the ACT in the EHR.
14. Central Line Care
    a. All patients with a central line will have a **chlorhexidine gluconate (**CHG) bath **daily**~~every 24 hours~~ by the day shift ACT unless contraindicated or patient refuses **per Patient Care Services Procedure: Central Venous Access Devices, Adults**. ~~Patient must be educated on reason for CHG bath (to prevent infection).~~
        i. CHG baths will be documented by the ACT in the EHR.
        ii. Do not use CHG wipes on: breast feeding mothers, non-intact skin, head, face, or genitalia (clean these areas with soap and water). Can be used on buttocks. CHG wipes should be used on buttocks and inner thigh after any episodes of fecal incontinence.
        iii. Patient must be moisturized after CHG bath is completed and when skin is dry
        iv. If patient has an allergic reaction to CHG report to RN
    b. High touch areas will be cleaned with hospital approved disinfectant (for example sani wipes) by the night shift ACT for all central line patients once a shift. Document in the EHR.
        i. The high touch areas to be cleaned include:
            1) Bedside table
            2) Remote
            3) Call light
            4) Phone
            5) Bathroom door handle
            6) Top 2 side rails
15. Pressure Injury Prevention
    a. Pressure injury prevention measures must be followed at all times. **See Pressure Injury Prevention Measures.**
    b. Always check with the RN if unsure of the patient's pressure injury prevention points or if unclear on what precautions need to be taken.

~~b.~~**16. To the extent that any applicable collective bargaining agreement that is consistent with applicable law conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement prevails.**

C. **PROCEDURE:**

1. Duties and Responsibilities of all ACT's **are represented and outlined within the ACT Shift Duties and Responsibilities Guidelines, please reference the related document.**
   a. Document all interventions performed.
   b. Answer telephones and patient call lights during RN shift hand-off and PRN
   c. Sitter relief as directed by the RN and/or ANM/relief charge nurse
   d. Weights (daily, admission, transfer and as directed by the RN)
   e. Pre-operative shower/baths for patients as directed by RN per **Patient Care Services Procedure**PCS: Pre-Operative Patient Preparation
      i. Cardiovascular surgery (CVS) patients pre-operative clipper prep and showers/bath should be performed by Telemetry ACTs hired for the Telemetry Unit.
   f. Distribute and assist with meal trays and bedtime snacks as directed by RN
   g. Ambulate patients as directed by RN
      i. Documentation should include the patient's distance and tolerance of the activity
   h. Assist with passive Range of Motion (ROM) as directed by the RN
   i. Assist with pressure **injury**ulcer reduction by completing the following and document in EHR:**.**
      i. Assist with and/or ensure the patient is repositions every 2 (two) hours and more often as directed by the RN
      ii. Use chair cushion when out of bed. Limit OOB to 2 hour intervals with hourly weight shifts
      iii. Use lift sheet/ pad to avoid shear and friction
      iv. Ensure for tubing and other medical devices are not under the patient
      v. Use pillows between knees and bony prominences to avoid direct contact
      vi. Float heels on pillows or use heel offloading devices
      vii. Remove medical devices (e.g. stockings, sequential devices) every shift to inspect skin or as directed by RN
      viii. Offer toileting and hygiene care to incontinent patients every hour using perineal cleanser, barrier cream and wicking pads
      ix. Avoid using diapers unless ambulating incontinence patients or discharging
      x. Offer hydration as directed by the RN
      xi. Perform skin inspection during bath, and other care, report skin abnormalities to RN
      xii. Use skin moisturizers on dry skin daily
      xiii. Consider use of foam composite dressing on sacrum, bony prominences, or under a medical device
      xiv. Keep HOB no more than 30 degrees unless contraindicated
      xv. Avoid linen under patient while on specialty mattresses (air mattress)
   j. Discontinue foley catheters and saline locks as directed by the RN and document in the EHR. Notify RN immediately if unable to manage bleeding, reddene**d** skin, patient complaint of pain not related to removal of tape, drainage **and any** other blood **drainage.**
   k. **Discontinue indwelling urinary catheters as directed by the RN and document in the EHR.**
   l. Apply Falls Risk bands as directed by RN or as indicated from the information obtained from the hand-off tool per **Patient Care Services Procedure**PCS: Fall Risk Procedure and Scoring Tool
   m. Check and restock patient room supply baskets and remove inappropriate supplies every shift
   n. Document vital signs, weights, intake and output, and Activity of Daily Living (ADL)s
   o. **Perform** Oother duties as assigned by RN and/or **Nursing Leader/designee**ANM/relief charge nurse

2. Hourly Rounding ACT Standard Work

a. ACTs shall round on the odd hours and as direct by RNs.
b. Introduce yourself to patient and explain your role
c. Inform patient of the task(s) that you plan to perform prior to performing the tasks(s)
d. Address the four (4) P's i.e., Potty, Pain, Position and Possession
e. Address comfort needs
f. Ask patient prior to leaving room if there is anything else you may do for them
g. Document completed task in the EHR

3. Patient Safety
   a. Prior to leaving a patient's room ensure the following:
      i. Patient's room is clean and uncluttered
      ii. Bedside tray is clean, clear of clutter and within patient's reach
      iii. Call button, television remote control and patient's other personal items are within patient's reach
      iv. Water pitcher is filled per RN instructions and/or per unit specific policy
      v. Patient's bed is in low position with upper side rails in up position
      vi. Appropriate patient signs are posted as directed by RN
      vii. Ensure each room has appropriate urine or stool graduated collection containers.
      viii. Ensure graduated container is clearly marked with patient's name **initials** and bed location. For example:
         1) Mr. Doe
         2) Room 232
   b. **Ensure patients are turned, positioned, and heels are floated as appropriate.** Assist the lift team when they are in the room turning patients or ambulating patients
4. Equipment
   a. Ensure all patient care equipment is placed or returned to the appropriate location
   b. Ensure equipment that requires charging is plugged in a socket when not in use
   c. Ensure equipment is cleaned per TCMC policy or manufacturers recommendation after each patient use **(for transfers or discharges)**
   d. Ensure remote monitoring unit and remote monitoring cables are cleaned when **a** patient are **is** transferred or discharged
5. Admissions and/or Transfers
   a. Assist with admission and transfers to unit by completing the following:
      i. Set up room with hygiene items, water pitcher, cup and urine collection container (label container with patient's **initials**name and **bed location**room number)
      ii. Ensure chair scale is available, zeroed, and near patient room; use the chair scale to weigh ambulatory patients.
         1) If a bed with a scale is needed, ensure the bed is zeroed per unit specific policy.
      iii. Assist patient into a gown if needed.
      iv. If abnormal skin findings are observed, notify the RN.
   b. Orient patient on the use of bed controls, call button, television (TV) remote, telephone, meals times, and use of light controls
   c. Provide rationale for using urine collection container
   d. Document patient's belongings, vital signs, admission weight, height, and ADLs in the EHR
      i. Notify primary RN of abnormal vital signs, patient questions, concerns, complaints, and other abnormal findings.
   e. Monitored level of care:
      i. Telemetry
         1) Place clean Telemetry box with batteries inserted and leadwires in room
         2) Attach patient to Telemetry box, or DASH if needed, on arrival to room. Call the monitor technician (MT) to verify patients name and rhythm is visible on the monitor
         3) Ensure Telemetry box is placed in a plastic protective cover
      ii. Medically Monitored

~~1) Place clean remote monitoring unit with batteries inserted and leadwires in room~~
~~2) Attach patient to remote monitoring unit, on arrival to room. Call the monitor technician (MT) to verify patients name and rhythm is visible on the monitor~~

~~6. Post-Operative Transfers – set-up room before patient arrives~~
~~a. Bed available with linen pulled down and scale zeroed~~
~~b.~~ **Have** ~~E~~equipment available **as directed by RN. ~~Example include but not limited to~~**~~:~~
~~i. Vital sign machine~~
~~ii. Remote monitoring device appropriate to unit~~
~~iii. Oxygen regulator with tubing connector~~
~~iv. Suction set-up including regulator, tubing and container~~
~~v. Infusion pump~~
~~vi. Sequential compression pump~~
~~vii. Emesis basin~~

~~7. Discharges, transfers to non-monitored units, or rate monitoring discontinuation~~
~~a. For monitored patients, remove remote Telemetry box/ remote monitoring unit immediately after notification by the RN or~~ **Nurse Leader**~~ANM/relief cCharge nNurse~~
~~i. Clean Telemetry box/remote monitoring unit and leadwires with appropriate cleaning solution and store in the appropriate location~~
~~b. Place all patient belongings in a "Patient Belonging Bag"~~
~~i. Check room cabinets, drawers, and bedside table for patient's belongings~~
~~ii.~~ **Promptly** ~~I~~inform RN if patient/or their family reports personal items are missing~~, notify RN immediately.~~
~~c. Assist patient with discharge by performing the following as directed by the RN:~~
~~i. Removal of saline lock~~
~~ii. Removal of~~ **indwelling urinary**~~foley catheter~~
~~iii. Assist patient with applying clothing~~
~~d. Ensure vital signs including pulse oximetry are obtained at least one hour prior to discharge. Inform RN of the results immediately.~~
~~e. Assist with discharge transfer via wheelchair as directed by the RN~~

D. **SPECIALTY PATIENT POPULATIONS:**

1. Status Post Cardiac Catheterization
   a. Non-core Telemetry ACT will receive additional instructions from primary RN
   b. Do not reposition patient without instructions from the primary RN
   ~~c. Ensure a procedure vital sign sheet is placed in patient's room~~
   ~~d.~~**c.** Program vital sign machine to take vital signs every 15 minutes or as directed by an RN
2. Cardiovascular Surgery (CVS) Patients – shall be assigned to core Telemetry ACTs
   a. Pre-operative Care
      i. All AM showers should be completed 2 (two) hours prior to the surgery. Verify the time of AM shower with the RN.
      ii. Perform the following task as outlined below and/or as directed by the RN
         1) Obtain urine for urinalysis
         ~~2) Set up DVD player with the appropriate education DVD as directed~~
         ~~3)~~**2)** Assist patient with PM shower/bed bath
            a) Change linen prior to patient returning from bath or after completion of bed bath
         ~~4)~~**3)** Complete AM clipper prep
            a) Use surgical clippers only. Do not use disposable razors.
            b) Change clipper blade frequently as needed do not allow the clipper blades to become dull.
         ~~5)~~**4)** Change patient's electrodes and place patient on Telemetry box
         ~~6)~~**5)** Do not place electrodes on or near the sternum.
         ~~7)~~**6)** Notify the primary nurse of abnormal skin findings.

~~8)~~**7)** Weigh patient if more than **three (3)**~~(three)~~ days has passed since admission or as directed by the RN

~~9)~~**8)** Document shower or bed bath, clipper prep, weight and vitals in the EHR

b. Post-operative Care Prior to Shower/Bath

i. All patients must receive a shower or bed bath daily and/or as directed by the RN.

1) If a patient does not shower or receive a bed bath on the day shift, the patient shall have a shower/bed bath on the PM shift with the assistance of the ACT.

2) All CVS patients shall shower unless contraindicated, i.e., shortness of breath, attached to a pacemaker~~s~~, attached to infusion pump, and/or **has** abnormal vital signs as directed by the primary RN.

ii. Perform the following task as outlined below and/or as directed by the RN:

1) Verify with the RN patient may be escorted to shower. Remain with patient during first shower and/or until the primary RN states it is safe for the patient to be alone during their shower.

2) Report the following to the primary RN; patient complaints of dizziness, headache, light-headedness shortness of breath, increased pain, and/or drainage from incision sites.

3) ~~Remove and discard dressing and a~~Assist patient to the shower using the necessary equipment directed by the RN

4) Do not remove the patient's oxygen during the shower unless instructed by the RN

5) Cover peripheral IV access or central line IV access with water proof barrier or glove. Secure the water proof barrier or glove with waterproof plastic tape

6) Remove ted hose, if applied prior to going to the shower

7) Report patient's refusal of shower or bath to primary RN

c. Post-operative Care After Shower/Bath

i. Assist patient back to their room, remove water proof barrier from peripheral IV site or central IV site. Notify RN immediately if the central line dressing is wet or loose

ii. Ensure incisions are dry. Do not apply lotion, ointments, betadine, iodine, or creams to incisions.

iii. Re-apply **thromboembolic deterrent (**TED**)** hose if ordered

iv. Assist patient to bed or chair

v. Document patient's bath/shower and ambulation to shower in the EHR.

vi. Ensure all patient equipment is within reach i.e., call button, water cup, tissue, telephone, and Incentive Spirometer (IS).

d. Post-Operative Ambulation

i. Ambulate patients as ordered or at least 3-4 times a day.

1) Examples: ambulate patient after breakfast, before lunch or dinner, and after dinner or prior to the patient's bedtime.

ii. Patient's first ambulation shall be with oxygen, if ordered, and with a nursing staff and thereafter as directed by RN.

iii. Check patient's oxygen saturation during ambulation.

iv. Notify the primary RN if patient appears short of breath, patient complains of shortness of breath, has a decrease on oxygen saturation~~s~~, and/or complains of discomfort. Assist patient back to their room or to nearest chair.

v. Ambulate~~ion~~ post-op CVS **patients,** with patient pushing a wheelchair and oxygen, until informed by an RN patient may ambulate independently

vi. Encourage patients with steady gaits to ambulate ad lib, or as directed by RN.

vii. Document patient's ambulation distance and tolerance in the EHR

3. Seizure monitored patients on Medically Monitored unit

a. Non-core 4 Pavilion ACTs will receive additional instructions from primary RN

4. Orthopedic patient population
   a. Non-core 1 North ACTs will receive additional instructions from primary RN
5. Oncology patient population
   a. Non-core 2 Pavilion ACTs will receive additional instructions from primary RN
6. Progressive Care Unit
   a. ACTs assigned to the PCU will follow the guidelines identified within the ~~Advanced Care Technicians (~~ACT~~)~~ Assignments and Shift Routines for Telemetry and ~~Acute Care Services (~~ACS~~)~~ with the following exceptions:
      i. Showers will be completed per unit practice guidelines.
      ii. Baths (Bed Bath)
         1) Patients will receive a bed bath only if a shower is contraindicated
         2) If patient requires a bed bath, allow patient to bath self and provide assistance as needed
      ~~iii. Electrode Care – electrodes will be changed daily with AM vitals and scheduled baths/showers~~
      ~~iv.~~**iii.** Additional task and responsibilities are outlined in the PCU ACT Shift Task List

E. **FORMS:**
   ~~1. Acute Care Services Hand-Off Tool (ACT Report) - Sample~~
   ~~2.~~**1.** ACT Hand-Off Tool ~~- Sample~~
   ~~3.~~**2.** ACT Task List~~ - Sample~~
   ~~4. ACT Shift Helpful Hints - Sample~~
   ~~Progressive Care Unit ACT Shift Task - Sample~~

F. **RELATED DOCUMENT(S):**
   1. Patient Care Services Procedure: Central Venous Access Devices, Adults
   2. Patient Care Services Procedure: Fall Risk Procedure and Scoring Tool
   3. Patient Care Services Procedure: Pre-Operative Patient Preparation
   4. Patient Care Services: Standards of Care Adult
   5. Pressure Injury Prevention Measures
   6. Telemetry Procedure: Weighing Telemetry Patients
   ~~5.~~**7. Advanced Care Technician (ACT) Shift Duties and Responsibilities Guidelines.**

~~Acute Care Services Hand Off Tool (ACT Report) Sample~~**Remove page and replace with New ACT Handoff Tool**

ACT REPORT

PATIENT NAME: | ROOM
AGE: | SEX: | CODE: | FALL RISK: Y N
DIAGNOSIS: | ALERT | OXYGEN
ISOLATION: STANDARD C-DIFF
SITE:
ACTIVITY: | OUTPUT:
DIET: | A
NOTES:

PATIENT NAME: | ROOM
AGE: | SEX: | CODE: | FALL RISK: Y N
DIAGNOSIS: | ALERT | OXYGEN
ARD MRSA ESBL
FF AIRBORNE VRE
UT: | V/S:
ACCU CHECK: Y N

PATIENT NAME:
AGE: | SEX: | CODE: | F
DIAGNOSIS:
ISOLATION: STANDARD C-DIFF
SITE:
ACTIVITY: | OUTPUT:
DIET: | A
NOTES:

Remove page and replace with New ACT Handoff Tool

ROOM
DE: | FALL RISK: Y N
ALERT | OXYGEN
ARD MRSA ESBL
FF AIRBORNE VRE
UT: | V/S:
ACCU CHECK: Y N

PATIENT NAME:
AGE: | SEX: | CODE: | F
DIAGNOSIS:
ISOLATION: STANDARD C-DIFF AIRBORNE VRE
SITE:
ACTIVITY: | OUTPUT: | V/S:
DIET: | ACCU CHECK: Y N
NOTES:

ROOM
DE: | FALL RISK: Y N
ALERT | OXYGEN
DARD MRSA ESBL
C-DIFF AIRBORNE VRE
SITE:
ACTIVITY: | OUTPUT: | V/S:
DIET: | ACCU CHECK: Y N
NOTES:

~~ACT Hand-Off Tool Sample~~Remove page

TRI-CITY MEDICAL CENTER
NURSING UNIT CENSUS
NURSING UNIT: 2E
MON Current Date

SAMPLE

ROOM	PATIENT NAME	AGE	SEX	ADMIT DATE	LOS	MRUN	TYPE	SERVICE
DIAGNOSIS		CORE MEAS		ADMIT PHYSICIAN		FALL RISK	BRADEN	ACCOMMODATION
PRIMARY INSURANCE			URINARY CATHETER				CENTRAL LINE	
227-01	Patient's Nam						Inpatient	DOU
afib flutter	NPO						BS: 17	DOU
Medicare A and B	Up wi						Bath	
227-02	Patient's N						Inpatient	DOU
Sepsis Hypothermia							BS: 14	DOU
Medi-Cal	Up A Family						CL Triple	
228-01	Patient's Na						Inpatient	DOU
pneumonia	NO Code						BS: 15	DOU

Remove page

The following information ... ol

i. Code Status
ii. Isolation Statu
iii. Patient's orien
iv. Oxygen requir
v. Mobility i.e. wi
vi. Toileting need ... ectal tube, incontinent
vii. Tubes and dra
viii. Daily weight
ix. Equipment in ... n listed above and the follow
x. Admitting diag
xi. Safety Falls Ri
xii. Braden Scale

New ACT Hand Off Tool

ACT Handoff Tool

DATE:

Patient Name:		Room# ▾Monitor #
RN		
Diagnosis		
CODE STATUS		
ALLERGIES		
Vital Signs	Frequency	
Isolation		
Diet / Feeding Assistance	/	
ACTIVITY / LOC Ambulation needs Bath/Shower/Self Fall Risk (Y/N) Bed Alarm Restraints		
O2		
Continence Foley Catheter TUBES/DRAINS	Yes / No Purewick Rectal Tube	
IV	Peripheral IV Central IV	
CHG Bath Done	Yes No	
High Touch Areas	Yes No	
Belongings:	Hearing Aid Glasses Dentures Cell Phone	
Daily Weight		
SKIN CARE Pressure Injury		
NOTES		

Patient Name:		Room# ▾Monitor #
RN		
Diagnosis		
CODE STATUS		
ALLERGIES		
Vital Signs	Frequency	
Isolation		
Diet / Feeding Assistance	/	
ACTIVITY / LOC Ambulation needs Bath/Shower/Self Fall Risk (Y/N) Bed Alarm Restraints		
O2		
Continence Foley Catheter TUBES/DRAINS	Yes / No Purewick Rectal Tube	
IV	Peripheral IV Central IV	
CHG Bath Done	Yes No	
High Touch Areas	Yes No	
Belongings:	Hearing Aid Glasses Dentures Cell Phone	
Daily Weight		
SKIN CARE Pressure Injury		
NOTES		

Patient Name:		Room# ▾Monitor #
RN		
Diagnosis		
CODE STATUS		
ALLERGIES		
Vital Signs	Frequency	
Isolation		
Diet / Feeding Assistance	/	
ACTIVITY / LOC Ambulation needs Bath/Shower/Self Fall Risk (Y/N) Bed Alarm Restraints		
O2		
Continence Foley Catheter TUBES/DRAINS	Yes / No Purewick Rectal Tube	
IV	Peripheral IV Central IV	
CHG Bath Done	Yes No	
High Touch Areas	Yes No	
Belongings:	Hearing Aid Glasses Dentures Cell Phone	
Daily Weight		
SKIN CARE Pressure Injury		
NOTES		

Patient Name:		Room# ▾Monitor #
RN		
Diagnosis		
CODE STATUS		
ALLERGIES		
Vital Signs	Frequency	
Isolation		
Diet / Feeding Assistance	/	
ACTIVITY / LOC Ambulation needs Bath/Shower/Self Fall Risk (Y/N) Bed Alarm Restraints		
O2		
Continence Foley Catheter TUBES/DRAINS	Yes / No Purewick Rectal Tube	
IV	Peripheral IV Central IV	
CHG Bath Done	Yes No	
High Touch Areas	Yes No	
Belongings:	Hearing Aid Glasses Dentures Cell Phone	
Daily Weight		
SKIN CARE Pressure Injury		
NOTES		

ACT Task List – Sample

Beginning of the Shift Checklist

- ❑ Receive hand-off tool for the following:
  - ✓ Diet
  - ✓ Ambulatory needs
  - ✓ Code Status
  - ✓ Isolation Precautions
  - ✓ Special Considerations
    - ➢ Hard of Hearing
    - ➢ Legally Blind
    - ➢ No BP on Left or Right Arm
    - ➢ Restraints
    - ➢ Fall Risk
    - ➢ Pressure **Injury** ~~Ulcers~~
- ❑ Vitals Signs
  - ▪ Write your name and date on patient's board
  - ▪ Make sure all patients have an identification band or a risk for fall band. If the allergy band is missing, notify RN
- ❑ After completing vitals, if AM
  - ▪ Prepare patients for breakfast
  - ▪ Offer washcloth for hands and face

Before Meal Trays Arrive

- ❑ Document vitals and assist with answering call lights and telephones
- ❑ Document bath assignments on the bath board
- ❑ **Assist with Pressure Injury Prevention**

Arrival of Meal Trays

- ❑ Pass trays and assist with answering lights
- ❑ Pass HS snacks as directed by RN
- ❑ Assist feeders, if no feeders, go to break or document VSS and I & O's

Vital Signs AM Shift

- ❑ Begin AM vitals 0730-0900
- ❑ Begin Noon vitals at 1100-1200
- ❑ Begin Evening vitals at 1600 & 1930
- ❑ Begin Midnight vitals at 2200-0100
- ❑ Begin Night Shift AM vitals 0400-0600
- ❑ Documented vital signs as soon as possible

After meal times

- ❑ Complete documentation
- ❑ Ambulate patients

Intake and Output

- ❑ Document output after completing task
- ❑ Document intake as soon as possible

Hourly Rounding

- ☐ Assist with hourly rounding as directed

HS Snack

- ☐ Pass HS as directed by RN. Document intake in the medical record

HS Care

- ☐ Assist patients with HS care
- ❑ **Assist with Pressure Injury Prevention~~Reduction~~**

End of Shift Checklist

- ❑ I/Os documented
- ❑ Vital Signs documented
- ❑ Hand-off tool updated
- ❑ Patient's room clean, call button within reach
- ❑ Upper side rails up
- ❑ Water pitcher refilled per unit policy and/or as directed by RN
- ❑ Patient information signs posted above head of bed

Admission Checklist

- ✓ Assist ED staff by helping to transfer patient from gurney to their room
- ✓ If patient is ambulatory, use chair scale
- ✓ Ask patient for their height or estimate (verify with RN)
- ✓ Assist patient to bed
- ✓ Assist patient with removal of their clothes
- ✓ Assist patient into a hospital gown
- ✓ Obtain admission vital signs
- ✓ Provide the patient with the following:
  - ➢ Pitcher of water and cup, if not NPO
  - ➢ Box of tissue
  - ➢ Bedside trash bag
  - ➢ Toothbrush and toothpaste
  - ➢ Plastic comb
  - ➢ Slippers
  - ➢ Place a urinal or "hat" in the bathroom
  - ➢ Label urinal or hat with pt's name and room number
- ✓ Before leaving the room complete the following:
  - ➢ Instruct patient how to use the call button and place it near the patient
  - ➢ Instruct patient how to use to the bedside lights, TV remote, and bed controls
  - ➢ Place bedside table within reach of patient
- ✓ Document the patient's WT, HT, and vital signs

Transfer /Discharge Checklist

- ✓ Assist with discharges and transfers as directed by RN and/or ANM/relief charge nurse
- ✓ Ensure vital signs including pulse oximetry are obtained at least one (1) hour prior to discharge

Telemetry 2/08, Revised 11/10;5/11. 5/12, 3/13 PFR

ACT Shift Helpful Hints – Sample

TIME	TASK	HELPFUL HINTS
0700-0800	Provide/receive hand-off and round with off-going ACT. Identify sitters and arrange break coverage. Check to ensure previous ACT provided patients not NPO with a fresh pitcher of water Assist with answering phones and calls lights Receive update from RNs Offer washcloth for hand/face	Document any special task on your vital signs' worksheet Ask patients the following prior to leaving their rooms: 1. Would you like to sit in the chair or dangle on the side of the bed for breakfast? 2. Can I get you anything before I leave? 3. Check incontinent patients
0805-1100	Prepare patients for breakfast and pass trays Take vital signs, make copies of the vital signs' worksheet for the primary nurses, and receive approval of vitals before documenting. Document vitals, outputs, and ADLS Assist with answering phones and calls lights Start AM bath assignments **Assist with Pressure Injury PreventionReduction** Assist with answering call lights and answering telephone calls, reposition patients and Complete oral care as needed. Pick up trays, and Document breakfast intake	Bath assignments: Note the patients who will need oral care, baths, or require assistance with repositioning or ambulating. Assist patients with feeding as needed Take a few purple fall bands and keep them in your pocket. Put them on patients as needed while you are taking vital signs, answering calls lights, assisting with baths.
Until lunch trays arrive	Start Noon Vital signs Check incontinent patients; assist patients to the bathroom, and check urine collection containers. Sign falls log Document vitals, output, and ADLs prior to leaving for the next unit. Assist with answering call lights and answering phones. Assist with passing lunch trays and assist patients with feeding as needed	Note the patients who will require assistance with repositioning or ambulating. Ask patients the following prior to leaving their rooms: 1. **It is time** Would you like to be repositioned.? 2. Would you like to sit in the chair or dangle on the side of the bed for lunch? 3. Would you like to take a walk before or after lunch? Can I get you anything before I leave?
Breaks	Take morning break as assigned. Breaks shall not exceed 30 minutes	Inform ACTs and primary RNs you are leaving the floor for break
Until lunch trays arrive–1330	Go to lunch after patient lunch trays are passed (Breaks shall not exceed 30 minutes) Pick up lunch trays Document intake and complete documentation of noon vital signs. Complete AM Care and reposition patients **Assist with Pressure Injury PreventionReduction** Assist with answering call lights.	Inform primary nursing that you are leaving the floor for break Assist with discharges, transfers, and admissions
1331-until arrival of	Round: Check incontinent patients; assist patients to the bathroom, check urine	Assist with discharges, transfers, and admissions Prepare patient's for dinner (assist to chair, raise head of

dinner trays	collection containers and empty foley catheters, and other drainage collection containers. Refill water pitchers Assist with answering call lights and telephones Complete charting. Ambulate patients Set up room (s) for new admissions **Assist with Pressure Injury Prevention**	bed) Complete baths. Inform primary nursing that you are leaving the floor for break After ambulating patients offer the chair instead of returning them to bed. (This will prepare the patient for dinner). Call the lift team to assist as needed. Consider documenting any I & Os or ADLS that you have not completed. Do not restock supply baskets before you complete your documentation. Remember: an empty room will be filled and you will be expected to assist.

TIME	TASK	HELPFUL HINTS
-until dinner trays arrive	Prepare for break Take evening break as assigned. Breaks shall not exceed 30 minutes Assist with answering telephones and call lights	Inform ACTs and primary RNs you are leaving the floor for break
1700-1830 (Dinner Trays Arrive)	Pass trays Assist with patients as needed **Assist with Pressure Injury Prevention**	Once trays are passed and you have assisted patients requiring assistance with feeding, go to break.
1831-1900	Prepare for hand-off Review documentation Round on all patients	Complete task as needed
1901-2000	Provide/receive hand-off, round with off-going ACT. Assist with answering call lights and telephones Receive update for task to perform from primary RNs	
1931-2000	Pick up dinner trays Start vitals Make copies of the vital signs' worksheet for the primary nurses. Document vitals, intakes, outputs, and ADLS Get an update and sitters you may need to relieve for breaks. Check incontinent patients Place bedside table, with water pitcher, call button, and telephone within patient's reach. (Check to ensure the previous shift provided patients not NPO with a fresh pitcher of water). Assist with answering phones and calls lights Identify patients requiring baths, ambulation, repositioning every two hours, **and float heels** **Assist with Pressure Injury PreventionReduction**	Consider documenting intakes before starting vitals If you cannot complete your documentation, do not worry, chart as much information as you can and continue to assist as the primary nurses as needed. Assist with transfers, discharges, or admissions

2001-2230	Take dinner break (breaks shall not exceed 30 minutes) Assist primary RNs Continue to complete charting Offer PM oral and hygiene care Check supply baskets and restock as needed Assist with answering call lights Refill water pitchers, place NPO signs as needed, document I & Os and ADLs. Assist with night vital signs as directed Pass HS snack as directed by nursing Assist with answering call lights and complete unfinished documentation. Update primary nurse of any task not completed	Complete your charting before checking or restocking the supply baskets. If working with weaning ventilator patients, began PM bath. Complete baths assigned by RN or not completed by dayshift
2231-0030	Vital signs	
0031-0400	Complete task as assigned by RNs, Round on all patients, Check complete baths assigned by RNs **Assist with Pressure Injury Prevention Reduction, float heels**	Assist with admissions, Complete at least two baths on patients defined in this policy
0401-0659	Complete end of shift task i.e., vital signs, daily weights, intake and output, refill water pitchers, Task assigned by primary RNs	
	Provide/receive hand-off and round with off-going ACT. Identify sitters and arrange break coverage. Check to ensure previous ACT provided patients not NPO with a fresh pitcher of water Assist with answering phones and calls lights Receive update from RNs Offer washcloth for hand/face	
0700-0800	Review 0700-0800 previously stated	

~~Progressive Care Unit ACT Shift Task – Sample~~

~~Beginning of the Shift Checklist~~

- ~~Print Census~~ ~~**Use ACT handoff tool to,**~~ ~~receive hand-off from RNs~~
- ~~Obtain the following from RNs~~
  - ~~Diet~~
  - ~~Ambulatory needs~~
  - ~~Code Status~~
  - ~~Isolation Precautions~~
  - ~~Bath Assignment~~
    - ~~Check with RN if patient requires a shower or assistance~~
  - ~~Special Considerations~~
    - ~~Hard of Hearing~~
    - ~~Legally Blind~~
    - ~~No BP on Left or Right Arm~~
    - ~~Restraints~~
    - ~~Fall Risk~~
    - ~~Pressure **Injury**Ulcers~~

~~Vital Signs~~

- ~~Vitals Signs~~
  - ~~Complete vital signs as directed by RN~~
  - ~~Document results on VSS worksheet~~
  - ~~Give a copy to each RN to review prior to documenting~~
  - ~~Routine VSS~~
    - ~~Tele patients every 4 hours while awake~~
    - ~~Med/Surg patients every 8 or once a shift as directed by RN~~

~~Before Meal Trays Arrive~~

- ~~Document vitals and assist with answering call lights and the telephone~~
- ~~Perform additional duties as directed by RN~~

~~Arrival of Meal Trays~~

- ~~Ensure unapproved items are removed from tray as directed by Correctional Officers~~
- ~~Pass trays and assist with answering lights~~
- ~~Assist feeders as directed, if no feeders, go to break or document VSS and I & O's~~

~~After meal times~~

- ~~Complete documentation~~
- ~~Ambulate patients~~
- ~~Answer call lights and the telephone~~
- ~~Assist RNs as directed~~

~~Intake and Output~~

- ~~Document output after completing task~~
- ~~Document intake as soon as possible~~

~~Prior to Leaving Patient Rooms~~

- ~~Remove all items taken in room~~
- ~~Discarded items in proper container~~
- ~~Patient's room clean, call button within reach~~
- ~~Upper side rails up~~
- ~~Water pitcher refilled per unit policy and/or as directed by RN~~
- ~~Patient information signs posted per RN~~

~~End of Shift Checklist~~

- ~~Inform RNs of task not completed as soon as possible~~
- ~~I/Os documented~~
- ~~Vital Signs documented~~
- ~~Activity of Daily Living documented~~

~~Admission Checklist~~

- ~~Assist RN as directed~~
- ~~If patient is ambulatory, use chair scale~~
- ~~Ask patient for their height or estimate (verify with RN)~~
- ~~Obtain admission vital signs as directed by RN~~
- ~~Verify with RN or Correctional Officers items to place in patient's room (see the suggested item list below):~~
  - ~~Pitcher of water and cup, if not NPO~~
  - ~~Box of tissue~~
  - ~~Toothbrush and toothpaste~~
  - ~~Plastic comb~~
  - ~~Slippers~~
  - ~~Place a urinal or "hat" in the bathroom~~
  - ~~Label urinal or hat with patient's name and room number, if not contraindicated~~
- ~~Before leaving the room complete the following as directed by the RN:~~
  - ~~Instruct patient how to use the call button and place it near the patient~~
  - ~~Instruct patient how to use to the bedside lights, TV remote, and bed controls~~
  - ~~Place bedside table within reach of patient~~
- ~~Document the patient's WT, HT, and vital signs~~

~~Discharge Checklist~~

- ~~Do not discuss discharge plans or expected time of discharge with patient.~~
- ~~Assist with discharges directed by RN, ANM, or Correctional Officers~~
- ~~Ensure vital signs including pulse oximetry are obtained at least one (1) hour prior to discharge~~
- ~~Inform RN of VSS results after completing the task~~

Pressure Injury Prevention Measures

Pressure injury prevention measures should be followed at all times.

1. **Assist with and/or ensure the patient is repositions every 2 (two) hours and more often as directed by the RN**
2. **Use chair cushion when out of bed. Limit OOB to 2 hour intervals with hourly weight shifts**
3. **Use lift sheet/ pad to avoid shear and friction**
4. **Ensure for tubing and other medical devices are not under the patient**
5. **Use pillows between knees and bony prominences to avoid direct contact**
6. **Float heels on pillows or use heel offloading devices**
7. **Remove medical devices (e.g. stockings, sequential devices) every shift to inspect skin or as directed by RN**
8. **Offer toileting and hygiene care to incontinent patients every hour using perineal cleanser, barrier cream and wicking pads**
9. **Avoid using diapers unless ambulating incontinence patients or discharging**
10. **Offer hydration as directed by the RN**
11. **Perform skin inspection during bath, and other care, report skin abnormalities to RN**
12. **Use skin moisturizers on dry skin daily**
13. **Apply foam composite dressing on sacrum, bony prominences, or under a medical device**
14. **Keep HOB no more than 30 degrees unless contraindicated**
15. **Avoid linen under patient while on specialty mattresses (air mattress)**

Tri-City Medical Center
Oceanside, California

Advanced Care Technicians (ACT) Shift Duties and Responsibilities Guidelines

Shift duties including but not limited to:

A. **PROCEDURE:**

1. Duties and Responsibilities of all ACT's
   a. Document all interventions performed.
   b. Answer telephones and patient call lights during RN shift hand-off and PRN
   c. Sitter relief as directed by the RN and/or ANM/relief charge nurse
   d. Weights (daily, admission, transfer and as directed by the RN)
   e. Pre-operative shower/baths for patients as directed by RN per Patient Care Services Procedure: Pre-Operative Patient Preparation
      i. Cardiovascular surgery (CVS) patients pre-operative clipper prep and showers/bath should be performed by Telemetry ACTs hired for the Telemetry Unit.
   f. Distribute and assist with meal trays and bedtime snacks as directed by RN
   g. Ambulate patients as directed by RN
      i. Documentation should include the patient's distance and tolerance of the activity
   h. Assist with passive Range of Motion (ROM) as directed by the RN
   i. Assist with pressure injury reduction and document in EHR.
   j. Discontinue saline locks as directed by the RN and document in the EHR. Notify RN immediately if unable to manage bleeding, reddened skin, patient complaint of pain not related to removal of tape, drainage and any other blood drainage.
   k. Discontinue indwelling urinary catheters as directed by the RN and document in the EHR.
   l. Apply Falls Risk bands as directed by RN or as indicated from the information obtained from the hand-off tool per Patient Care Services Procedure: Fall Risk Procedure and Scoring Tool
   m. Check and restock patient room supply baskets and remove inappropriate supplies every shift
   n. Document vital signs, weights, intake and output, and Activity of Daily Living (ADL)s
   o. Perform other duties as assigned by RN and/or Nursing Leader/designee
2. Hourly Rounding ACT Standard Work
   a. ACTs shall round on the odd hours and as direct by RNs.
   b. Introduce yourself to patient and explain your role
   c. Inform patient of the task(s) that you plan to perform prior to performing the tasks(s)
   d. Address the four (4) P's i.e., Potty, Pain, Position and Possession
   e. Address comfort needs
   f. Ask patient prior to leaving room if there is anything else you may do for them
   g. Document completed task in the EHR
3. Patient Safety
   a. Prior to leaving a patient's room ensure the following:
      i. Patient's room is clean and uncluttered
      ii. Bedside tray is clean, clear of clutter and within patient's reach
      iii. Call button, television remote control and patient's other personal items are within patient's reach
      iv. Water pitcher is filled per RN instructions and/or per unit specific policy
      v. Patient's bed is in low position with upper side rails in up position
      vi. Appropriate patient signs are posted as directed by RN
      vii. Ensure each room has appropriate urine or stool graduated collection containers.
      viii. Ensure graduated container is clearly marked with patient's initials and bed location.

b. Ensure patients are turned, positioned, and heels are floated as appropriate.

4. Equipment
   a. Ensure all patient care equipment is placed or returned to the appropriate location
   b. Ensure equipment that requires charging is plugged in a socket when not in use
   c. Ensure equipment is cleaned per TCMC policy or manufacturers recommendation after each patient use (for transfers or discharges)
5. Admissions and/or Transfers
   a. Assist with admission and transfers to unit by completing the following:
      i. Set up room with hygiene items, water pitcher, cup and urine collection container (label container with patient's initials and bed location)
      ii. Ensure chair scale is available, zeroed, and near patient room; use the chair scale to weigh ambulatory patients.
         1) If a bed with a scale is needed, ensure the bed is zeroed per unit specific policy.
      iii. Assist patient into a gown if needed.
      iv. If abnormal skin findings are observed, notify the RN.
   b. Orient patient on the use of bed controls, call button, television (TV) remote, telephone, meals times, and use of light controls
   c. Provide rationale for using urine collection container
   d. Document patient's belongings, vital signs, admission weight, height, and ADLs in the EHR
      i. Notify primary RN of abnormal vital signs, patient questions, concerns, complaints, and other abnormal findings.
   e. Monitored level of care:
      i. Telemetry
         1) Place clean Telemetry box with batteries inserted and leadwires in room
         2) Attach patient to Telemetry box, or DASH if needed, on arrival to room. Call the monitor technician (MT) to verify patients name and rhythm is visible on the monitor
         3) Ensure Telemetry box is placed in a plastic protective cover
      ii. Medically Monitored
         1) Place clean remote monitoring unit with batteries inserted and leadwires in room
         2) Attach patient to remote monitoring unit, on arrival to room. Call the monitor technician (MT) to verify patients name and rhythm is visible on the monitor
6. Post-Operative Transfers – set-up room before patient arrives
   a. Bed available with linen pulled down and scale zeroed
   b. Have equipment available as directed by RN. Example include but not limited to:
      i. Vital sign machine
      ii. Remote monitoring device appropriate to unit
      iii. Oxygen regulator with tubing connector
      iv. Suction set-up including regulator, tubing and container
      v. Infusion pump
      vi. Sequential compression pump
7. Discharges, transfers to non-monitored units, or rate monitoring discontinuation
   a. For monitored patients, remove remote Telemetry box/remote monitoring unit immediately after notification by the RN or Nurse Leader/Charge Nurse
      i. Clean Telemetry box/remote monitoring unit and leadwires with appropriate cleaning solution and store in the appropriate location
   b. Place all patient belongings in a "Patient Belonging Bag"
      i. Check room cabinets, drawers, and bedside table for patient's belongings
      ii. Promptly inform RN if patient/or their family report personal items are missing,.
   c. Assist patient with discharge by performing the following as directed by the RN:
      i. Removal of saline lock
      ii. Removal of indwelling urinary catheter
      iii. Assist patient with applying clothing

d. Ensure vital signs including pulse oximetry are obtained at least one hour prior to discharge. Inform RN of the results immediately.
e. Assist with discharge transfer via wheelchair as directed by the RN

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 10/10 **SUBJECT:** Antimicrobial Stewardship

REVISION DATE: 07/13, 05/17, 05/20

Patient Care Service Content Expert:	~~03/20~~10/22
Clinical Policies & Procedures Committee Approval:	~~03/20~~11/22
Nursing Leadership ~~Executive Council~~ Approval:	~~04/20~~01/23
Medical Staff Department/Division Approval:	n/a
Pharmacy & Therapeutics Committee:	~~03/20~~01/23
Medical Executive Committee Approval:	~~04/20~~02/23
Administration Approval:	~~05/20~~03/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. **PURPOSE:**
1. To provide a process in order to promote judicious use of antimicrobials
2. The goals of the Antimicrobial Stewardship Program (ASP) include, but are not limited to:
    a. Minimize adverse effects and events secondary to the use of antimicrobial agents.
    b. Reduce, minimize, and/or prevent the emergence of resistant microorganisms.

B. **POLICY:**
1. A physician supervised multidisciplinary antimicrobial stewardship workgroup shall evaluate the judicious use of antimicrobials in accordance with guidelines established by the federal government and professional organizations.
2. Antimicrobial stewardship activities, outcomes, and all quality indicators shall be reported quarterly by the Infectious Disease physician or pharmacist to the Pharmacy Therapeutics Committee, Infection Control and bi-annually to the Quality Assurance / Performance Improvement (QAPI) Committee.

C. **PROCEDURE:**
1. Antimicrobial Stewardship Workgroup:
    a. Clinicians:
        i. A single physician leader, knowledgeable in the area of infectious diseases, responsible for program outcomes.
        ii. A pharmacist leader, knowledgeable in the area of infectious diseases, will co-lead the program.
    b. Infection Control:
        i. Infection control activities
        ii. Quality indicators (*C. difficile*, MDRO, device related infections, procedure related infections, etc.)
    c. Information Systems:
        i. Computerized alerts and warnings
        ii. Data generation and reporting
    d. Microbiology:
        i. Culture and sensitivity reporting/alerting
        ii. Annual antibiogram
    e. Administration:
        i. Financial support of program
2. Antimicrobial Stewardship Activities:

a. Prospective audit and feedback conducted by pharmacist leader in conjunction with physician leader.
   i. This process involves prospectively reviewing the use of antimicrobial agents and contacting the prescriber with recommendations for optimizing current antimicrobial therapy on an individual patient.

b. Development and implementation of a restricted antibiotic policy (Refer to Pharmacy policy "Restricted Antimicrobials").

c. Surveillance and trending of antimicrobial use patterns and quality indicators.

d. Education to clinicians and staff:
   i. Development of evidence based, institution-specific guidelines for the treatment of common infections.

e. Other activities:
   i. IV to Oral route conversion program.
   ii. Renal dose adjustment of antimicrobials.
   iii. Preparation of retrospective reviews (i.e. Medication Use Evaluation).

D. **REFERENCE(S):**

1. Barlam TF, Cosgrove SE, Abbo LM, et al. Implementing an Antibiotic Stewardship Program: Guidelines by the Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America. Clin Infect Dis 2016; 62:e51.
2. Centers for Disease Control and Prevention. Core Elements of Hospital Antibiotic Stewardship Programs. http://www.cdc.gov/getsmart/healthcare/implementation/core-elements.html (Accessed on December 12, 2016).

Tri-City Medical Center | Patient Care Services

PROCEDURE:	**BLOOD PRODUCTS ADMINISTRATION**
Purpose:	To outline the nursing care and management of adult/adolescent/pediatric/newborn patients receiving blood or blood products. This includes, but not limited to, red blood cells (RBC), **packed red blood cells (PRBC)**, irradiated blood products, platelet pheresis (PLPH), thawed plasma (TP) and cryoprecipitate.
Supportive Data:	Blood and blood products are unlike other intravenous medications administered due to the human/organic nature of the substance. Special precautions and timeliness are required for proper management of the patient receiving a transfusion.
Equipment:	Blood Product Blood Administration Set with a 170 micron filter Normal Saline Intravenous (IV) Electronic Infusion Pump Automatic Blood Pressure (BP) machine Pressure **Pump Bag/Rapid Infusion Device (e.g., Level 1) (if indicated)**~~pump bag (if indicated)~~

A. **DEFINITION(S):**

1. Qualified transfusionists are:
    a. Registered Nurses (RN) who have completed annual/ongoing competency in blood/blood product administration
    b. **Anesthesia provider**~~Anesthesiologists~~
    c. Perfusionists in surgery

B. **PROCEDURE:**

1. Refer to ~~**Elsevier**~~ Online Skills ~~Nursing Skills procedure: Blood Products: Administering~~ for **more**~~complete~~ information **related to blood/blood product administration**.
2. Confirm patient identity using two-identifier system. Refer to Patient Care Services Policy: Identification, Patient.
3. Verify order **of blood/blood products.**~~and complete a Transfusion Request Form~~
4. **Verify the patient, parent, conservator or legal guardian has received, read and understands, "A Patient's Guide to Blood Transfusions".**
5. **For convalescent plasma a RN will verify the patient has received, read and understands the Fact Sheet for Patients and Parents/Caregivers.**
6. **Obtain the patients signature on the consent form for all blood products from Transfusion Services.**
    a. **Notify the ordering provider if the patient, parent, conservator or legal guardian has not received informed consent regarding blood or blood product administration.**
    b. **When a patient is a minor or is physically/mentally incapable of understanding and signing the consent, a parent, conservator or legal guardian may sign.**
    c. **If the patient, parent, conservator or legal guardian refuses to permit the use of blood or blood products in their care or the care of the patient, then the refusal section of the consent will be completed.**
7. **Print the Blood Transfusion Requisition from the patient's electronic health record (EHR).**
    a. **The requisition must include:**
        i. **Two patient identifiers**
        ii. **Blood product requested**
8. **Have a qualified employee take the Blood Transfusion Requisition to the Blood Bank for**

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursing Leadership**Ex** ~~ecutive Committee~~	Blood Utilization Review Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
05/94, 07/09, 10/10, 05/12, 12/17, 07/18, **09/22**	05/12, 03/13, 01/15, 11/18, **10/22**	05/12, 03/13, 02/15, 11/18, **11/22**	04/17, 11/18, **02/23**	n/a	06/12, 06/13, 08/17, 01/19, **02/23**	01/19, **03/23**	07/12, 07/13, 09/17, n/a	07/12, 07/13, 09/17, 02/19

retrieval of blood/blood product.

a. **Transfusion Services will use a dual bag system to protect patient's privacy and contain possible spillage of blood products not transported in a cooler. Single and double units will be placed in a re-closable clear plastic bag. This clear plastic bag will be placed in a ~~white~~ bag labeled "Handle with Care: Human Blood".**

b. **Areas designated by Transfusion Services may be issued a cooler to store blood waiting to be transfused. Cooler blocks are good for nine (9) hours, after which they must be returned to Transfusion Services and switched for fresh cooler blocks. Transfusion Services monitors the time limit of the cooler blocks.**

i. **For areas storing units of blood in a cooler, verify the temperature indicator on each unit of blood/blood product prior to initiating transfusion of the unit.**

1) **If the temperature indicator has changed outside of the acceptable range, return the unit to Transfusion Services for investigation. Do not initiate transfusion of the affected unit until approved by Transfusion Services.**

ii. **Any units of blood/blood products remaining in the cooler that will not be transfused must be returned to Transfusion Services in the original cooler.**

~~3.~~

~~a. A nurse will verify that patient has received, read and understands, "A Patient's Guide to Blood Transfusions". The nurse will also verify that the patient has had opportunity to discuss this process with their physician.~~

~~i. After reviewing the copy of "A Patient's Guide to Blood Transfusions" if the patient, parent, conservator or guardian refuses to permit the use of blood or blood derivatives in their care or the care of the patient, the patient will date, time and sign the refusal section of the consent.~~

~~ii. When a patient is a minor or physically or mentally incapable of understanding and signing the consent, a parent, conservator or guardian may sign. Check the box which indicates the relationship of the signature for consent.~~

~~b. Obtain patient's signature on consent form, if not previously signed, for all blood products from Transfusion Service.~~

~~i. Notify the physician who ordered the blood product if patient has not received informed consent regarding blood administration.~~

~~ii.~~

~~c. Take the pre-transfusion vitals and only continue if the vitals are not significantly different than the most recently recorded on the chart.~~

~~4. Obtain blood products from the Transfusion Service:~~

~~a. Send the Transfusion Request Form with a Tri-City Healthcare District (TCHD) employee to pick up blood products from the Blood Bank in lab.~~

~~b. Transfusion Services will use a dual bag system to protect patients' privacy and contain possible spillage of blood products not transported in a cooler. Single and double units will be placed in a re-closable clear plastic bag. This clear plastic bag will be placed in a white bag labeled "Handle with Care: Human Blood".~~

~~5.~~**9.** Initiate the transfusion within 30 minutes of obtaining **blood products**~~component~~ from ~~the~~ Transfusion Service**s**.

a. It is permissible to start the transfusion even if it is delayed more than 30 minutes from issue as long as the entire unit can be infused within 4 hours of issue. After 4 hours the remainder of the unit must be discarded. The time issued is **documented by Transfusion Services and sent with the blood product.**~~recorded on the Transfusion Request Form.~~

i. Blood and blood products that are not going to be transfused should be returned to ~~the~~ Transfusion Service**s** immediately, as they are temperature sensitive.

ii. If the patient has received any **portion** of **a** ~~the~~ blood product~~s~~ **but the transfusion was not completed**, discard the remainder of unused blood **product** in biohazardous waste ~~if the transfusion is discontinued~~ unless there is

a transfusion reaction.

iii. Do not store blood products in any refrigerator outside of~~ the~~ Transfusion Services.

~~b. Exception: Areas designated by the laboratory may be issued coolers to store blood while waiting to be transfused. blocks are good for 9 hours, after which they must be switched for fresh blocks. The blood bank monitors the time limit of the blocks. Any remaining units of blood in the cooler at the conclusion of the procedure must be returned to blood bank in their original cooler.~~

~~6. Verify blood product and patient information~~

~~a. Verify the following information from blood products, unit tag, transfusion record, and patient information from attached armbands with another RN (in Operating Room may verify information with a Perfusionist/Anesthesiologist whenever possible).~~

~~i. The RN /perfusionist/anesthesiologist (whenever possible) administering the blood products must participate in the verification process.~~

~~b. Unit tag, armband number highlighted on forms must match the number on the Transfusion Service identification band attached to the patient.~~

~~i. Return blood product to Transfusion Services if number does not match.~~

~~c. Patient's name and medical record number on hospital armband with unit tag and Transfusion Record form.~~

~~d. Type of blood product issued matches blood product ordered by Physician.~~

~~e. Blood group and Rh type on blood product label matches blood group and Rh type on unit tags and for red cell products are compatible with patient's blood group and Rh type on the unit tags.~~

~~i. Platelet and cryoprecipitate ABO/Rh types may not match the patient's blood ABO/Rh but are compatible to be transfused. Call the Transfusion Service with questions concerning ABO/Rh compatibility.~~

~~f. Donor unit number (Blood Unit ID#) on blood product label matches donor unit number on unit tag and Transfusion Record form.~~

~~g. Expiration date/time on blood product label has not elapsed. Record the expiration date/time on the Transfusion Record Form.~~

~~i. If the expiration date is the current calendar day, the blood products must be infused by midnight or the remainder discarded at midnight (23:59).~~

~~ii. If the expiration date includes a specific time that time is the expiration time rather than 23:59 as above.~~

~~h. Compatibility status if blood product is red blood cell unit.~~

~~i. Document verification on Transfusion Record form and Blood Administration Powerform.~~

~~i. Anesthesiology documents on anesthesia record~~

~~7.~~**10.** All ~~non-autologous~~ PR**B**Cs and all platelet pheresis products used at **Tri-City Medical Center (TCMC)**~~this hospital~~ are leuko-reduced.

~~8.~~**11.** Pressure Pump/Bag may be used if blood needs to be infused at a rapid rate.

a. Use only external pressure devices equipped with a pressure gauge, and that exert uniform pressure against all parts of the blood container.

b. Maintain 300 mmHg or less when pressure transfusing blood components as higher pressures may cause bag rupture or hemolysis through small-gauge lines.

12. Blood may be infused using an electronic infusion device.

~~9.~~**13.** Blood warmer may be used. Use only equipment specifically designed to warm blood product and maintain blood warmer temperature at specified temperature for equipment used throughout transfusion

~~10. Document temperature of blood warmer on Transfusion Record form.~~

~~11.~~**14.** Medications may not be given in the same Intravenous (IV) line while blood is transfusing.

a. IV push medication may only be given via the lowest injection port while the normal saline is infusing immediately before or after transfusing the blood product.

~~12.~~**15.** Change the blood administration set after 4 hours. Up to 2 units may be given with each set if the total infusion time is less than or equal to 4 hours.

~~13.~~**16.** Assess and document vital signs **(VS)** (~~including~~ blood pressure, heart rate, respiratory rate, and temperature) **in Bridge™** ~~on Blood Administration Powerform:~~
   a. ~~Pre-transfusion~~
   ~~14.~~**b.** ~~**Vital signs will**~~ ~~It is recommended that vital signs be obtained immediately p~~Prior to sending for blood/**blood products** ~~and initiating a transfusion~~, not to exceed 1-2 hours prior to the transfusion initiation
   c. **Immediately prior to transfusion initiation**
   ~~a.~~**d.** 15 minutes after blood product initiated
   ~~b.~~**e.** 1 hour after blood product initiated
   ~~c.~~**f.** Every 1 hour until blood product infused
   g. Immediately post transfusion~~.~~
   ~~d.~~**h.** **VS will be captured on the Anesthesia Record while the patient is under the care of an Anesthesia provider**

17. **The transfusing RN will log into Bridge™ for verification and documentation of blood products using the appropriate workflow for transfusion. See "Cerner Bridge Transfusion Administration Workflow".**
   a. **Start Transfusion (regular)**
   b. **Massive Transfusion Protocol (MTP) Transfusion**
   ~~i.~~**c.** **Rapid Start Transfusion**
   d. **If bridge not available, complete documentation in** Electronic Health Record (HER), **see Blood Product Administration Documentation Outside Bridge Guidelines**

   ~~**Anesthesia providers administering blood products will document on the Anesthesia Record**~~

18. A patient receiving blood must be accompanied by a nurse when leaving the nursing floor.

19. **Blood/blood products that have been checked into Bridge™, but were not transfused, (MTP workflow) must be released in Bridge™ before returning the units to Transfusion Services. See "Cerner Bridge Transfusion Administration Workflow".**

~~15.~~**20.** **Dispose of blood products and administration sets in red bags, if no transfusion reaction.**

~~16. Complete Transfusion Record and Blood Administration Powerform including documentation of amount of blood product infused and any adverse reactions and place the chart copy of the Transfusion Record in the laboratory section of the patient's chart. Return the Blood Bank copy to the Lab.~~
   ~~a. Document any adverse reactions on the Transfusion Reaction section of the Blood Administration Powerform.~~
   ~~b. A form must be completed for each unit of blood product transfused.~~

~~17. Upon discharge of Outpatients, provide patient with an Outpatient Post Transfusion Reaction information sheet.~~

~~18.~~**21.** Initiate Blood Transfusion Reaction process for suspected transfusion reaction.
   a. Check unit and patient information to verify that the unit was started on the correct patient.
   b. See ~~**Elsevier**~~ Online Skills **"Blood Product Administration:** ~~Nursing Skills~~ Transfusions ~~:~~ Reaction" ~~Management~~
   c. **Initiate Transfusion Reaction order set in the patient's EHR**
   d. **Complete transfusion reaction section in Bridge™**
   ~~b.~~**e.** **Send blood product with the attached blood administration set, blood product tag and first void urine specimen to Transfusion Services.**
   ~~c. Complete Reaction section of the Blood Administration Powerform and the Transfusion Record form.~~
   ~~d. Send blood product with attached blood administration set, the printed Blood Administration form, the Blood Bank Transfusion Record, record forms and first void urine specimen to Transfusion Service.~~

~~19.~~**22.** **Upon discharge of Outpatients, provide patient with an Outpatient Post Transfusion**

Reaction information sheet~~Dispose of blood product containers, and administration sets in red bags, if no transfusion reaction~~.

C. **SPECIAL CONSIDERATIONS FOR: PEDIATRIC/NEONATAL:**

~~1. A nurse will verify that patient/parent/legal guardian has received, read and understands a patient guide to blood transfusion. The nurse will also verify that the patient/parent/legal guardian has had opportunity to discuss this process with their physician. Obtain consent for blood and blood products administration from parents.~~

~~2.~~**1.** Verify Newborn Screening has been obtained prior to the first **RBC**~~PRC~~ transfusion **and is documented on the newborn screening test request form.**~~providing Hct greater than 25 or as ordered by the physician.~~

~~3.~~**2.** Ensure ~~that~~ all cellular blood products are Cytomegalovirus (CMV) negative, leukoreduced and irradiated for newborns or per physician order.

~~4.~~**3.** Consult with physician regarding the use of donor specific blood.

~~5. As above a second qualified transfusionist must verify all blood products prior to administration to ensure that the proper blood is administered to the infant in the Neonatal Intensive Care (NICU).~~

~~6.~~**4.** Administer all blood products via an ~~Alaris~~**electronic infusion device** ~~pump~~ except with exchange or emergency transfusions.

~~7.~~**5.** Prime tubing with blood product and attach to T-connector **(extension set).** ~~or double or triple lumen connector tubing.~~

~~8.~~**6.** Administer blood products through largest bore catheter available (24 gauge minimum recommended).

~~9. Transfuse PRCs per physician order.~~

~~10.~~**7.** Allow blood products to warm to room temperature (approximately 20 minutes) prior to administration to reduce thermal stress.

~~11.~~**8.** Transfuse blood over time specified by physician order, but not more than 4 hours. If transfusion orders require infusion greater than 4 hours, request smaller aliquots from the Transfusion Service.

~~12.~~**9.** Use a controlled blood warmer when performing large volume transfusions (exchange transfusions).

~~13. Document, to the nearest tenth of an mL, the amount of blood product infused in the electronic health record (EHR).~~

D. **SPECIAL CONSIDERATIONS FOR: INTRAOPERATIVE REINFUSION OF PROCESSED BLOOD:**

1. Label each unit with patient's full name, Medical Record Number, date, time of start of collection, time of expiration and for "Autologous Use Only", at time of collection.
2. Reinfusion of intra operatively processed blood must begin within 6 hours of end of collection.
3. Blood collected intra operatively is to be transfused to the donor only.
4. Contraindicated in cases of sepsis or malignancy.

E. **ENERGY RELEASE:**

~~E.~~**1.** **For all blood products issued as emergency release, the physician/AHP must sign the** ~~following~~ **statement at the bottom of each emergency tag: "Due to critical condition of patient, I accept unit without crossmatch".**

F. **FORM(S):**

1. Authorization for Consent to Blood Transfusion or Blood Refusal 7420-4004 - English - Sample
2. Authorization for Consent to Blood Transfusion or Blood Refusal 7420-1006 - Spanish - Sample
3. Blood Bank Transfusion Record 7500-5006 - Sample
4. Outpatient Post Transfusion Reaction Information Sheet 7725-1003 - Sample
5. Transfusion Request Form 7500-1009 - Sample

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

1. A Patient's Guide to Blood Transfusion – English (external link) – Sample http://www.mbc.ca.gov/Publications/Brochures/blood_transfusion_english-print.pdf)
2. A Patient's Guide to Blood Transfusion – Spanish (external link) – Sample http://www.mbc.ca.gov/Publications/Brochures/blood_transfusion_spanish-print.pdf)
3. Patient Care Services Policy: Identification, Patient
4. Patient Care Services Procedure: Constavac, Reinfusion of Blood
5. **Blood Product Administration Outside Bridge Guidelines**
~~4.~~**6. Cerner Bridge Transfusion Administration Workflow**

H. **REFERENCE(S):**

1. Transfusion Therapy Guidelines for Nurses, National Blood Resource Education Program, Public Health Service of National Institutes of Health, U.S. Department of Health/Human Services
2. Stryker Constavac Blood Conversion (CBC) System Operating Instructions, 98. See TCHD Equipment Manual
3. Technical Manual, American Association of Blood Banks, current Edition, Bethesda, MD 20814-2749
4. TCMC Blood Utilization Review Committee. Chair, Gary Wilcox, M.D., 2000
5. AWHONN Core Curriculum for Neonatal Intensive Care Nursing, Deacon, J, and O'Neil, P (Eds), 5th Edition, W. B. Saunders, Philadelphia 1999
6. American Association of Blood Banks, Standards for Blood Banks and Transfusion current Edition: Bethesda, MD, 20814-2749
7. ~~Merenstein, G.B., Gardner, S.L. (2011). Handbook of neonatal intensive care, 7th Edition. Mosby-Elsevier: Philadelphia, PA~~
~~7.~~**8. Gardner, S. L., Carter, B. S, Hines, M. E., Niermeyer, S. & Merenstein, G. B. (2021). Merenstein & Gardner's Handbook of Neonatal Intensive Care: An Interprofessional Approach (9th ed.). Elsevier.**

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

SAMPLE

CONSENT TO BLOOD TRANSFUSION

My signature below indicates that: (1) I have received a copy of the brochure, "***If You Need Blood: "A Patient's Guide to Blood Transfusions,"*** (2) I have received information concerning the risks and benefits of blood transfusion and of any alternative therapies, (3) I have had the opportunity to discuss this matter with my physician, including pre-donation, (4) subject to any special instruction listed below, my consent to such blood transfusions as my physician may order in connection with the operation or procedure described in the "Consent For Operative Or Other Procedures," (5) I have read and understand the information in the "Blood Transfusion and/or Refusal of" section provided on this form, (6) I have received all of the information I desire concerning the procedure(s), and (7) I authorize and consent to the performance of the procedure.

[Describe here any specific instructions for patient's blood transfusion, e.g., pre-donation, directed donation, etc.]

____
____
____
____

Date:____________ Time: ____________ A.M./P.M. Signature: ____________________

If signed by other than the patient, indicate relationship: ☐ Parent ☐ Conservator ☐ Guardian

Witness: ____________________________
Hospital Representative

REFUSAL OF BLOOD TRANSFUSION

I request that no blood derivatives be administered to:____________________________, during this hospitalization. I hereby release the hospital, its personnel, and the attending physician from any responsibility whatsoever for unfavorable reactions or any untoward results due to my refusal to permit the use of blood or its derivatives. The Possible risks and consequences of such refusal on my part have been fully explained to me by my attending physician and I fully understand that such risks and consequences may occur as a result of my refusal, **even if this results in my death.**

Date:____________ Time: ____________ A.M./P.M. Signature: ____________________

If signed by other than the patient, indicate relationship: ☐ Parent ☐ Conservator ☐ Guardian

Witness: ____________________________
Hospital Representative

Tri-City Medical Center

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Affix Patient Label

AUTHORIZATION FOR CONSENT TO BLOOD TRANSFUSION OR BLOOD REFUSAL

7420-4004
(Rev. 11/09)

White - Chart Yellow - Patient

SAMPLE

TRI-CITY MEDICAL CENTER

CONSENTIMIENTO PARA RECIBIR O RECHAZAR TRANSFUSIÓN DE SANGRE

Al firmar este documento, indico que: (1) he recibido una copia del folleto titulado ***"If you Need Blood: "A Patient's Guide to Blood Transfusions,"*** (2) he recibido información sobre los riesgos y beneficios de la transfusión de sangre y de cual(es)quier terapias alternativas, (3) he tenido la oportunidad de hablar con mi médico sobre este asunto, inclusive sobre la donación previa, (4) sujeto a las instrucciones especiales que aparezcan a continuación, doy mi consentimiento para recibir las transfusiones de sangre que mi médico ordene en conexión con la cirugía o el procedimiento descrito en el "Consentimiento para procedimientos quirúrgicos o de otra naturaleza", (5) he leído la sección de este formulario titulada "Consentimiento para recibir transfusión de sangre" y/o "Rechazo de transfusión de sangre" y la(s) he comprendido, (6) he recibido toda la información que deseo sobre el (los) procedimiento(s), y (7) doy mi autorización y mi consentimiento para la realización del procedimiento.

[Describir aquí las todas instrucciones específicas para la transfusión de sangre que recibirá el/la paciente, como, p. ej., la donación previa, la donación bajo dirección, etc.]

____
____
____
____

Fecha: _________ Hora: ________ A.M./P.M. Firma: ___________________________

Si alguien que no sea el/la paciente firmó, indicar relación o parentesco: ☐ Padre/Madre ☐ Conservador ☐ Guardián

Testigo: ___________________________________
Representante del hospital

RECHAZO DE TRANSFUSIÓN DE SANGRE

Solicito que no se administren derivados de sangre a (nombre del/de la paciente ___________________________, durante su presente hospitalización. Por este medio libero al hospital, a su personal y al médico que me atiende de toda responsabilidad debido a cualquier reacción desfavorable o adversa causada por mi rechazo del uso de sangre o de sus derivados. El médico que me atiende me ha explicado claramente los riesgos y consecuencias posibles de tal rechazo de mi parte y yo comprendo claramente que tales riesgos y consecuencias podrán ocurrir como resultado de mi rechazo, **aun si esto causara mi muerte.**

Fecha: _________ Hora: ________ A.M./P.M. Firma: ___________________________

Si alguien que no sea el/la paciente firmó, indicar relación o parentesco: ☐ Padre/Madre ☐ Conservador ☐ Guardian

Testigo: ___________________________________
Representante del hospital

Tri-City Medical Center

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Affix Patient Label

AUTHORIZATION FOR CONSENT TO BLOOD TRANSFUSION OR BLOOD REFUSAL (SPANISH)

7420-1006
(Rev 11/09)

White - Chart Yellow - Patient

SAMPLE

BEDSIDE VERIFICATION

Before administering this unit, we the undersigned licensed personnel, have verified the following items:

- Physician's order verified, component matches the order & Informed Consent documented
- Name, medical record number (MRN), and Blood Bank (BB) Armband Number are identical on patient's armband, patient identification (ID) band, Transfusion Record and Unit Tag.
- Unit number, Unit ABORh, Component type and Expiration date/time are identical on the Unit product label, the Transfusion Record and Unit Tag.
- Patient Transfusion Requirements (Irradiated, CMV Neg.) for RBC and Platelets are verified on Unit product label, Transfusion Record and Unit Tag. For RBC: Crossmatch compatibility is verified on Transfusion Record and Unit Tag.
- The Unit is normal in appearance.
- Unit has not expired.

Checked by: ______________________ ______________________

Transfusion Started By: ______________________ Date: __________ Time: __________

Completed: Date: __________ Time: __________ Amount Transfused: __________

Discontinued By: ______________________ Blood Warmer Temp (if used): __________

Transfusion Reaction: ☐ No ☐ Yes, follow direction on back

EMERGENCY DISPENSE:
☐ Due To Critical Condition Of Patient, Accept Unit Without Crossmatch: ______________________ MD

Document Vital Signs in IView/ Anesthesia Record. Use this section for Downtime Only:

	Pre	Start + 15 min.	Start +1hr	Start +2hr	Start +3hr	Start +4hr	1 hr. post
TIME							
INITIALS							
TEMP							
PULSE							
RESP							
BP							

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Medical Director: M. Contardo, MD, MPH
Section Designee: M. Shahidi-Asl, MD

Label

BLOOD BANK TRANSFUSION RECORD

7500-5006

(Rev. xx/xx)

SAMPLE

READ BEFORE ADMINISTERING, ABBREVIATED INSTRUCTIONS:
(Complete Instructions in Patient Care Services Procedure: Blood Products Administration)

1. Record/upload vital signs in IView. Follow current timing-policy for documenting vitals during product administration in IView.
2. Read unit label and unit tag carefully to assure blood type on unit label matches blood type on unit tag. Donor type and patient type should be compatible for red cell products.
3. Check patient's identification bands Name and numbers on armbands must match name and numbers on unit tag
4. After verifying, sign BB transfusion Record as having verified information and/or started the product administration.
5. Mix unit thoroughly and gently before administering, especially RBC.
6. Always administer all blood products through appropriate administration set with filter.
7. No Medication is to be added to blood or blood components.
8. Return any unused product to the blood bank if the patient has not received any of the unit (even if unit has been spiked but patient has not received product) as soon as possible.
9. Product Administration: Should be completed within 4-hours of release from the Transfusion Service. The time released is recorded on the Transfusion Request Form. If problem at bedside occurs delaying starting unit, keep unit at bedside if administration can be completed within 4-hr. limit.
10. DO NOT store blood or blood components in any of the floor's refrigerators.

IF THERE IS NO REACTION:

1. Upon completion of transfusion, fill in volume, check No- adverse reaction box and sign form.
2. Place this form in patient's chart.
3. If there is not an adverse reaction, discard bag in appropriate bio-hazard waste container

IF THERE IS A REACTION:

1. Stop Transfusion Immediately. Maintain venous access with normal saline.
2. Call patient's MD STAT, determine if they want to discontinue the transfusion and want to workup the suspected transfusion reaction. If decision is made to discontinue unit and do workup, hold bag and attached administration set and saline (unit) at bedside (hold for phlebotomist secured in sealed bag).
3. Call Transfusion Service STAT at ext. 7394.
4. If the symptoms are LOCALIZED URTICARIAL ONLY, no blood sample or urine is collected. After reporting urticaria to MD and Transfusion Service, the transfusion may continue if directed by MD.
5. Document Vital Signs in IView.
6. Complete the Transfusion Reaction section of the Blood Products Administration powerform
7. Transfusion Reaction Report will print automatically in the Transfusion Service when the powerform is signed.
8. Make a copy of this Transfusion Record to send to the Transfusion Service.
9. Collect the first voided or catheter urine after reaction. Phlebotomist who responds for workup sample collection will bring the Transfusion Record copy, the urine and the unit when they return to the Lab.

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

SAMPLE

The transfusion of blood and its components is, ordinarily, a safe and temporarily effective way to correct hematologic problems. However, some adverse effects may occur. The following is a list of symptoms that can be associated with transfusion reactions. Your illness may already cause some of these symptoms before the transfusion. If you notice any of your current symptoms rapidly increasing, or any new symptoms listed below, consult your physician immediately.

1. Fever
2. Dark or red-colored urine
3. Back pain
4. Nausea, vomiting, abdominal cramps or diarrhea
5. Increased or decreased urinary output
6. Acute shortness of breath (difficulty breathing)
7. Chills
8. Severe headache
9. Swollen extremities
10. Coughing
11. Rash, hives or itching
12. Jaundice and/or fatigue 2-4 weeks following transfusion

Care of Site

1. Leave dressing on for 24-hours.
2. If bleeding at the infusion site, use pressure with two fingers for 10 minutes. If bleeding continues, call the physician.

At the time of discharge:

Temperature___________ Pulse ___________ Blood Pressure ____________________

I have read and understand these instructions.

___________________________________ ________________________________

___________________________________ ________________________________

Signature of Patient ____________________ Signature of Nurse ____________________

Date ____________________ Date ____________________

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Affix Patient Label

7725-1003
(Rev. 06/09)

OUT PATIENT POST TRANSFUSION INSTRUCTIONS

White - Medical Records Yellow - Patient

SAMPLE

TRANSFUSION REQUEST FORM

Physician ordering transfusion: (Last name, first name)

____, M.D.

SPECIAL PATIENT REQUIREMENTS: ☐ IRRADIATED

OTHER: ____

Product ordered for transfusion and quantity to be dispensed now:

Product (check)	Quantity
☐ **EMERGENCY RELEASE RED BLOOD CELLS (RBC)**	______
☐ RANDOM RBC, LEUKOPOOR	______
☐ PLATELET PHERESIS **(PLPH)**, LEUKOPOOR	______
☐ THAWED PLASMA **(TP)**	______
☐ CRYOPRECIPITATE	______
☐ AUTOLOGOUS RBC	______
☐ DONOR SPECIFIC RBC, LEUKOPOOR	______

Change to PACKED RED BLOOD CELL (PRBC)

☐ OTHER BLOOD COMPONENT: ____

ADDITIONAL ORDER NOTES: ____

☐ **Massive Transfusion Protocol (5 RBCs:5FP:1PLPH) until ordering physician discontinues/stops**

~~**Transfusion Service Identification Band Number:** ______________________~~

Order verified by: ______________________, R.N. Date: __________ Time: ________

Dispensed: Date: ______________ Time: ______________

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Affix PatientLabel

7500-1009
(Rev. 5/14)

TRANSFUSION REQUEST

White - Chart Yellow - Blood Bank

SAMPLE

Guidelines for Completing Transfusion Request Form
(Add to back of page 1)

1. Attach a current patient chart label to each copy of the form.
2. Record the name of the physician ordering the transfusion on the corresponding line.
3. Check the type of product requested and indicate the number required for the current transfusion.
4. ~~Record the Transfusion Service ID band (BB ID) number in the corresponding area on the form. Use the current band number verified from the patient's BB ID armband.~~

References:

- Circular of Information for the Use of Human Blood and Blood Components. AABB. Nov 2013 (revised April 2014)
- AABB Technical Manual. 18th Edition.

This brochure was developed by the California Department of Public Health, Laboratory Field Services (850 Marina Bay Parkway, Richmond, CA 94804)

In partnership with the Medical Technical Advisory Committee of the Blood Centers of California.

For information about brochure contents, please call Laboratory Field Services: (213) 620-6574

SAMPLE

This brochure is provided as a source of information and is not considered a replacement for the Informed Consent process prior to the transfusion of blood.

Distributed by the Medical Board of California

To place an order for this brochure, please FAX your request to: (916) 263-2497

This information may be obtained electronically at:

http://www.mbc.ca.gov/Publications/Brochures/Blood_Transfusions.aspx

Revised 06/2018

A Patient's Guide to Blood Transfusion

California
Department of Public Health

June 2018

SAMPLE

This document provides written information regarding the benefits, risks, and alternatives of transfusion of blood products (including red blood cells, plasma, platelets, or others) collected from the patient (autologous) or another person. This material serves as a supplement to the discussion you have with your physician. It is important that you fully understand this information, so please read this document thoroughly. If you have any questions regarding the procedure, ask your physician prior to consenting to receive a transfusion.

Information about the treatment

Transfusions of blood products are provided to increase the amount of blood components in your body when they are below a reasonable level for your health. The transfusion may be made up of red blood cells, plasma, platelets or other specialized products made from blood. Your physician will decide on the right amount and type of blood product based on your medical condition or diagnosis.

Potential benefits of the treatment

Transfusion of blood products may be necessary to correct low levels of blood components in your body, and may also make you feel better. In some cases, failure to receive transfusion(s) may result in death.

Risks of the treatment

Known risks of this treatment include, but are not limited to:

- Irritation, pain, or infection at the needle site
- Temporary reaction such as a fever, chills, or skin rashes.

Other rare but more serious complications include severe allergic reactions, heart failure due to fluid overload, acute pulmonary edema (fluid leaking into the lungs), hemolysis (destruction of red blood cells), shock, or death.

Transfusion of blood products carries a very small risk of transmission of infectious diseases such as HIV (about 1 in 1.5 million), Hepatitis C (about 1 in 1.2 million), and Hepatitis B (about 1 in 1 million). Other significant infections may also be transmitted by transfusion, but overall this risk is low.

Treatment Options/Alternatives

If you need blood you have several options. Most patients requiring transfusion receive blood products donated by volunteer community donors. These donors are extensively screened about their health history and undergo numerous blood tests as mandated by state and federal regulations in order to ensure the safest possible blood supply. Alternatives to transfusion with blood products from volunteer community donors include:

- Pre-operative autologous donation (using your own previously donated blood), see below for more information
- Directed donation (blood donated by people who you have asked to donate for you), see below for more information
- Intra-operative autologous transfusion/ Hemodilution (collecting your own blood during surgery to be given back to you)
- Medications (certain medications may increase blood volume prior to surgery or reduce active bleeding to lessen the need for transfusion)

These options may be available only if your health, time, and procedure permit. They may not be available at all locations or for all patients. You may also choose not to receive blood transfusion; however this decision may hold life-threatening consequences.

Pre-operative autologous donation is not appropriate for all patients. Autologous donation involves collecting your own blood prior to a planned surgery for storage in the hospital blood bank. It is important to discuss with your physician if it is safe for you to donate and the likelihood of needing a transfusion based on your surgery and current transfusion guidelines. Receiving your own blood may reduce, but will not eliminate, the risk of transfusion-related complications. Insurance company policies may vary regarding reimbursement for this service. Overall, although autologous donation is an option to consider for those who qualify, the number of autologous donations in the United States has significantly decreased in the last few decades mainly due to major advances in blood safety and efforts to decrease unnecessary blood transfusions.

Directed donation refers to blood collected from "directed donors" who are donating blood for a specific patient by request. Directed donors are often family and friends of the patient. Directed donors go through the same qualification process as volunteer donors. Directed donations are not considered to be safer than the general blood supply.

Referencias:

- Circular de información para el uso de sangre humana y componentes sanguíneos. AABB. Noviembre de 2013 (revisada en abril de 2014).
- Manual técnico de AABB. 18ª edición

Este folleto fue desarrollado por el Departamento de Salud Pública de California, Servicios de Laboratorios (850 Marina Bay Parkway, Richmond, CA 94804).

En asociación con el Comité de Asesoría Técnica Médica (en inglés, Medical Technical Advisory Committee) de los Bancos de Sangre de California.

Para más información sobre el contenido del folleto, llame a Servicios de Laboratorio al (213) 620-6574

SAMPLE

Este folleto se proporciona como fuente de información y no se considera un reemplazo del proceso de Consentimiento Informado previo a la transfusión de sangre.

Distribuido por la
Junta Médica de California

Para solicitar este folleto, envíe por Fax su pedido al:
(916) 263-2497

Esta información se puede obtener de forma electrónica en la página:

http://www.mbc.ca.gov/Publications/Brochures/Blood_Transfusions.aspx

Revisado el 06/2018.

Una guía para el paciente sobre la transfusión de sangre

Departamento de Salud Pública de California
Junio de 2018

SAMPLE

Este documento proporciona información escrita sobre los beneficios, riesgos y alternativas de la transfusión de productos sanguíneos (incluyendo glóbulos rojos, plasma, plaquetas u otros) que hayan sido extraídos del paciente (transfusión autóloga) u otra persona. Este material es complementario a la conversación que usted tiene con su médico. Es importante que comprenda totalmente esta información, por lo que debe leer este documento a fondo. Si tiene alguna pregunta con respecto al procedimiento, consulte con su médico antes de firmar el consentimiento para recibir la transfusión.

Información sobre el tratamiento

Las transfusiones de productos sanguíneos se proporcionan para aumentar la cantidad de componentes sanguíneos en su cuerpo, cuando estos se encuentran por debajo del nivel razonable para su salud. La transfusión puede estar compuesta de glóbulos rojos, plasma, plaquetas u otros productos especiales de la sangre. Su médico decidirá la cantidad y el tipo de productos sanguíneos correctos basándose en su diagnóstico o estado de salud.

Beneficios potenciales del tratamiento

La transfusión de productos sanguíneos puede ser necesaria para corregir niveles bajos de componentes sanguíneos en su cuerpo y también puede hacerlo sentir mejor. En algunos casos, no recibir una transfusión puede causar la muerte.

Riesgos del tratamiento

Los riesgos conocidos de este tratamiento incluyen, entre otros:

- Irritación, dolor o infección en el sitio de inserción de la aguja; y
- Reacciones temporales como fiebre, escalofríos o erupciones en la piel.

Otras complicaciones raras pero más serias incluyen reacciones alérgicas graves, insuficiencia cardíaca debido a la sobrecarga de fluidos, edema pulmonar agudo (fluido en los pulmones), hemólisis (destrucción de los glóbulos rojos), estado de shock o la muerte.

La transfusión de productos sanguíneos conlleva un riesgo muy bajo de transmisión de enfermedades infecciosas, como VIH (alrededor de 1 en 1.500.000), Hepatitis C (alrededor de 1 en 1.200.000) y Hepatitis B (1 en 1.000.000). Otras infecciones importantes también se pueden transmitir a través de la transfusión sanguínea, pero el riesgo general es bajo.

Opciones de tratamiento/ Alternativas

Si necesita sangre, tiene varias opciones. La mayoría de los pacientes que requieren una transfusión reciben productos sanguíneos de donantes voluntarios de la comunidad. Estos donantes son evaluados en profundidad acerca de su historia clínica y pasan muchos exámenes de sangre, de conformidad con las normas estatales y federales, para así garantizar un suministro sanguíneo lo más seguro posible. Las alternativas a la transfusión de productos sanguíneos donados por voluntarios de la comunidad incluyen:

- Donación de sangre autóloga preoperatoria (utilizar su propia sangre previamente donada), vea abajo para más información.
- Donación dirigida (sangre donada por personas a quienes usted le pidió que le donen sangre), ver abajo para más información.
- Transfusión autóloga intraoperatoria/ Hemodilución (extraer su propia sangre durante la cirugía para que le sea suministrada nuevamente).
- Medicación (ciertos medicamentos pueden aumentar el volumen sanguíneo antes de una cirugía o reducir el sangrado activo para disminuir la necesidad de transfusiones).

Estas opciones pueden estar disponibles para usted solo si su salud, el tiempo y el procedimiento así lo permiten. Puede que no estén disponibles en todas las ubicaciones o para todos los pacientes. También podrá elegir no recibir una transfusión sanguínea. Sin embargo, esta decisión puede tener consecuencias que pongan en peligro su vida.

La donación autóloga preoperatoria no es apropiada para todos los pacientes. Este método requiere extraer su propia sangre antes de una cirugía planeada para que sea almacenada en el banco de sangre del hospital. Es importante que discuta con su médico si es seguro para usted donar y las probabilidades de que necesite una transfusión según la cirugía y los manuales de transfusión actuales. Recibir su propia sangre puede reducir, pero no eliminará, el riesgo de complicaciones relacionadas con las transfusiones. Las pólizas de las compañías de seguros pueden variar con respecto a los reembolsos por este servicio. En general, aunque la donación autóloga es una opción a considerar para quienes califican, el número de donaciones autólogas en los Estados Unidos ha aumentado significativamente en las últimas décadas principalmente debido a los grandes avances en la seguridad sanguínea y los esfuerzos para disminuir las transfusiones de sangre innecesarias.

La donación dirigida refiere a sangre extraída de "donante directos" que donan sangre para un paciente especifico por solicitud. Los donantes directos por lo general son familiares y amigos del paciente. Estos donantes directos pasan por el mismo proceso de cualificación que los donantes voluntarios. Las donaciones dirigidas no se consideran más seguras que el suministro general de sangre.

Tri-City Medical Cent
Oceanside, California

RETIRE – Automatically Documented (plotted) in Electronic Health Record (EHR)

PATIENT CARE SERVICES

ISSUE DATE:	**10/07**	**SUBJECT:**	**Growth Chart Documentation for Pediatrics, Adolescents, and Neonates**

REVISION DATE~~(S)~~: 10/10, 01/11, 01/15, 06/19

Patient Care Services Content Expert Approval:	**~~08/17~~10/22**
Clinical Policies & Procedures Committee Approval:	**~~01/19~~11/22**
Nursing Leadership ~~Executive Committee~~ Approval:	**~~01/19~~01/23**
Department of Pediatrics Approval:	**~~04/19~~02/23**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~05/19~~02/23**
Administration Approval:	**~~06/19~~03/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**06/19**

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

1. ~~Monitoring of growth (weight and length/heightand head circumference of neonates, infants, pediatric, and adolescent patients (up to twenty-one [21] years of age) is necessary to evaluate nutrition status, growth, and appropriateness of nutrition intake.~~

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

1. ~~Nursing shall document (plot) weight and height/length data on predetermined growth charts for all neonate, infant, pediatric, and adolescent patients.~~
   a. ~~Weight and height/length data shall be plotted on admission and as indicated.~~
   b. ~~Head circumference for infants, neonates, and children less than three years of age, shall be plotted on admission.~~
      i. ~~Head circumference shall be monitored after admission per physician/Allied Health Professional (AHP) order.~~
2. ~~Growth Charts used for specific age groups are as follows per Center for Disease (CDC) recommendations and shall be added to the medical record:~~
   a. ~~Term Infant boys (birth to twenty-four [24] months):~~
      i. ~~Length–for–Age and Weight–for–Age, 3 – 97th Percentiles~~
      ii. ~~Head circumference–for–Age and Weight–for–Length, 3 – 97th Percentiles~~
   b. ~~Term Infant girls (birth to twenty-four [24] months):~~
      i. ~~Length–for–Age and Weight–for–Age, 3 – 97th Percentiles~~
      ii. ~~Head circumference–for–age and Weight–for–length, 3 – 97th Percentiles~~
   c. ~~Children and adolescent boys (two [2] to twenty-one [21] years):~~
      i. ~~Stature–for–Age and Weight–for–Age, 3 – 97th Percentiles~~
      ii. ~~Body Mass Index (BMI)–for–Age, 3 – 97th Percentiles~~
      iii. ~~Cerner: Weight by age percentile for boys aged two (2) – twenty (20) years~~
      iv. ~~Cerner: Stature by age percentile for boys aged two (2) – twenty (20) years~~
   d. ~~Children and adolescent girls (two (2) to twenty-one [21] years):~~
      i. ~~Stature–for–Age and Weight-for-Age, 3 – 97th Percentiles~~
      ii. ~~BMI–for–Age, 3 – 97th Percentiles~~
      iii. ~~Cerner: Weight by age percentile for girls aged two (2) – twenty (20) years~~
      iv. ~~Cerner: Stature by age percentile for girls aged two (2) – twenty (20) years~~
   e. ~~Fenton Fetal-Infant Growth Chart for Preterm Infants (Fenton Growth Chart Form #6070-1015)~~

i. Infant boys (Twenty two [22] weeks to fifty [50] weeks - Gestational age (weeks)
1) Length–for–Age and Weight–for–Age, 10 – 97th Percentiles
2) Head circumference–for–Age and Weight–for–Length, 3 – 97th Percentiles

ii. Infant girls (Twenty two [22] weeks to fifty [50] weeks - Gestational age (weeks)
1) Length–for–Age and Weight–for–Age, 10 – 97th Percentiles
2) Head circumference–for–age and Weight–for–length, 3 – 97th Percentiles

A. **FORM(S):**

1. 2 to 20 Years: Boys Stature-for-Age and Weight-for-Age Percentiles and Boys Body Mass Index-for-Age Percentiles 6290-1021 - Sample
2. 2 to 20 Years: Girls Stature-for-Age and Weight-for-Age Percentiles and Girls Body Mass Index-for-Age Percentiles 6290-1019 - Sample
3. Birth to 36 Months: Boys Length-for-Age and Weight-for-Age Percentiles and Boys Head Circumference-for-Age and Weight-for-Length Percentiles 6290-1020 - Sample
4. Birth to 36 Months: Girls Length-for-Age and Weight-for-Age Percentiles and Girls Head Circumference-for-Age and Weight-for-Length Percentiles 6290-1018 - Sample
5. Fenton Growth Chart 6070-1015 – Sample
6. Fenton Preterm Growth Chart – Boys – Sample
7. Fenton Preterm Growth Chart – Girls – Sample
8. Classification of Newborns – Based on Maturity and Intrauterine Growth - Sample

B. **REFERENCE(S):**

1. American Academy of Pediatrics and The American College of Obstetricians and Gynecologists. (2012). *Guidelines for Perinatal Care* (7th ed.).
2. *Gestational Charts and Growth Charts.* (2015). Retrieved Jan 20, 2015, from Meadjohnson: http://www.meadjohnson.com/pediatrics/us-en/nurse-connections/helping-moms-and-babies/gestational-growth-charts
3. Simpson, K. R., & Creehan, P. A. (2014). *Perinatal Nursing* (4th ed.). N.p.: Lippincott Williams & Wilkins.

2 to 20 Years: Boys Stature-for-Age and Weight-for-Age Perce[ntiles and BMI-inde]x-for-Age Percentiles #6290-1021 - Sample

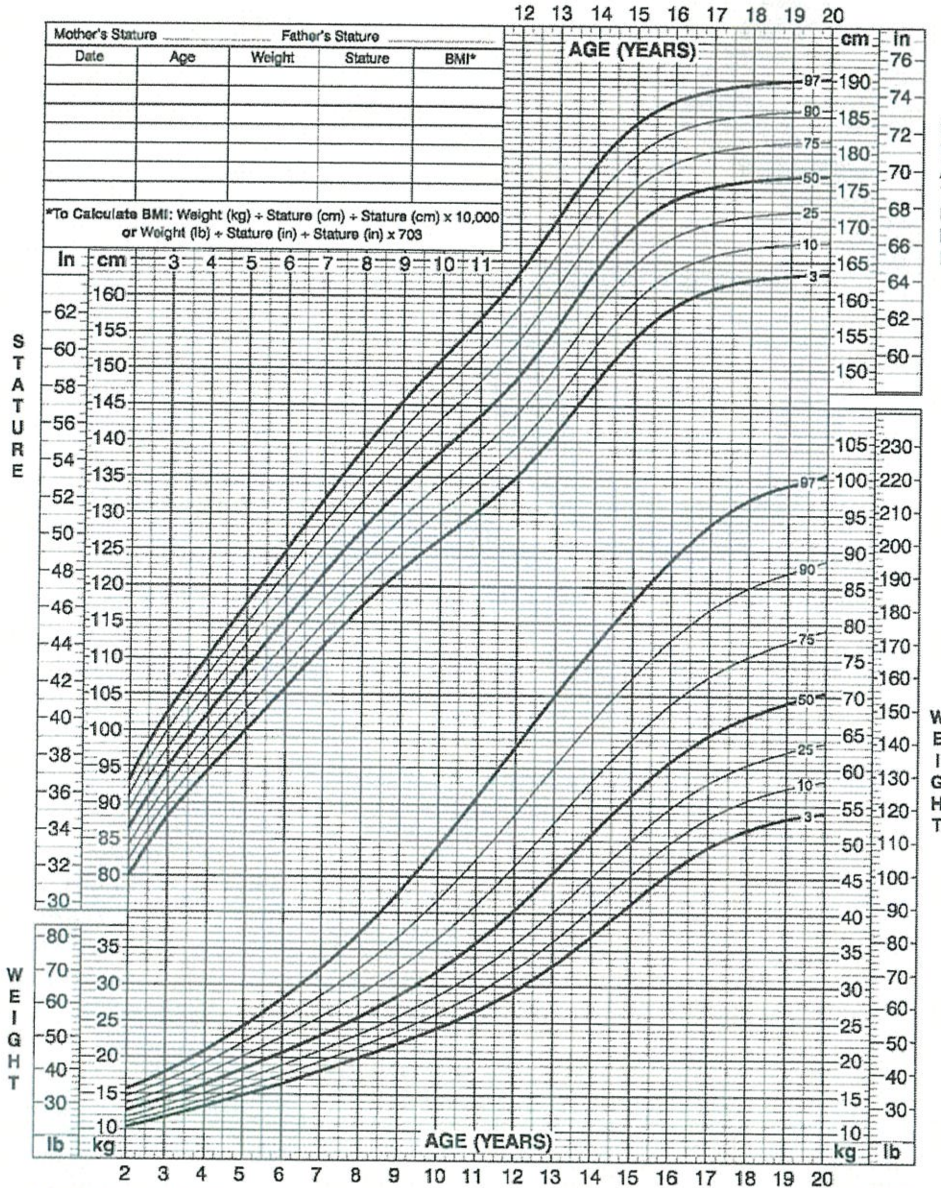
RETIRE – Automatically Documented (plotted) in Electronic Health Record (EHR)

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

2 to 20 years: Boys
Stature-for-age and Weight-for-age percentiles

NAME ____________

RECORD # ____________



Published May 30, 2000 (modified 11/21/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

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6290-1021
(Rev 12/07)

2 TO 20 YEARS: BOYS STATURE-FOR-AGE AND WEIGHT-FOR-AGE PERCENTILES

RETIRE – Automatically Documented (plotted) in Electronic Health Record (EHR)

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

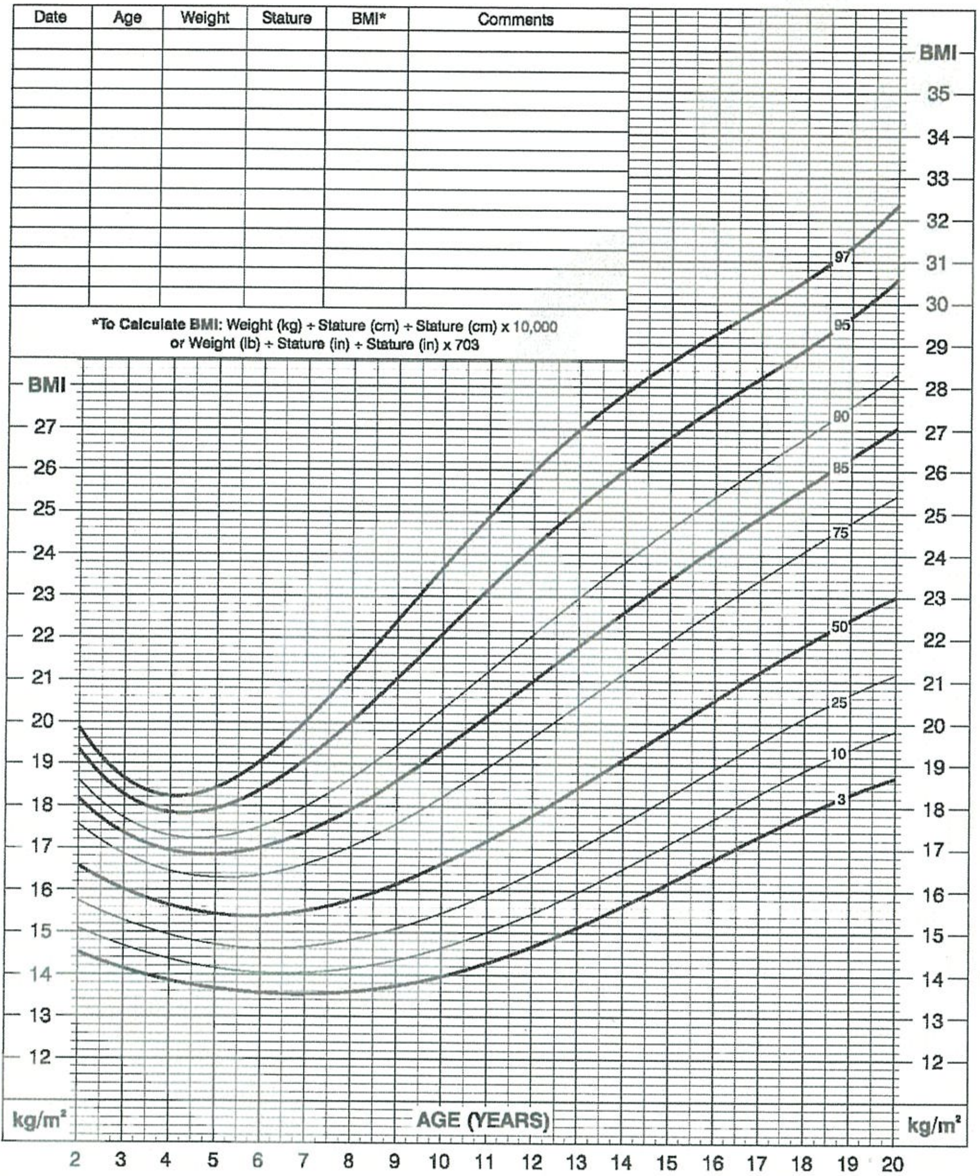
2 to 20 years: Boys
Body mass index-for-age percentiles

NAME ____________

RECORD # ____________

Date	Age	Weight	Stature	BMI*	Comments

*To Calculate BMI: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



Published May 30, 2000 (modified 10/16/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

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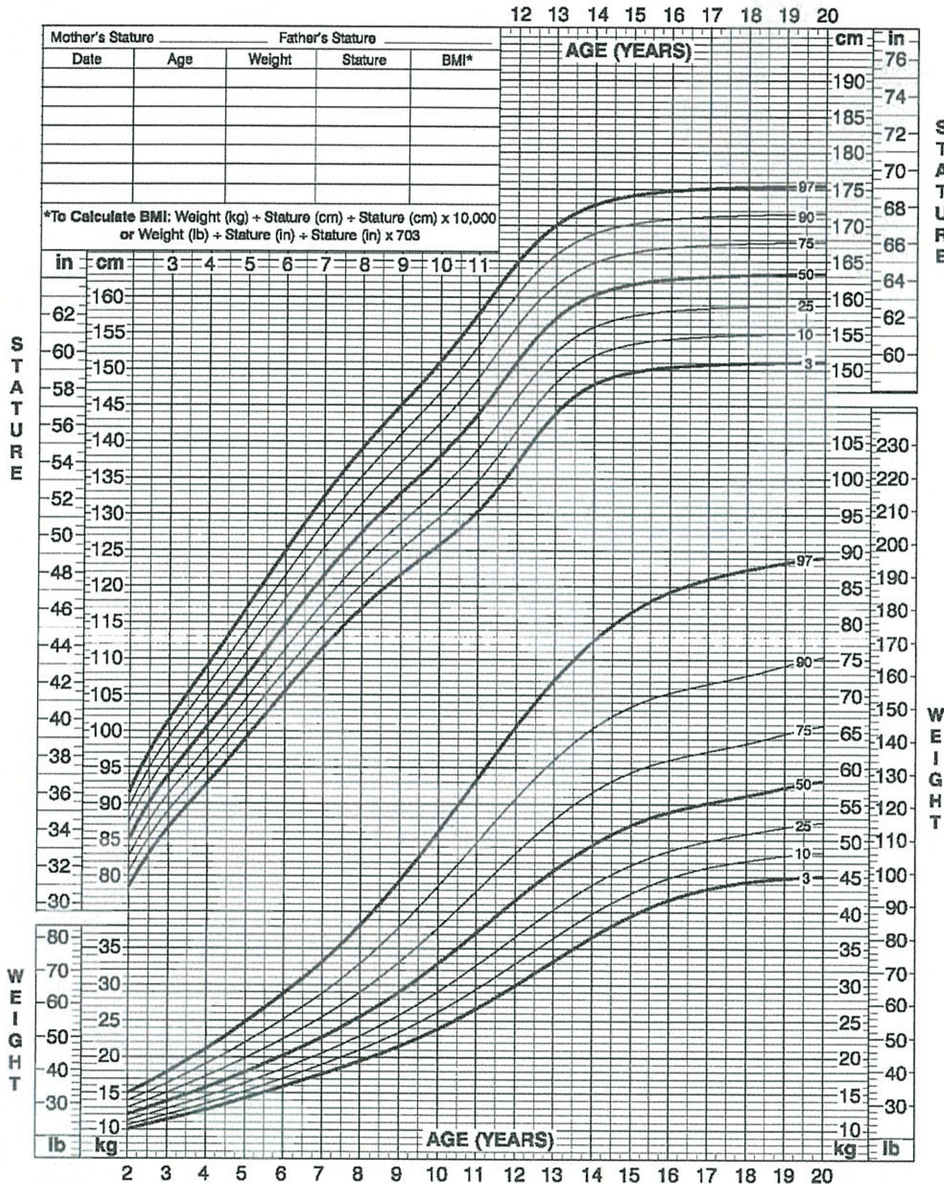
2-20 YEARS: BOYS
BODY MASS INDEX-FOR-AGE
PERCENTILES

2 to 20 Years: Girls Stature-for-Age and Weight-for-Age Percer[...]ge Percentiles #6290-1019 - Sample

RETIRE – Automatically Documented (plotted) in Electronic Health Record (EHR)



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(Rev 12/07)

2 TO 20 YEARS: GIRLS
STATURE-FOR-AGE AND
WEIGHT-FOR-AGE PERCENTILES

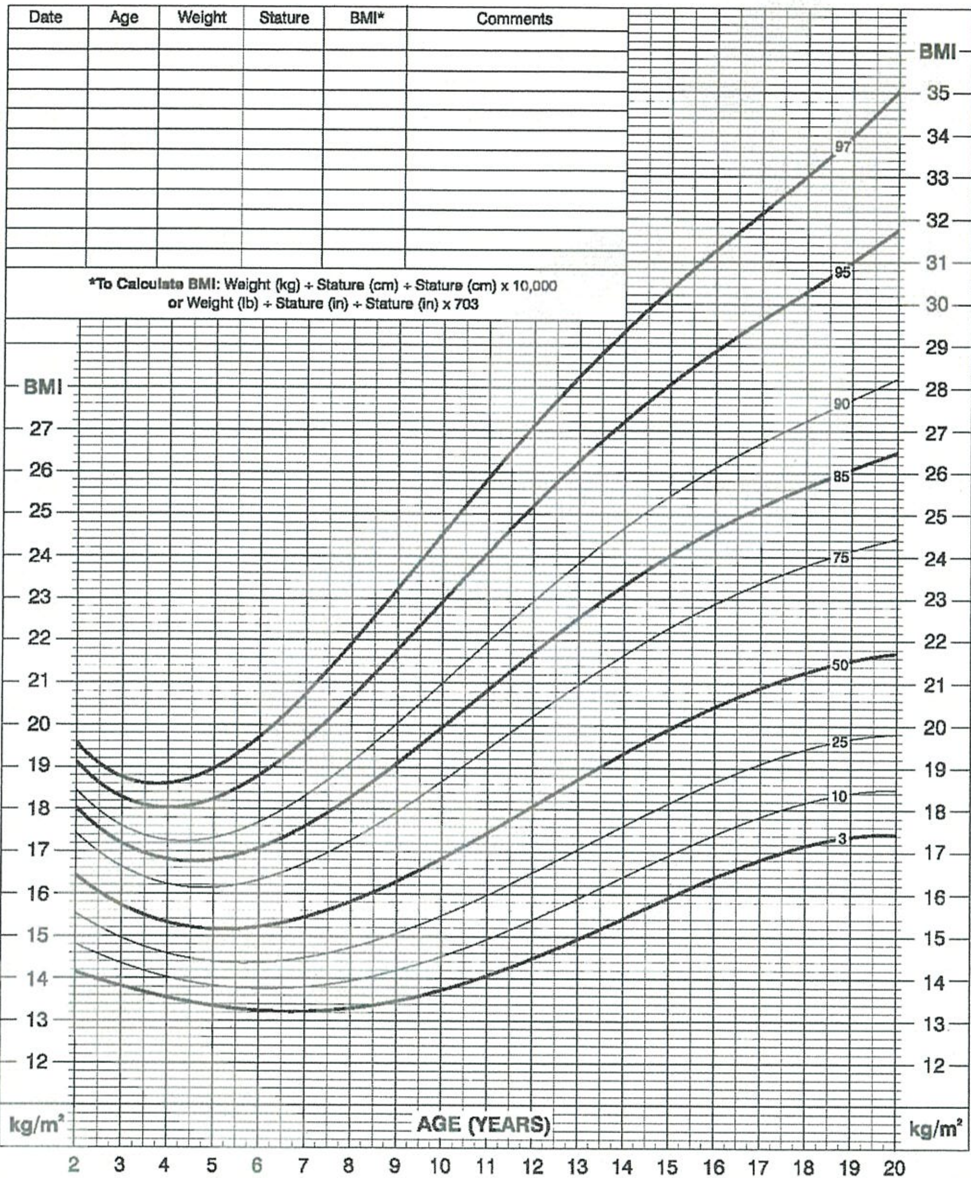
RETIRE – Automatically Documented (plotted) in Electronic Health Record (EHR)

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

2 to 20 years: Girls
Body mass index-for-age percentiles

NAME ______________________

RECORD # ______________



Published May 30, 2000 (modified 10/16/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
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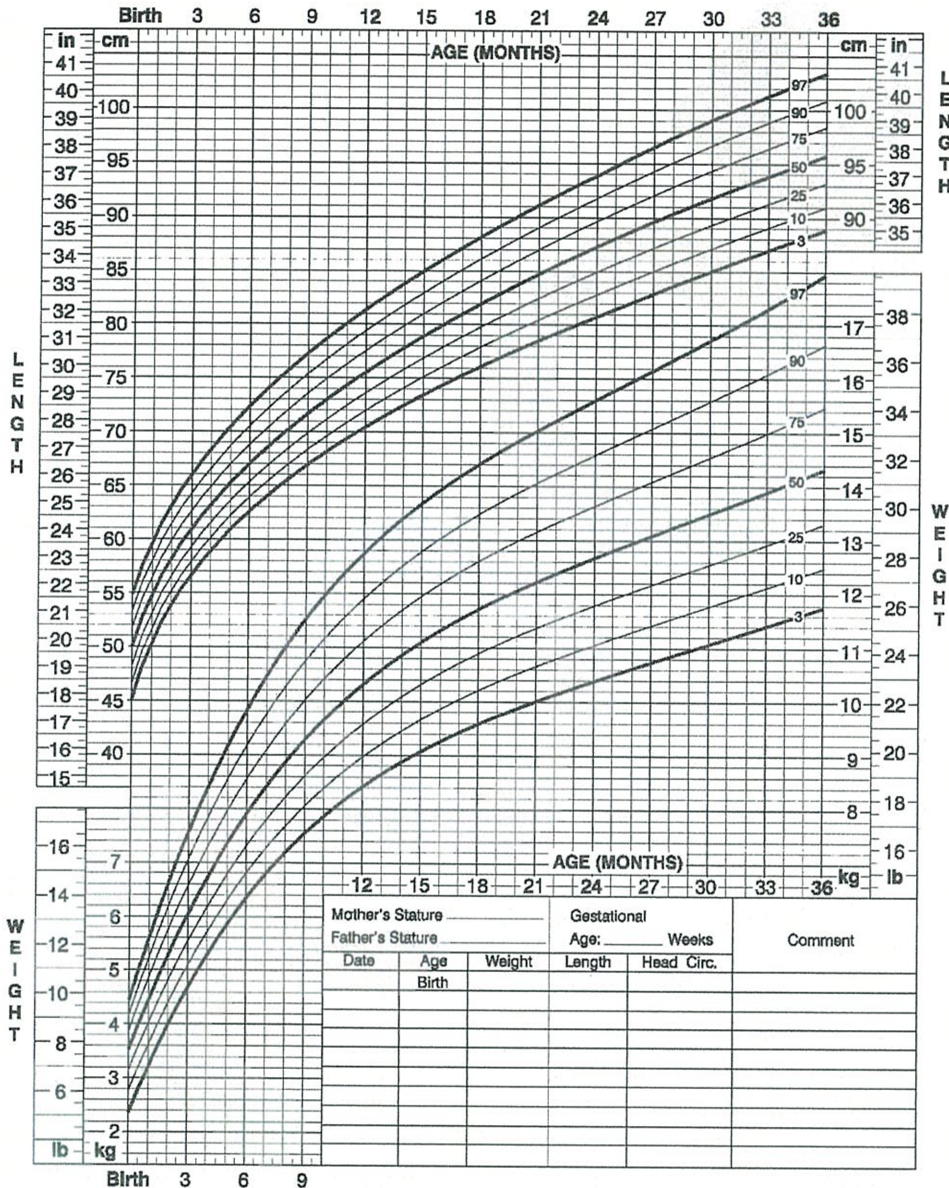
**2 TO 20 YEARS: GIRLS
BODY MASS INDEX-FOR-AGE
PERCENTILES**

Birth to 36 Months: Boys Length-for-Age and Weight-for-Age Per[centiles and Head] Circumference-for-Age and Weight-for-Length Percentiles #6290-

RETIRE – Automatically Documented (plotted) in Electronic Health Record (EHR)



Published May 30, 2000 (modified 4/20/01).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000). http://www.cdc.gov/growthcharts

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6290-1020
(Rev 12/07)

BIRTH TO 36 MONTHS: BOYS LENGTH-FOR-AGE AND WEIGHT-FOR-AGE PERCENTILES

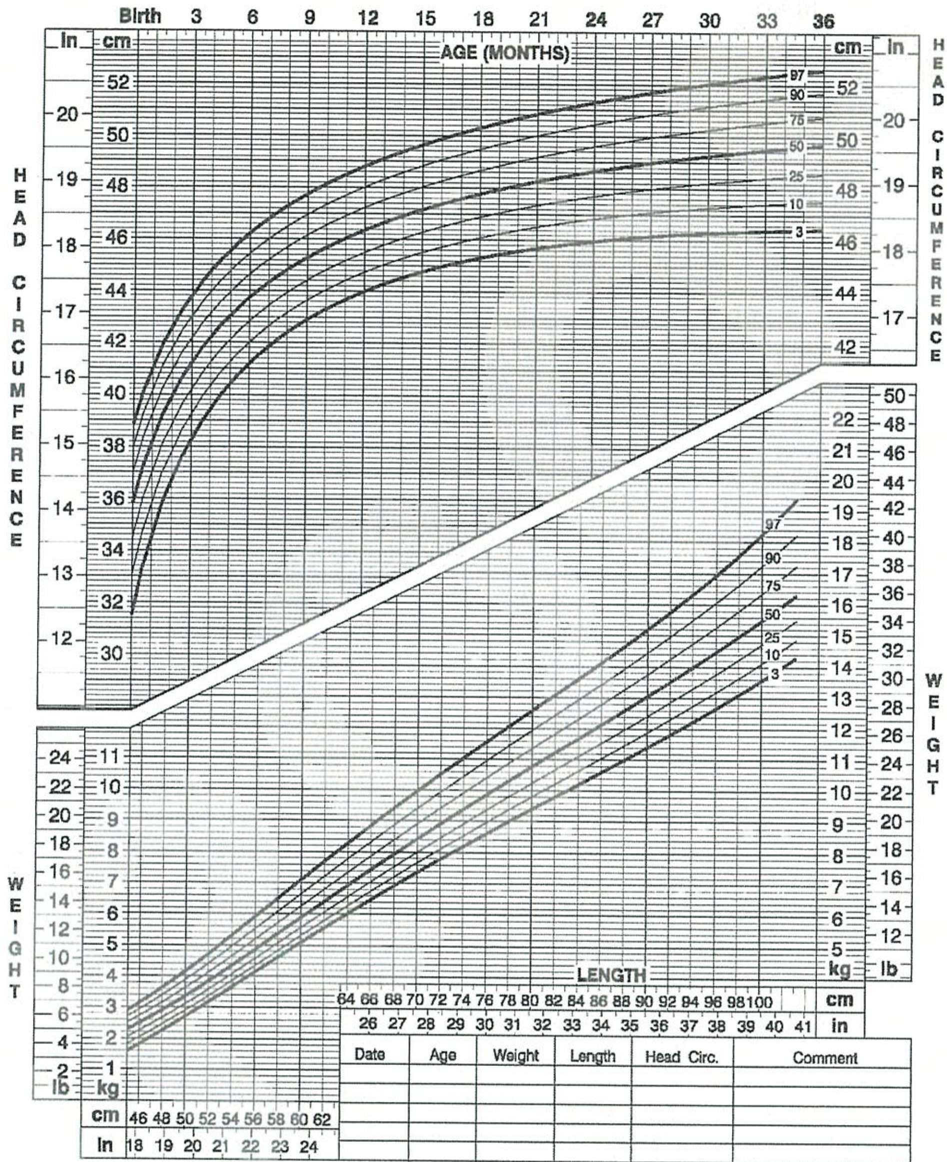
RETIRE – Automatically Documented (plotted) in Electronic Health Record (EHR)

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

Birth to 36 months: Boys
Head circumference-for-age and
Weight-for-length percentiles

NAME ______________________

RECORD # ______________



Date	Age	Weight	Length	Head Circ.	Comment

Published May 30, 2000 (modified 10/16/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
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6290-1020
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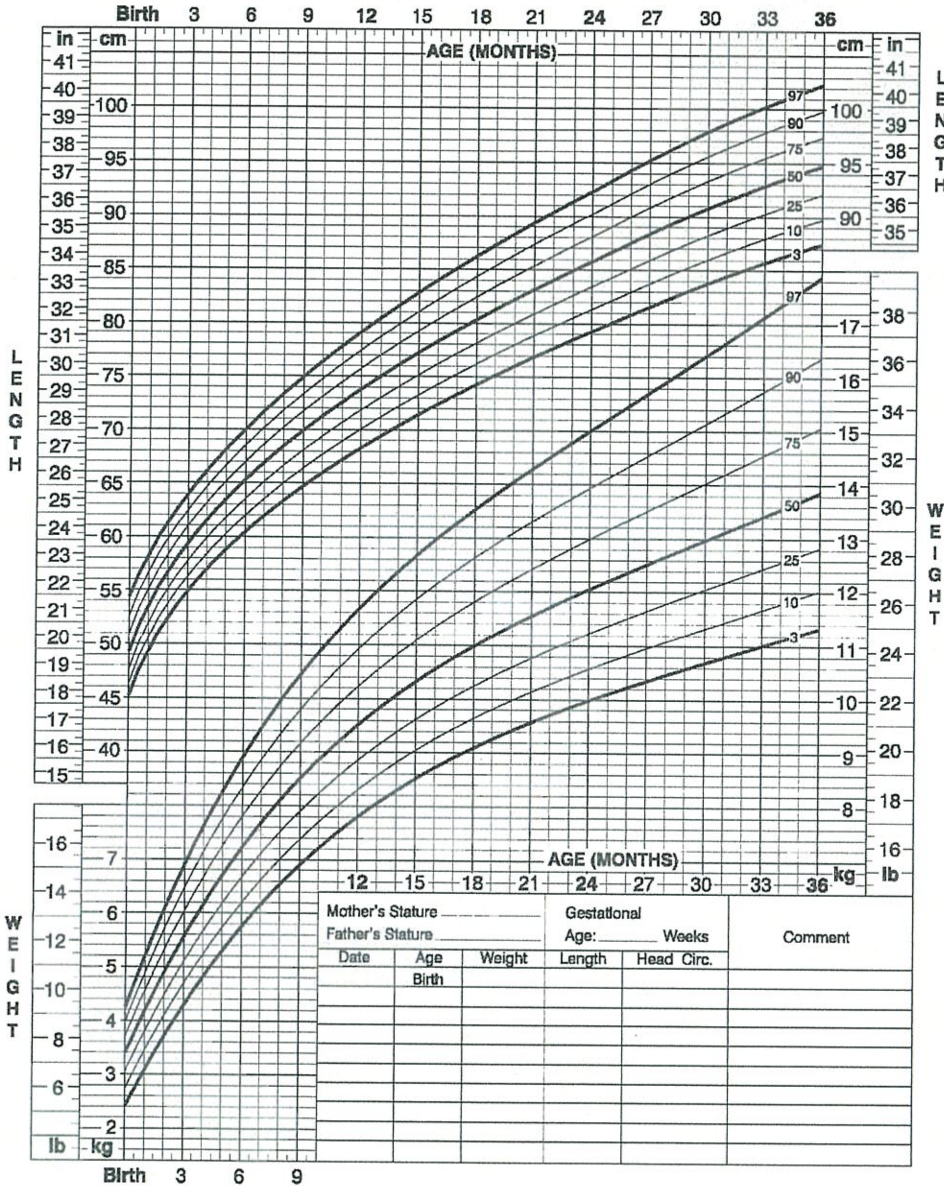
BIRTH TO 36 MONTHS: BOYS
HEAD CIRCUMFERENCE-FOR-AGE AND
WEIGHT-FOR-LENGTH PERCENTILES

RETIRE – Automatically Documented (plotted) in Electronic Health Record (EHR)

Birth to 36 Months: Girls Length-for-Age and Weight-for-Ag Circumference-for-Age and Weight-for-Length Percentiles



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BIRTH TO 36 MONTHS: GIRLS LENGTH-FOR-AGE AND WEIGHT-FOR-AGE PERCENTILES

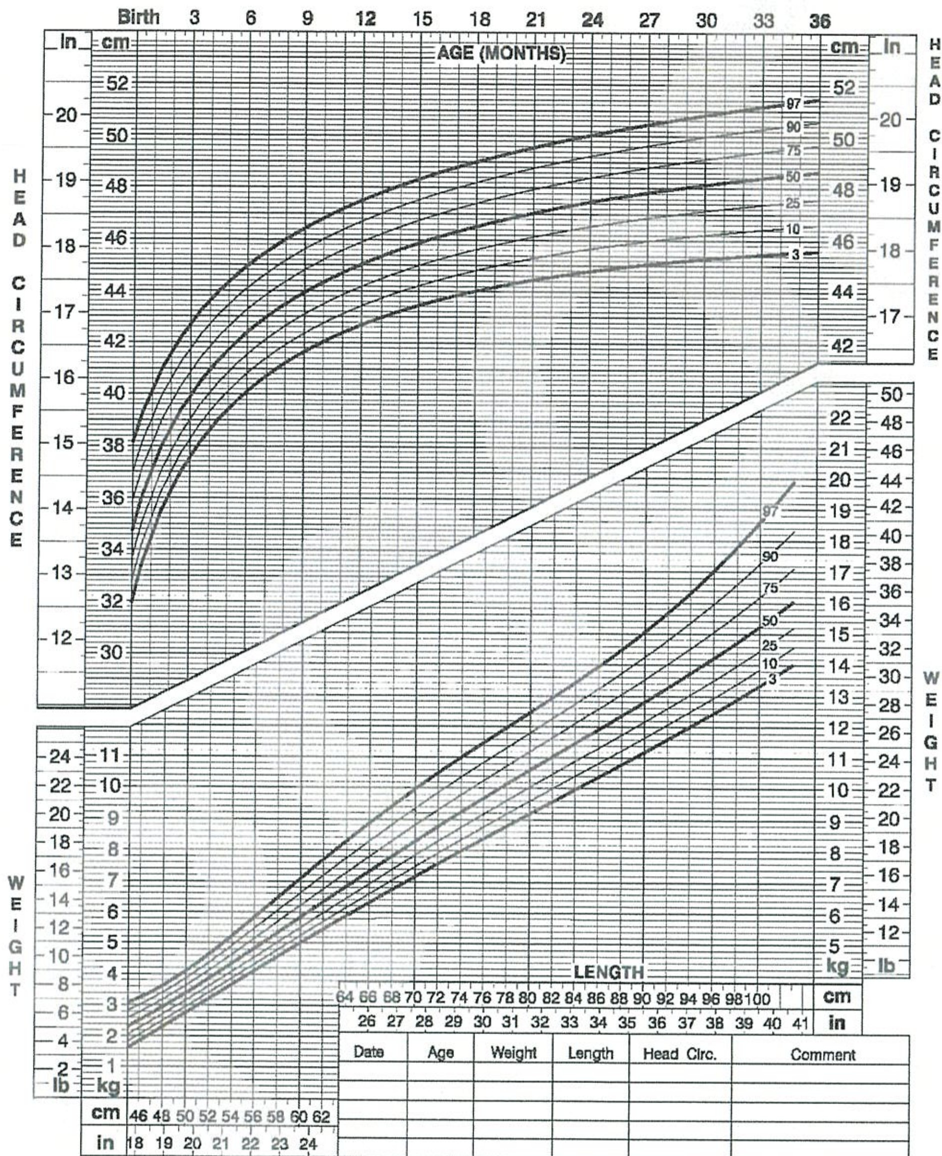
RETIRE – Automatically Documented (plotted) in Electronic Health Record (EHR)

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

Birth to 36 months: Girls Head circumference-for-age and Weight-for-length percentiles

NAME ____________

RECORD # ____________



Date	Age	Weight	Length	Head Circ.	Comment

Published May 30, 2000 (modified 10/16/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
http://www.cdc.gov/growthcharts

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BIRTH TO 36 MONTHS: GIRLS HEAD CIRCUMFERENCE-FOR AGE AND WEIGHT-FOR-LENGTH PERCENTILES

Fenton Growth Chart #6070-1015 - Sample

RETIRE – Automatically Documented (plotted) in Electronic Health Record (EHR)

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

Fetal-Infant G

Length

Head Circumference

Weight

Centimeters: 20, 25, 30, 35, 40, 45, 50, 55, 60, 65

Weight (kilograms): 0, 0.5, 1, 1.5, 2, 2.5, 3, 3.5, 4, 4.5, 5, 5.5, 6

Plot growth in terms of completed weeks of gestation.

Sources: Intrauterine weight - Kramer MS et al (ePediatr 2001); Length and Head circumference - Niklasson A et al (Acta Pediatr Scand 1991) and Beeby PJ et al (J Paediatr Child Health 1996). Post term sections - the CDC Growth Charts, 2000. The smoothing of the disjunction between the pre and post term sections generally occurs between 36 and 46 weeks.

Date: 22 24 26 28 30 32 34 36 38 40 42 44 46 48 50

Gestational age (weeks)

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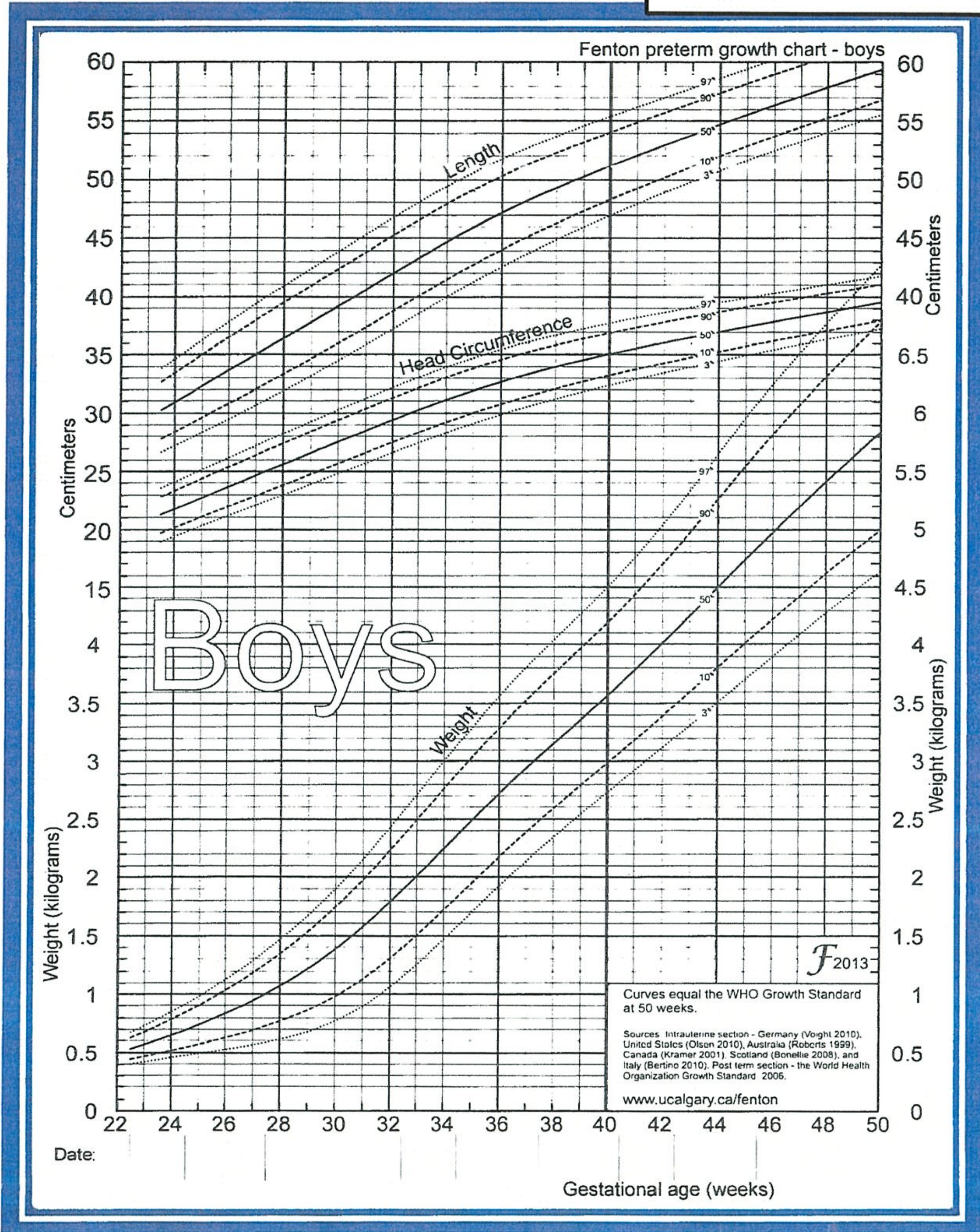
FENTON GROWTH CHART

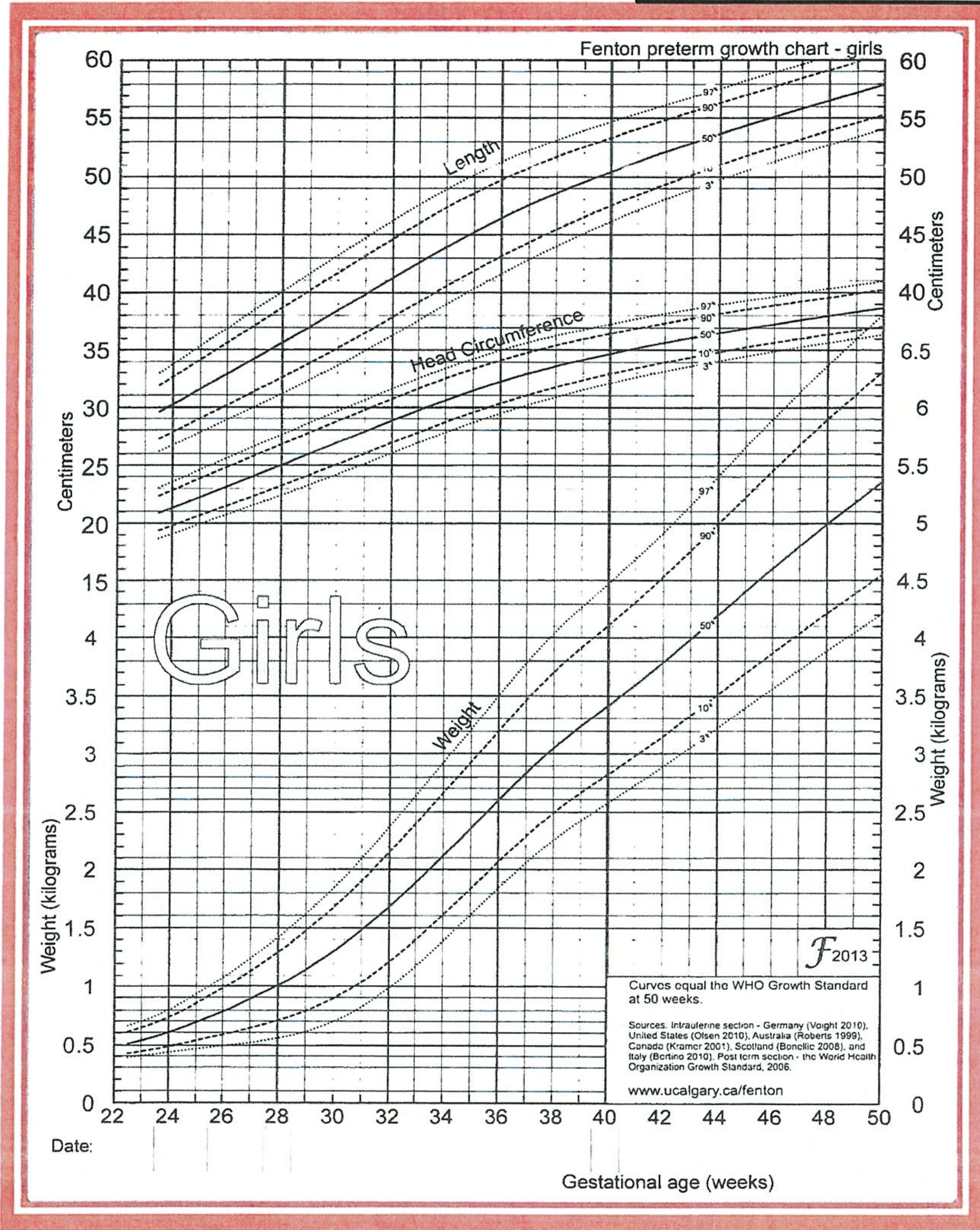
Fenton Preterm Growth Chart – Boys – Sample

RETIRE – Automatically Documented (plotted) in Electronic Health Record (EHR)



RETIRE – Automatically Documented (plotted) in Electronic Health Record (EHR

Fenton Preterm Growth Chart – Girls – Sample



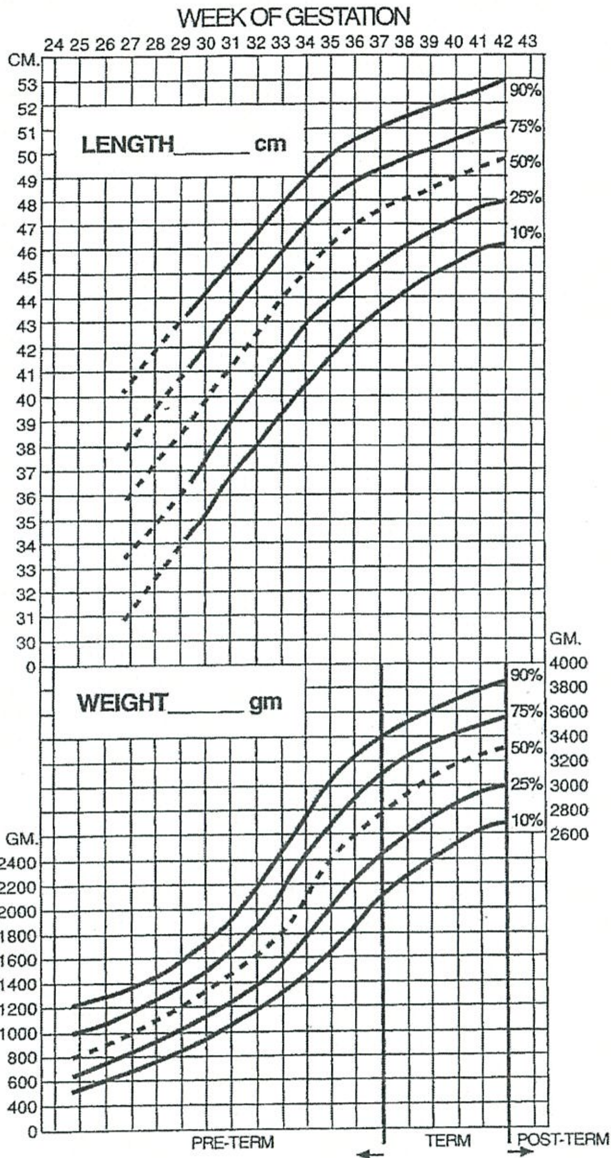
Classification of Newborns – Based on Maturity and Intrauterine

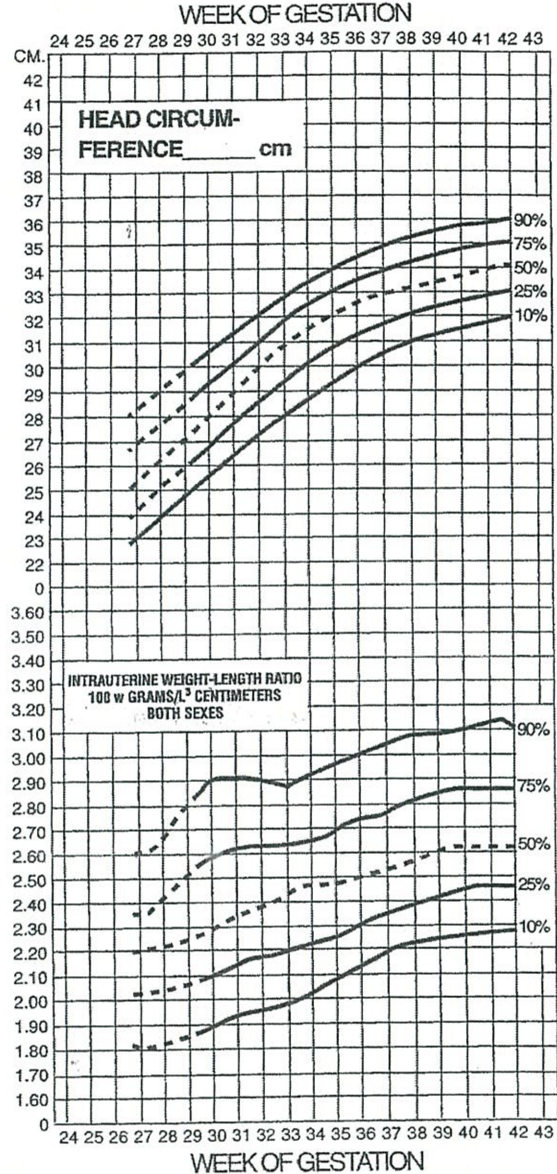
RETIRE – Automatically Documented (plotted) in Electronic Health Record (EHR)

CLASSIFICATION OF NEWBORNS - BASED ON MATURITY AND INTRAUTERINE GROWTH

Side 2

Symbols: X - 1st Exam O - 2nd Exam





	1st Exam (X)	2nd Exam (O)
LARGE FOR GESTATIONAL AGE (LGA)		
APPROPRIATE FOR GESTATIONAL AGE (AGA)		
SMALL FOR GESTATIONAL AGE (SGA)		
Age at Exam	hrs	hrs
Signature of Examiner	M.D./R.N.	M.D./R.N.

Adapted from Lubchenco LO, Hansman C, and Boyd E: *Pediatr.* 1966;37:403; Battaglia FC, and Lubchenco LO: *J Pediatr.* 1967;71:159.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	~~IV SOLUTION,~~ **WARMING & REFRIGERATION OF STERILE SOLUTIONS~~FLUIDS~~**
Purpose:	To provide guidelines for warming and refrigeration of ~~IV~~**sterile** solution**s** ~~bagsArthromatic and Uromatic irrigation solution bags, and plastic irrigation solution containers.~~

A. **PROCEDURE:**

1. It is recommended that IV solution bags, plastic irrigation solution containers (sterile water and saline) and irrigation solution bags be stored at room temperature 77ºF (25ºC) and excessive heat should be avoided; however, IV **and irrigation** solution bags **and plastic irrigation solution containers** of volumes greater than 150mL may be placed in monitored warming units per manufacturer guidelines.
2. Warming units:
    a. The temperature of all solution warming units shall be monitored daily and recorded. If the temperature has risen above the acceptable set limit, the solutions shall be discarded.
    b. All flexible solution bags shall remain in their overwrap/overpouch until use to ensure solution integrity is maintained. Elevated temperatures increase water vapor transmission and therefore may result in decreased volumes with increased solute concentration. Such effects can be minimized when the overwrap/overpouch is left in place.
    c. The manufacturer's expiration date and the warmer expiration date must both be checked and verified as current for all solutions prior to use.
    d. All solutions must be visually inspected for discoloration and/or bottle distortion prior to use. Visual changes should not occur if temperatures remain below the maximum limits.
3. The use of autoclaves or microwave oven radiation to warm or thaw solutions is not allowed.
4. Contrast:
    a. Contrast materials may be maintained in a controlled temperature warmer not exceeding 37°C in their original packing unopened for up to 30 days.
    b. Contrast that is **infrequently used**~~slow moving~~ may require a rotation schedule to minimize warming time.
    c. Contrast shall be dated before placing in the warmer.
    d. Expiration dates shall be checked **prior to use and expired solutions** ~~every Monday and solutions that expire before the next Monday~~ shall be removed and discarded.
    e. Discoloration may occur if contrast remains in the warmer for extended time periods.
    f. After 30 days in the warmer, contrast material shall be discarded.
5. Refrigeration:
    a. All solutions (IV and irrigation, bags and bottles) may be refrigerated for up to six (6) months.
    b. All solutions in the refrigerator must be tagged and dated with this 6-month expiration date.
    c. Acceptable refrigerator temperature range is 36-46°F (2-8°C).
    d. Discard solutions that have not been used by the 6-month refrigeration expiration date or manufacturer's expiration date, whichever occurs first.

B. **FORM(S):**

1. Refrigerator Temperature Monitoring Log **Drugs**
2. **Fluid** Warmer Temperature Monitoring Log

Patient care Services Content Expert	Clinical Policies & Procedures Committee	Nursing Leadership ~~Executive Council~~	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
07/09, 8/12, 05/18, **09/22**	08/12, 06/18, **11/22**	08/12, 07/18, **01/23**	n/a	07/18, **01/23**	09/12, 08/18, **02/23**	09/18, **03/23**	10/12, n/a	11/12, 09/18

C. **RELATED DOCUMENT(S):**
1. Solution Outdate Reference Guide

D. **REFERENCE(S):**
1. Puertos, E. (2014). Extended Stability of Intravenous 0.9% Sodium Chloride Solution After Prolonged Heating or Cooling. Hospital Pharmacy; 49(3): 269-272.

Tri-City Medical Center

ADVANCED HEALTH CARE...FOR YOU

FLUID WARMER TEMPERATURE MONITORING LOG

Year: ________ Month: ________ Location: -----

Guideline: Mark an "X" in the corresponding box for the observed temperature daily. Shaded area indicates that the temperature is outside the range
IF TEMPERATURE IS OUTSIDE OF ACCEPTABLE RANGE: 1) Notify Clinical Engineering @ x7148 and place a Work Order. 2) Relocate contents to an alternate location with appropriate temperature control. 3) Record actions taken and resolution.
IRRIGATION/IV SOLUTIONS require 59°F to 104°F (15°C to 45°C). All Irrigation/IV Solutions must be dated when placed in the warmer.

Temperature (°F)

FLUID WARMER (Lower Cabinet)

Temperature (°F)																															
116																															
112																															
108																															
104																															
100																															
96																															
92																															
88																															
84																															
80																															
76																															
72																															
68																															
64																															
60																															
56																															
52																															
48																															
Day of Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Problem/Action Resolution Documentation – Record with reference to above date. **KEEP THIS RECORD ON FILE FOR 36 MONTHS, THEN DISCARD.**

Date	Problem	Action Taken	Resolution Achieved

Revision 09/2018; 03.2020

Tri-City Medical Center
ADVANCED HEALTH CARE...FOR YOU

Year:
Location:

Refrigerator Temperature Monitoring Log (Drugs)

Definition: Drugs require 36F to 46F Food requires 41 or less
Cold = Refrigerator = 36 to 46 Fahrenheit (Same as 2 to 8 Centigrade)
Guidelines:
* Mark an "X" (NICU Initials) in the corresponding box for the observed temperature daily.
* Shaded area indicates that the temperature is outside the range; document corrective action.
* If temp is outside of range : 1.) Adjust thermostat & monitor results in 1 hour
  2.) If not correct within 1 hour contact Engineering @ 7148
  3.) Relocate contents to an alternative location with appropriate temperature control

* Contact Pharmacy Ext. 3012 , If quetions about stability of medications at room temperature.
* **Medication refrierators must be cleaned/Defrosted monthly. See documentation below.**

Note: If the small freezer setion is used for storage Use a seprate freezer log. If not used monitorung is not required. If unit closed on weekend or holiday, write closed in column

AM

Temperature (°F)

51																															
50																															
49																															
48																															
47																															
46																															
45																															
44																															
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Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

PM

Temperature (°F)

51																															
50																															
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Date	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

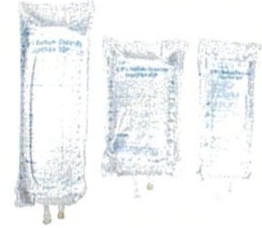
Problem/ Action/ Resolution- Record with reference to above date. Use reverse side to report additional problems

Date	Problem	Action Taken	Resolution Achieved

****Keep This Record for 36 Months then Discard****

Revision 09.2018

Tri-City Medical Center
ADVANCED HEALTH CARE...FOR YOU



SOLUTION OUTDATE REFERENCE GUIDE

REFRIGERATOR

- All solutions (IV and irrigation, bags and bottles) are good for **6 MONTHS** in the refrigerator.
- All solutions in the refrigerator must be tagged & dated with this 6-month expiration date.
- Acceptable refrigerator temperature range is 36-46°F (2-8°C).
- Discard solutions that have not been used by the 6 month refrigeration expiration date or manufacturer's expiration date (whichever occurs first).

WARMER

- Solutions may be warmed according to manufacturer guidelines (see grids below).
- All solutions in the warmer must be tagged & dated with the appropriate warmer expiration date.
- If the temperature in the warming unit rises above the acceptable range, all fluids must be discarded.
- Discard fluids that have not been used by the manufacturer's maximum time limit for warming or manufacturer's expiration date (whichever occurs first).

IV BAGS

Must remain in plastic overwrap

MANUFACTURER	MAXIMUM TEMPERATURE	MAXIMUM TIME LIMIT
B. Braun Excel	104°F (40°C)	4 weeks
Baxter Viaflex Solutions must be size 150mL or greater and must be more than 3 months from manufacturer expiration date.	104°F (40°C)	14 days

IRRIGATION BOTTLES

MANUFACTURER	MAXIMUM TEMPERATURE	MAXIMUM TIME LIMIT
B. Braun	104°F (40°C)	4 weeks
Baxter	122°F (50°C)	60 days

IRRIGATION BAGS

MANUFACTURER	MAXIMUM TEMPERATURE	MAXIMUM TIME LIMIT
B. Braun	150°F (66°C)	14 days
Baxter Arthromatic® & Uromatic® Solutions must remain in plastic overwrap and must be more than 3 months from manufacturer expiration date.	104°F (40°C)	14 days

References:

1. Baxter Healthcare Corporation Letter dated June 8, 2018
2. Baxter Healthcare Corporation Letter dated November 30, 2017
3. B. Braun Medical, Inc. Letter dated May 29, 2012
4. B. Braun Medical, Inc. Letter dated August 4, 2009

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**04/00**	**SUBJECT:**	~~**Lift Team**~~ **Patient Mobility Technician Services**
REVISION DATE(S):	**06/03, 09/05, 6/08, 08/11, 05/15 02/19, 08/20**		

Patient Care Services Content Expert Approval:	~~**02/20**~~**11/21**
Clinical Policies & Procedures Committee Approval:	~~**05/20**~~**12/21**
Nursing Leadership Approval:	~~**06/20**~~**03/22**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Administration Approval:	~~**07/20**~~**03/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/20**

A. **POLICY:**
1. Tri-City Healthcare District (TCHD) is committed to providing a safe environment for patients and staff. To minimize the risk of workplace injuries associated with the handling of patients, TCHD shall implement and maintain a safe patient handling policy for all patient care units.
2. This will include ~~Lift Team~~ **Patient** ~~Technicians~~**Mobility Technicians (PMT)** and safe patient handling procedures with mechanical lifting devices for every total body lift of non-ambulatory patients weighing more than 50 pounds.
   a. TCHD personnel shall not be required to lift non-ambulatory patients weighing more than 50 pounds by themselves, except in an urgent or emergent situation.
3. ~~Lift Team Technicians (LTT)~~ **PMT's** are available for lifting assistance in the hospital.
   a. When a ~~LTT~~ **PMT** is not available on a unit or outpatient area, the **Nurse Leader**~~Charge Nurse~~ **or** ~~,~~Registered Nurse (RN) ~~or Supervisor~~ shall obtain assistance with lifts ~~from other patient care areas as well as other unit staff.~~ **from clinical staff on the unit and/or use lift equipment.**
   ~~b. LTT **PMT** duties in Women and Newborns Services and Surgical Services are provided by the peri-operative aides as well as other unit staff **unless requested to ensure safe patient handling**.~~
4. ~~LTT~~ **PMT's** shall remain **available for requests outside of routine patient repositioning.** ~~on their designated units during working hours unless instructions are received from the unit's leadership team.~~
5. ~~LTT~~ **PMT's** shall respond to all Rapid Response Team (RRT), Code Blue, and Dr. Strong alerts to assist as needed.
   a. At the scene of the emergency event, ~~LTT~~ **PMT's** will be released to regular duty by ~~an Charge~~ **the** Nurse **Leader** or Administrative Supervisor (AS) if not needed
   b. ~~LTT~~ **The PMT** assigned to the Intensive Care Unit shall accompany the RRT or Code Blue RNs, and released to regular duty when directed.
6. RNs and Advanced Care Technicians (ACTs) are expected to assist in the transfer and repositioning of ambulatory patients not requiring full body lift (i.e., bed to chair/wheelchair, bed to commode, or floor to bed.)
   ~~c.~~**a. The RN will perform an assessment prior to the PMT team transferring a patient from the floor to the chair/bed.**
~~6.~~**7.** A RN or ACT shall be present when patients require repositioning by a **PMT** ~~LTT~~
8. ~~LTTs~~ **PMTs** shall follow the**se** practices **during the shift:** ~~of their unit for the following:~~

a. **Use the hospital hand held device for communication during the shift**

b. Change of shift task

- **i.** Obtain a brief shift hand-off to identify the patient's requiring repositioning **or proning from the off going PMT personnel.**

c. **Shift duties**

- **Please reference Patient Mobility Technician Guidelines to review recommended task.**~~**rovide patient transportation, transfer and discharge services while assisting nursing with patient lift requests.**~~
- ~~**Respond to routine tasks and priority requests timely.**~~
- ~~**Receives and acknowledges requests to utilize hospital lift equipment.**~~
- ~~**Effectively coordinates each lift procedure with the PMT members and nursing staff.**~~
- **i.** ~~**Educates the patient on lift procedure and expectations**~~**.**
- ~~i.~~ ~~**Completes documentation.**~~
- ~~ii.~~ ~~Assist with answering telephones and call lights during the RN and ACT shift hand-off on Acute Care Services and the Telemetry unit~~

~~c.~~**d.** Patient rounding times

- i. Scheduled rounds shall occur at least every two hours on assigned units
- ii. Initial the patient education/rounding board in the appropriate time space after repositioning a patient

~~d.~~**e.** ~~Lift Team Technicians~~ **PMTs** will be assigned **to the following units:**~~, when available, in the following manner:~~

- i. Women and Newborn Services
  - 1) Assist with the transport of patients from the Emergency Department when notified per department practices (i.e., pager system)
- ~~ii.~~ ~~Acute Care Services (ACS)~~
  - ~~1)~~**2)** ~~One LTT will be assigned to 4 Pavilion (4P) and one LTT will be assigned to 1 North (1N) on each day shift and will assist on 2P.~~
- **ii.** Intensive Care Unit:
  - **1)** **1 PMT will be assigned to the ICU to assist with patient mobility requests and routine repositioning**
    - **a)** **Depending upon census and acuity, additional team members will be available to assist as needed**
    - **b)** **PMT will complete the ICU checklist as directed**
- **iii.** **1 North, 2 Pavilion (2P), 4 Pavilion (4P) and Telemetry**~~**services**~~**:**
  - **1)** **PMTs will be assigned to** ~~**the following units to**~~ **assist with patient mobility requests and routine repositioning**
  - **2)** **Priority will be given to patient repositioning and complex lifts as needed**
- **iv.** **PMT members will be available as needed to assist with patient mobility in other departments**

9. PMT Dispatchers

a. **Prioritizes and manages the fluctuating patient census and requests**

b. **Ensures equipment is ready to use**

c. **Assists with the planning, coordinating and scheduling of staff and PMT activities**

d. **Maintains communications with PMT staff, the Administrative Supervisor and nursing leadership. Utilizes hospital hand held devices for communication.**

e. **Responds to requests and takes appropriate action to meet patient needs**

~~e.~~ **Collects shift data on patient mobility requests**

~~1)~~ ~~One LTT will be assigned to the 1East and one LTT will be assigned to 1West when rounds are completed~~

- ~~2)~~ ~~LTTs shall work together as needed~~
- ~~ii.~~ ~~Telemetry Unit:~~

~~1)~~**f.** ~~One LTT will be assigned to the second floor~~

~~2) One LTT will be assigned to the fourth floor~~
~~3) Both LTT will collaborate to assist with task on the third floor~~

~~7. Break and meal times~~
~~i. Follow unit practices~~
~~ii. Acute Care Services~~

~~b.~~**10.** ~~LTTs~~ **PMTs** will sign up for their lunch/break times on the designated break logs at the beginning of the shift.
~~1) LTTs will notify all ACS floors of their lunch/break times~~
~~ii. Telemetry~~
~~1) Sign-up for break by documenting your name in an allotted time on the break sheet.~~
~~2) One LTT will be on the unit all times~~

~~8.~~**11.** ~~The~~ **PMT** ~~LTT~~ personnel shall use a mechanical lifting device, when available, for every total body transfer. Equipment available may include:
a. Mechanical vertical or horizontal lifts
b. Full Length Slide Boards
c. Gait Belts
d. Mechanical Weighing Devices
e. Glide mat

~~9.~~**12.** The **PMT**~~Lift Team~~ shall be called for all lifts as specified in this policy on their assigned units **or as requested**~~.~~
a. Lifts are defined as total body transfers to and from:
i. Bed to chair/wheelchair
ii. Bed to gurney
iii. Bed to commode
iv. Floor to bed
v. Bed or chair to scale
vi. Any other lift where total body movement of the non-ambulatory patient is required.

~~10.~~**13.** Patient Safety
a. Prior to leaving a patient's room ensure the following:
i. Patient's room is clean and uncluttered
ii. Bedside tray within patient's reach
iii. Call button, television remote control and patient's other personal items are within their reach
iv. Patient's bed is in low position with upper side rails in the raised position
v. Patients are covered with a blanket or per their preference
vi. Ask if there is anything they can get for the patient

~~11.~~**14.** Performs the following task as directed by an RN and assist ACTs as directed by RN:
a. Assist ACTs and RNs with the following:
~~i. Admission and daily weights~~
~~ii.~~**i.** Positioning patients during baths
ii. Ambulating patients to bathroom that are potential risk for falls and the patient requires more assistance than one RN or ACT
~~iii.~~**1) Initial post-operative ambulation should be performed by the RN and ACT**
~~b. Answers telephones and patient call lights during the RN shift hand-off, Protected Time, Quiet Time and PRN as directed by RN or per unit practices~~
~~c.~~**b.** Answers patient's call lights and relays message to RN or ACT
~~d.~~**c.** Transport specimens to the lab
~~e.~~**d.** Transport patient belongings or equipment to other nursing departments
~~f.~~**e.** Pick up medications (not controlled substances) from the pharmacy department and transport to nursing unit as directed by a RN
~~g.~~**f.** Obtain blood products from Transfusion Services

~~h.~~**g.** Transfers inpatients to other inpatient nursing departments
h. Transports discharged patients to personal vehicles
i. **Assists with Emergency Department requests for patient mobility or admission transport for the bariatric patient**
j. Keeps halls free from clutter and ~~equipment~~ and ensures **lift** equipment is not placed near or blocking fire doors or entrance to patient's room
~~k.~~ Assist with positioning patients during bedside procedures and treatments as delegated by RNs
~~l. Assist with stocking supplies as directed by RN~~
~~m. Assist with inventorying supplies and equipment as directed by RN~~
~~n.~~**k.** ~~Other duties as assigned by RN/Charge Nurse~~

~~12.~~**15.** The ~~Lift Team~~ **PMT** shall respond to a priority lift ~~(in their designated area or when delegated by a Charge Nurse or Supervisor)~~ immediately or as soon as it is safe to leave their current patient assignment.

16. Personnel who do not comply with this policy may be subject to discipline under Administrative Policy, Employee Health and Safety.

~~13.~~**17. To the extent that any applicable collective bargaining agreement that is consistent with applicable law conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement prevails.**

~~B. **RELATED DOCUMENT(S):**~~
~~1. Lift Team Helpful Hints (ICU, Telemetry, and ACS)~~

Lift Team Helpful Hints (ICU, Telemetry, and ACS)

TIME	TASKS	HELPFUL HINTS
0700-0759 And 1900-1930	1. Obtain Shift Hand-off Remain near nurses' station during RN shift hand-off to assist with answering telephones and patient call lights	Breakfast ➢ Ask patients the following questions prior to leaving their rooms: 1. Would you like to sit in the chair or dangle on the side of the bed for breakfast? 2. Can I get you anything before I leave? 3. Ensure patients are covered with a blanket Lunch and Dinner ➢ Ask patients the following prior to repositioning or assisting or leaving room: 1. Would you like to be repositioned? 2. Would you like to sit in the chair or dangle on the side of the bed for lunch? Dinner? 3. Would you like to take a walk before or after lunch? Dinner? 4. Can I get you anything before I leave? ➢ **Rapid Response (RR), Code Blue, Dr. Strong** • All LTTs shall respond, and either assist or return to regular duties as directed.
0800- until 1900 And 2000-0700	1. Begin Rounding (round every 2 hours) 2. Note the patients who will require assistance with repositioning every two hours 3. Note the patients who will require assistance ambulating 4. Knock prior to entering a patient's room 5. Introduce yourself to patient 6. Write your name on patient's education board 7. Assist ACT with weights, repositioning patients. 8. Assist ACT as directed by RN with: • Assisting patients to chairs for meals • Repositioning positions for meals • Assist with repositioning for hygiene care 9. Perform duties assigned by RNs 10. Assist with discharges, transfers, and admissions	
Breaks	1. Take breaks as assigned 2. Inform RNs and ACTs prior to leaving the floor for break 3. Inform 2nd LTT, if applicable	
PRN Task examples	1. Assist with answering call lights and telephones during Protected Time and Quiet Time 2. Remove unused equipment from halls, ensure fire doors are not blocked with equipment 3. Ensure halls are free of clutter 4. Ask RNs or ACTs if new admissions or transfer patients require assistance with repositioning or ambulating	

Tri-City Medical Center
Oceanside, California

Patient Mobility Technician Shift Duties Guidelines

Shift duties including but not limited to:

1. Provide patient transportation, transfer and discharge services while assisting nursing with patient lift requests.
2. Respond to routine tasks and priority requests timely.
3. Receives and acknowledges requests to utilize hospital lift equipment.
4. Effectively coordinates each lift procedure with the PMT members and nursing staff.
5. Educates the patient on lift procedure and expectations

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: **03/16** **SUBJECT: Massive Transfusion Protocol (MTP)**

REVISION DATE~~(S)~~: 03/16, 01/19

Patient Care Services Content Expert Approval:	~~05/18~~09/22
Clinical Policies & Procedures Committee Approval:	~~10/18~~10/22
Nursing~~e Executive Committee~~Leadership ~~-~~Approval:	~~11/18~~11/22
Blood Utilization Review Approval:	~~11/18~~02/23
Pharmacy & Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~11/18~~02/23
Administration Approval:	~~01/19~~03/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/19

A. **PURPOSE:**

1. Protocolized transfusion has been shown to improve clinical outcomes and transfusion efficiency in trauma patients who require massive transfusion. This document provides guidelines for utilization of the massive transfusion protocol (MTP) at Tri-City Medical Center (TCMC).

B. **DEFINITIONS:**

1. Massive Transfusion (MT): Acute administration of 4 or more units of **Packed** Red Blood Cells (**P**RBC) in 1 hour or 8 or more units in 24 hours. Alternatively: Replacement of 1 or more blood volumes (1 blood volume equals approximately 5000 mL) in 24 hours.
2. Massive Transfusion Protocol (MTP): The coordinated team process to meet the physician identified need for MT, led by the physician, between clinical staff, the Blood Bank staff and ancillary staff. MTP includes collaboratively agreed upon ratios of blood and blood components to be prepared and transfused to meet identified patient's needs.
3. Emergency Release: Due to the critical condition of the patient, blood and blood products are released for transfusion before all required compatibility testing is completed.

C. **POLICY:**

1. Patients meeting the definition of MT with current, ongoing or impending use should be considered for activation of MTP by the physician.
   a. MTP activation should be considered for patients who will/have received greater than 4 **P**RBC units in 1 hour and appear to have an acute on-going requirement for **P**RBC use.
2. MTP may be activated by the order of a physician/Allied Health Professional (AHP) in the Operating Room (OR), Interventional Radiology (IR), Emergency Department (ED), Intensive Care Unit (ICU) or Women and Newborn Services (WNS).
   a. The requesting department should identify a primary contact person for communicating with the Blood Bank when possible.
   b. Multiple people contacting the Blood Bank during MTP are to be discouraged.
3. If the patient needs to have additional **P**RBC on hand at all times but does not need the MTP, order ~~"Lab Prepare RBC"~~ with a comment to "Keep Ahead (X number) of **P**RBC". **See Ordering Blood Products Guidelines.**

D. **PROCEDURE:**

1. Activate MTP upon the order of the physician/AHP by calling a telephone order to the Blood Bank (x7904). Blood Bank will indicate patient testing status and whether Emergency Release is necessary for immediate transfusions. Historical problems such as antibodies may also be available with the initial call.
2. Include the following information in the telephone order to initiate MTP:
   a. Patient name, gender and age
   b. Medical Record Number (MRN)
   ~~c. Blood Bank armband number, if available~~
   ~~d.~~**c.** Diagnosis or source of bleeding
   ~~e.~~**d.** Current or intended location—The Blood Bank will contact phlebotomy for STAT draw if necessary for the MTP.
   ~~f.~~**e.** Staff member name and phone number for notifications
3. If not already done, obtain sample and enter a STAT order for **Massive Transfusion Protocol (on the Blood Product Transfusion Order Set City)**~~type and crossmatch~~ as soon as possible (ASAP).
   a. If possible, the type and crossmatch should be collected prior to the start of the transfusion.
   b. Blood Bank staff will notify the physician/AHP if known history of clinically significant antibody and collaborate with pathologist to determine how to proceed.
   c. Turnaround time to issue blood is approximately ~~20~~**5** minutes if crossmatch is already completed.
4. If necessary, at least two (2) Group O uncrossmatched units are available for emergency release prior to completion of the type and crossmatch.
   a. Call Blood Bank for emergency release units and enter an electronic order for **Red Blood Cells with** "Emergency O ~~Neg~~" **noted in order comments**, if possible.
   b. At a minimum, provide ordering physician/AHP name and number of requested units. It is preferred to also provide patient name~~,~~ **and** MRN~~, and Blood Bank armband number (if available)~~. **At minimum, in an emergency, the courier must bring a patient chart label and note the number of units to be picked up.**
   c. Send a courier to the Blood Bank with a **printed requisition**~~completed Transfusion Request form~~ to obtain the emergency release units.
   d. Blood Bank personnel will dispense requested emergency release units to the courier.
   e. For all blood products issued as emergency release, the physician/AHP must ~~initial~~**sign** the ~~following~~ statement at the bottom of each **emergency tag**~~Transfusion Record~~: "Due to critical condition of patient, I accept unit without crossmatch".
5. The initial MTP will consist of releasing two **P**RBC immediately for use without cooler~~to courier 1~~. Then units will be prepared in multiples of five (5) **P**RBC units and five (5) Thawed Frozen Plasma (FP) units at a 1:1 ratio followed by one (1) unit of Plateletpheresis (PLPH).
   a. 30 minutes are required to thaw and label FP ~~if a second Clinical Laboratory Scientist (CLS) is available in the Blood Bank. Total turnaround time to issue FP is 45 minutes.~~
   b. One (1) PLPH is normally on hand. The first PLPH will be issued for immediate transfusion, and Blood Bank will keep ahead one (1) PLPH until end of event or alternative physician/AHP instruction.
6. The clinical team must send a courier for subsequently prepared rounds of blood products as long as the MTP event continues unabated. Notify Transfusion Service when MTP is discontinued by the physician/AHP.
7. Dispensing Blood Products for use:
   a. Products (including emergency released O ~~Neg~~ uncrossmatched units) are picked up by a designated TCMC staff member presenting a **printed requisition**~~correctly completed "Transfusion Request Form"~~ for the products.
   b. **P**RBC and FP units will be issued in coolers.

   c. PLPH and **cryoprecipitate** (cryo) pools are placed in a dual bag delivery system after dispense is completed in Cerner. Do not infuse after expiration date and do not store in coolers.
8. Transfuse ~~10~~**2** units **pooled** ~~Cryoprecipitate (~~Cryo~~)~~ as needed for decreased fibrinogen values, per physician/AHP orders.
   a. Cryo units will be set up as ordered by the clinical team.
   b. Normally 5-unit pools in single bags are available within 10-20 minutes.
9. Send the following labs STAT after four (4) units of blood products received by patient, per physician/AHP orders:
   a. CBC
   b. ~~Chem 12~~ **Comprehensive metabolic panel (CMP)**
   c. PTT
   d. PT/INR
   e. Fibrinogen
10. Calcium administration should be considered and calcium labs be ordered at the discretion of the practitioner during massive transfusion scenarios.
11. Send the following labs STAT as needed, per physician/AHP orders:
   a. ~~Comprehensive metabolic panel~~**CMP**
   b. ABG
12. Endpoints/termination
   a. Orders to keep ahead will be maintained until a member of the clinical team notifies the Blood Bank of end-of-event or the physician/AHP updates orders.
   b. Blood Bank staff may call patient location to verify continuation of MTP.
   c. Once stabilized, Blood Bank will keep ahead two (2) **P**RBC units and one (1) FP (2:1 ratio), for 24 hours.
   d. When appropriate endpoints are reached, as judged by the clinical team, the MTP must be discontinued by phone-notification to the Blood Bank, to limit resource wastage.
   e. Most reliable transfusion endpoint is a collaborative decision based on operative field examination, laboratory results, and clinical parameters.
   f. At the completion of the case, the department will be responsible for the return of all unused blood products and coolers to the blood bank.
   g. Any products returned unacceptable for reissue will be discarded.
13. Documentation
   a. Document blood units in Bridge using MTP transfusion.
   ~~g.~~**b. If Bridge unavailable, complete documentation in the EHR, see Blood Product Administration Documentation Outside Bridge Guidelines.**

E. <u>FORM(S):</u>
   1. Transfusion Request Form — ~~Sample~~**Downtime**

F. <u>RELATED DOCUMENT(S)</u>:
   1. Ordering Blood Products Guidelines
   ~~1.~~**2. Blood Product Administration Documentation Outside Bridge Guidelines**

SAMPLE

TRANSFUSION REQUEST FORM

Physician ordering transfusion: (Last name, first name)

____, M.D.

SPECIAL PATIENT REQUIREMENTS: ☐ IRRADIATED

OTHER: ____

Product ordered for transfusion and quantity to be dispensed now:

Product (check)	Quantity
☐ **EMERGENCY RELEASE RED BLOOD CELLS (RBC)**	________
☐ RANDOM RBC, LEUKOPOOR	________
☐ PLATELET PHERESIS(**PLPH**), LEUKOPOOR	________
☐ THAWED PLASMA **(TP)**	________
☐ CRYOPRECIPITATE	________
☐ AUTOLOGOUS RBC	________
☐ DONOR SPECIFIC RBC, LEUKOPOOR	________

Change to PACKED RED BLOOD CELL (PRBC)

☐ OTHER BLOOD COMPONENT: ____

ADDITIONAL ORDER NOTES: ____

☐ Massive Transfusion Protocol (5 RBCs:5FP:1PLPH) until ordering physician discontinues/stops

~~**Transfusion Service Identification Band Number:** ______________________~~.

Order verified by: ______________________, R.N. Date: __________ Time: ________

Dispensed: Date: ______________ Time: ______________

Tri-City Medical Center

4002 Vista Way • Oceanside • CA • 92056

Affix Patient Label

7500-1009
(Rev. 5/14)

TRANSFUSION REQUEST

White - Chart Yellow - Blood Bank

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	03/02	SUBJECT:	Sitter Policy
REVISION DATE(S):	11/02, 02/03, 03/03, 02/05, 05/05, 07/06, 11/06, 11/07, 12/07, 10/10, 01/11, 01/15, 04/19		

Patient Care Services Content Expert Approval:	~~05/18~~09/22
Clinical Policies & Procedures Committee Approval:	~~02/19~~10/22
Nursing Leadership~~e Executive~~ Committee:	~~03/19~~11/22
Medical Staff Department/Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~04/19~~03/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/19

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

B. **PURPOSE:**
1. To provide guidance to the health care team to:
   a. Ensure patient safety and protect the patient from harm
   b. Identify the circumstances under which a sitter shall be permitted
   c. Understand the procedure to be followed when all alternatives have been exhausted and proven ineffective in maintaining patient safety.

C. **POLICY:**
1. Suicide observation -and precautions shall be instituted immediately for any patient who has either verbalized suicidal ideation, a suicidal plan, or has made a recent suicide attempt per Patient Care Services Policy: Assessing and Managing Patient at Risk for Suicide.
   a. The sitter shall review the Environmental Safety Guidelines for Suicidal Patient each time they are assigned to a suicidal patient.
2. Unless suicide observation is required, a sitter can be assigned to more than one patient in the same room as deemed appropriate by the **Charge Nurse** ~~ANM~~/designee. All attempts shall be made to cohort patients depending on their situation. Whenever possible the patient will be placed in a room close to and in view of the nurse's station.
3. **A s**~~S~~itter is not relieved of their duties and responsibilities until their relief person arrives and hand-off is provided.
~~3.~~**4.** **A family member as a sitter needs approval from the Charge Nurse or designee and are not allowed if the patient is a 1:1 suicidal observation.**

~~4.~~**5.** When family requests a sitter, and it is determined that the patient does not meet the criteria for a sitter, then the family is responsible to contact, contract, and pay for the use of the sitter.
   a. A list of agencies is available for family members who choose to obtain caregiver services at their own expense.
   b. Family funded caregivers shall be required to sign in with the Staffing Office prior to the start of each shift and shall complete the Non-TCMC Employment Packet.

~~5.~~**6.** A physician order for sitter for a non-suicidal patient is not required. If the physician orders a sitter, discontinuation of the patient sitter assignment requires a physician order after discussion with the physician, and other members of the health care team.

~~6.~~**7.** Every 4 hours, attempts shall be made to employ alternatives to the use of sitter while still ensuring patient safety. Refer to Sitter – Alternatives to Use for possible alternatives.

D. **~~ASSISTANT NURSE MANAGER (ANM)~~CHARGE NURSE/DESIGNEE RESPONSIBILITIES:**
1. Determine the need for a sitter based on clinical data, potential patient safety concerns, unique patient care needs or potential danger to self (suicide) or others.
2. Review the need for a sitter with the Registered Nurse (RN). The determination must be made that alternatives have been ineffective, causes for confusion/agitation have been identified and treated if applicable, and that there is clinical justification of a need for a sitter. Refer to Sitter – Decision Tree for Use.
3. Evaluate the need to continue the sitter at least every 4 hours and/or as patient status changes.
   a. Any patient with a sitter, who is being transferred to a new unit, must be re-evaluated for ongoing sitter needs prior to transfer.
4. Orient the sitter to the unit as needed.

E. **PRIMARY RN RESPONSIBILITIES:**
1. Confirm approval for use of a sitter with the ~~ANM~~**Charge Nurse**/designee.
2. Explain to the patient and/or family the rationale for the safety precautions.
3. Ensure sitter:
   a. Receives safety instructions at the beginning of shift and as needed
   b. Is covered by another health care provider to document in the medical record and for meal/break.
4. Attempt to employ alternatives to the use of a sitter every four (4) hours, while still ensuring patient safety

F. **SITTER RESPONSIBILITIES:**
1. Receives assignment and reports to the ~~ANM~~ **Charge Nurse**/designee.
2. Perform all duties in a manner that respects all patient rights.
3. Direct and continuous observation of the patient at all times.
   a. If a sitter is assigned more than one patient they must call for assistance when unable to visualize both patients.
   b. Sitters are prohibited from the following activities while assigned to patients:
      i. Engaging in any activities which distracts attention from the patient
      ii. Giving any advice regarding personal matters to the patient or family.
      iii. Documenting Activities of Daily Living (ADLs) in the patients' room
         1) Work Stations on Wheels (WOWs) are not allowed in patients' rooms for use by sitters.
      iv. Initiating, working on, or completing homework, sleeping, reading, drawing, coloring, painting, sketching, needle work (sewing, knitting, crocheting, etc.) or playing games using printed or electronic devices.
      v. Using electronic devices e.g., personal cell phones, laptops, Kindle, iPads, iPods etc.
   c. In the Emergency Department (ED)
      i. The sitter must remain in the doorway at a safe distance from the patient, e.g., your arm distance from the patient, doorway

ii. Ensure the blinds remain open at all times.

4. Accompany the patient off unit to tests or procedures and remain with the patient, unless instructed otherwise by the assigned nurse or the individual performing the test.
5. Notify the assigned nurse and receive permission if asked by family or visitors of the patient to temporarily leave the room.
6. **Sitters may perform p**~~P~~rovide personal care (i.e., oral care, skin care, foot care, bathing, toileting, position changes, linen changes, shampoo and hair care) **if competent to do so. A Patient Safety Technician may assist the nursing staff with ADLs~~1~~.**
7. Provide nutritional care (i.e., feeding or assisting with meals, reporting and documenting percent of food eaten by patient) **if competent to do so.**
8. Maintain safety precautions as directed by the primary nurse/designee to include but not limited to:
   a. Ensure side rails are up **times three**~~x 3~~
   b. Ensure bed is in low and locked position
   c. Assist with restraint application and removal as directed by the RN
9. Assist qualified caregivers with range of motion, transfers, ambulation, and other activities as directed by the primary nurse/designee.
10. Maintain a neat, clean, and organized environment.
11. Introduce self to the patient and interact with the patient as appropriate.
    a. Reinforce information the nurse has provided regarding procedures and tests; provide clear and direct information to the patient.
    b. Listen, but do not offer advice or counseling.
       i. Refer to RN for sensitive issues.
    c. Conceal extreme emotional response from the patient (i.e., fear, sympathy, disgust, irritability).
12. Notify the primary nurse/designee immediately for any alarms, hazards, or safety risks to the patient.
    a. Check observable areas for sharps, matches, lighters, illegal drugs or any other item the patient may use to harm self or others.
    b. Notify the primary nurse/designee immediately with concerns or questions.
    ~~b.~~**c. Notify the primary nurse if visitors bring in patient belongings.**
13. Inform primary nurse/designee of any behavior that may be unsafe.
    a. If patient becomes agitated**, threatening,** or violent, contact Security, RN and ~~ANM~~ **Charge RN** and they will determine appropriate next steps for assistance. **Do**~~n't~~ **not leave the patient unattended and use the call bell for assistance.**
14. Report changes in patient clinical condition to primary nurse or designee immediately.
15. Obtain report at the beginning of the shift and provide report to the primary nurse/designee and relief person at the end of shift.
16. Ensure there is direct and immediate coverage for rest-periods and meal breaks.
    a. The sitter shall receive breaks in accordance with department procedures.
    b. The sitter is responsible to arrange these with the RN or designee at the beginning of the shift and is not relieved of duty until the relief person arrives.

G. RELATED DOCUMENT(S):

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

Environmental Safety Guidelines for Suicidal Patient

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

Sharp Objects Removed from Room

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

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

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

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

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

Dietary:

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

Hand-off:

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

Visitors:

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

Tri-City Medical Center
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Sitter Alternatives to Use During Care

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

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

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

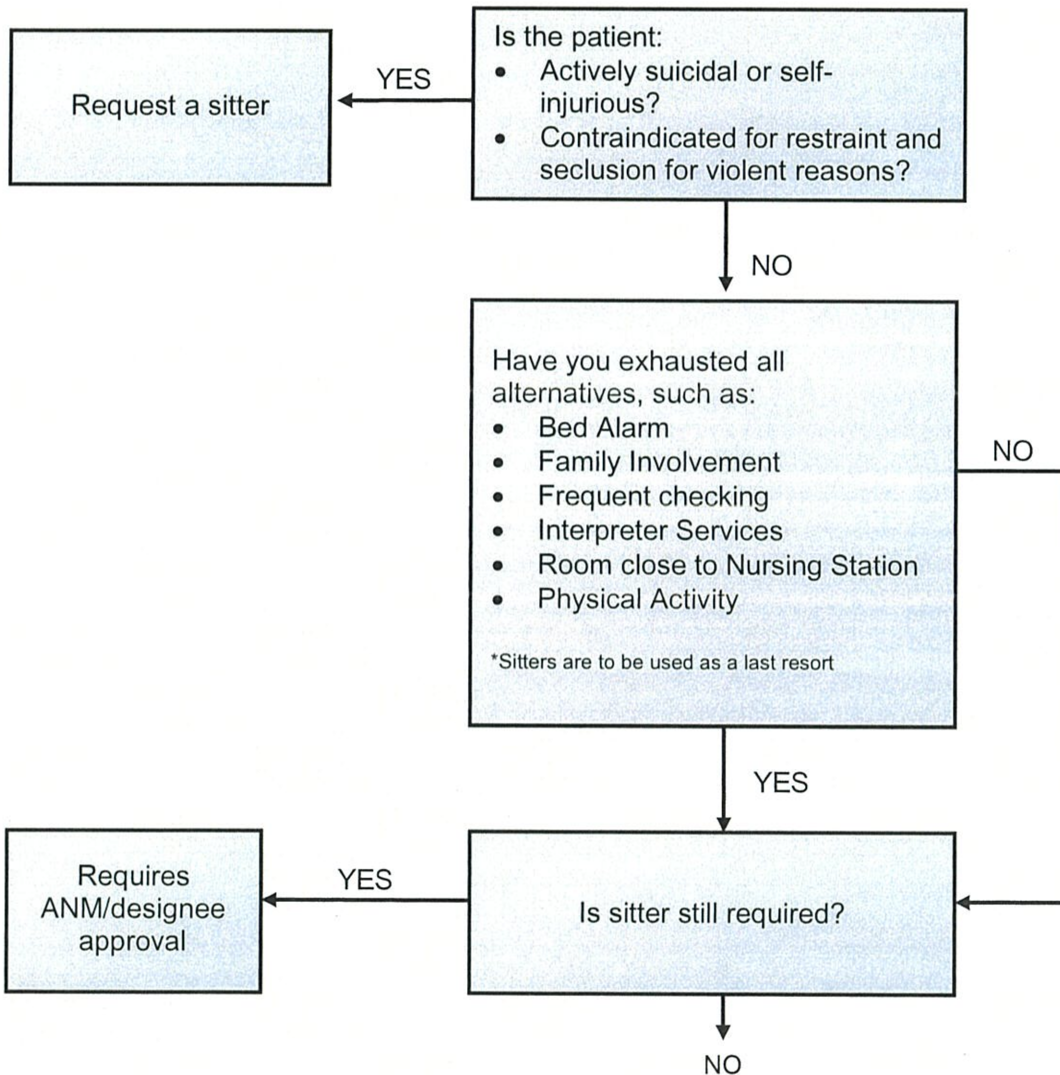
Tri-City Medical Center
Oceanside, California

Sitter Decision Tree for Use

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

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

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



Tri-City Medical Center
Oceanside, California

Sitter Responsibilities

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

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

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**03/85**	**SUBJECT:**	**Telephone Service for Patient Rooms**
REVISION DATE:	**05/88, 09/91, 10/96, 03/00, 11/00, 06/03, 08/05, 07/07, 05/10, 03/17, 03/20**		

Department Approval:	**~~11/19~~12/22**
Clinical Policies & Procedures Committee Approval:	**~~12/19~~01/23**
Nurse Executive Council Approval:	**~~02/20~~02/23**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~03/20~~03/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**03/20**

A. <u>POLICY:</u>

1. Tri-City Medical Center (TCMC) shall allow telephone access to and from patient rooms, while providing adequate amounts of rest for both patients in the room.
   - ~~1.~~**a. In the Intensive Care Unit (ICU), patient may request use of a TCMC phone to make or receive calls. The phone is returned to nursing station after use.**

2. All telephones in patient rooms have the capability for direct dialing. Patients can initiate and receive phone calls on a twenty-four hour basis.
3. Incoming calls to the PBX operator shall not be connected to the patient rooms between the hours of 2200, and 0700, but shall be referred to the Nursing Unit.
4. If telephone communications need to be limited based on nursing assessment or patient behaviors, the process shall be verbally explained to the patient and/or family. Restrictions shall be evaluated by nursing for their effectiveness, so that at the earliest possible time the restriction may be lifted.
5. At the patient's request, phone service may be blocked.
6. Accommodations shall be made for patients requesting a private area for telephone usage. The Management Team/designee or the Administrative Supervisor may be contacted for assistance.

ISSUE DATE:	09/08	SUBJECT:	Therapeutic Anticoagulation Management

REVISION DATE~~(S)~~: 12/09, 03/12, 05/12, 07/17, 08/19

Patient Care Services Content Expert Approval:	~~04/19~~11/22
Clinical Policies & Procedures Committee Approval:	~~05/19~~11/22
Nursinge Leadership ~~Executive Committee~~ Approval:	~~05/19~~01/23
Pharmacy & Therapeutics Committee Approval:	~~05/19~~01/23
Medical Executive Committee Approval:	~~06/19~~02/23
Administration Approval:	~~07/19~~03/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/19

A. **PURPOSE:**
1. Joint Commission has identified therapeutic anticoagulation (unfractionated heparin infusion, low molecular weight heparins and warfarin) as a high risk therapy that "often leads to adverse drug events due to complex dosing [and] requisite follow-up monitoring".
2. This Therapeutic Anticoagulation Program includes comprehensive anticoagulation policies, order sets, guidelines and general tools to assist all health care providers in providing the optimal anticoagulant therapy for Tri-City **Healthcare**~~Hospital~~ District (TCHD) patients. This document describes the overall Therapeutic Anticoagulation Program developed for TCHD intended to ensure regulatory compliance and improve the care of patients.
3. Given the broad, multi-disciplinary scope of the anticoagulation **National Patient Safety Goals (**NPSG**)**, this document will also be broad in scope but will emphasize the inpatient management of therapeutic anticoagulation. The TCHD Therapeutic Anticoagulation Program addresses the activities of the following department and groups:
   a. Physician/Allied Healthcare Professional (AHP)
   b. Pharmacy
   c. Nursing
   d. Dietary
   e. Laboratory
   f. Education Department
   g. Patients
   h. Patients' Families

B. **OVERVIEW OF THE TCHD INPATIENT THERAPEUTIC ANTICOAGULATION PROGRAM**
1. Prescribing:
   a. Overview:
      i. Prescribing of therapeutic anticoagulation therapy is expected to be standardized. Accordingly, all prescribers will be expected to utilize a master ~~TCHD~~ Pharmacy Procedure: Anticoagulation Dosing Protocol Policy for adults and pediatrics. This dosing policy has been developed to assist the Physician/AHP in appropriate medication selection (based on patient's co-morbidities), medication dosing as well as mandated baseline and follow-up medication monitoring. See Pharmacy Procedure: Anticoagulation Dosing Protocol.

ii. The prescribing of anticoagulants in specialized patient care settings where it is reasonably expected for a Physician/AHP to be present during the entire course of therapy (such as in or en route to the cardiac catheterization laboratory or operating rooms) does not require the use of the Pharmacy Procedure: Anticoagulation Dosing Protocol.

iii. Short term heparin usage (e.g., 4 hours or less) during the course of hemodialysis is deemed "prophylactic" anticoagulation that is not expected to produce prolonged alterations in the coagulation studies. Accordingly, heparin usage in this manner is also considered exempt from the mandatory use of the Pharmacy Procedure: Anticoagulation Dosing Protocol.

b. Unfractionated Heparin Infusion:

i. The Physician/AHP has the option of consulting pharmacy services to manage the heparin therapy or retaining the heparin management responsibilities. The pharmacy heparin dosing/monitoring service is guided by the Pharmacy Procedure: Anticoagulation Dosing Protocol that is consistent with the elements of the NPSG and approved by the organization.

ii. For adults, if the Physician/AHP elects to retain the heparin management responsibilities, the Pharmacy Procedure: Anticoagulation Dosing Protocol will allow the Physician/AHP to select one of the 2 heparin nomograms (venous thromboembolism/deep vein thrombosis/pulmonary embolism or Cardiac). The selection of an appropriate nomogram will depend on the patient's indication for anticoagulation and the risk for severe bleeding complications

iii. Upon receipt of the order, the inpatient clinical pharmacist will review the order for accuracy and completeness (patient weight and indication), and ensure that the completed nomogram is entered as an order comment prior to order verification. The nomogram will be visible to the nurse within the electronic **Medication Administration Record (**MAR**)**

c. Low Molecular Weight Heparin:

i. All orders for therapeutically-dosed low molecular weight heparin must be initiated on a weight based (mg/kg) dosing regimen.

ii. Guidelines to assist the Physician/AHP in the safe use of low molecular weight heparins based on patient's renal function or other co-morbidities are incorporated into Pharmacy Procedure: Anticoagulation Dosing Protocol.

d. Warfarin:

i. The Physician/AHP has the option of consulting pharmacy services to manage the warfarin therapy or retaining the warfarin management responsibilities. The pharmacy warfarin dosing/monitoring service is guided by the Pharmacy Procedure: Anticoagulation Dosing Protocol that is consistent with the elements of the NPSG and approved by the organization.

ii. Pharmacy services shall monitor warfarin patients to ensure compliance with required NPSG monitoring expectations before warfarin daily administration and to provide recommendations to prescribers as needed.

2. Dispensing:

a. Overview:

i. Only oral unit dose products, pre-filled syringes, or pre-mixed infusion bags will be dispensed whenever possible. If these products are not commercially available, patient-specific doses will compounded to be dispensed.

b. Unfractionated Heparin Infusion:

i. When possible, only standardized, pre-mixed heparin infusion bags (25,000 units/500 mL D5W) will be dispensed for therapeutic anticoagulation. Shortages may require other diluents/concentrations, which will be communicated to nursing and Medical Staff prior to use.

1) For Impella use, multiple concentrations may be needed, which will be admixed by pharmacy and labeled accordingly

c. Low Molecular Weight Heparin:
   i. For adults, pre-filled enoxaparin syringes (doses rounded to nearest 10 mg) will be dispensed whenever possible. If an appropriate enoxaparin does is not commercially available as a pre-filled syringe, pharmacy will compound the doses for the patient, so to eliminate the need for nursing to administer a partial syringe.
   ii. For pediatrics, enoxaparin doses will be rounded to the nearest 5 mg. Pre-filled enoxaparin syringes will be dispensed whenever possible. If an appropriate dose is not commercially available as a pre-filled syringe, pharmacy will compound the syringe, using a 100 mg/mL diluted vial.
   iii. Exact warfarin doses will be dispensed for patient administration. The nursing staff will not be expected to split any warfarin tablets to obtain the prescribed dose.

3. Baseline Monitoring:
   a. Overview:
      i. Baseline laboratory monitoring within 24 hours prior to initiation of therapeutic anticoagulation will be mandated by the use of the Pharmacy Procedure: Anticoagulation Dosing Protocol. The specific baseline laboratory tests that will be assessed are listed below.
   b. Unfractionated Heparin Infusion:
      i. Complete Blood Count (CBC)
      ii. Activated Partial Thromboplastin Time (PTT)
      ~~ii.~~**iii.** **Prothrombin Time (PT) and International Normalized Ratio (INR)**
   c. Low Molecular Weight Heparin
      i. Complete blood count (CBC), Blood Urea Nitrogen (BUN), and serum creatinine
      ii. Baseline Activated, Prothrombin Time (PT) and International Normalized Ratio (INR) are optional but recommended
   d. Warfarin
      i. Complete Blood Count (CBC), PT, and INR
   e. Direct Oral Anticoagulants (DOAC's)
      i. CBC, BUN, SCr, as needed

4. Administration:
   a. Unfractionated Heparin Infusions
      i. All heparin infusions will be administered by a programmable infusion pump with "smart pump" technology.
      ii. All heparin bolus doses will be administered in units using the 1,000 unit per mL concentration.
      iii. All heparin infusions will be programmed as units/kg/hour.
      iv. Independent double checking and documentation is to be performed as per Patient Care Services ~~(PCS)~~ Policy: ~~Medication Administration~~**Medications, High Risk/High Alert/Look Alike Sound Alike**
   b. Low Molecular Weight Heparin:
      i. Administer per manufacturer's instructions for use.
      ii. The injection should be administered by deep **subcutaneous (**SC**)** injection.
      iii. Rotate SC injection sites. Do not rub the injection site after completion of the injection.
   c. Warfarin:
      i. Pharmacy will track all warfarin dosing and monitoring via **E**~~e~~lectronic **H**~~h~~ealth **R**~~r~~ecord (EHR).

5. Follow-up Monitoring:
   a. Overview
      i. Patients receiving therapeutic anticoagulation are expected to receive follow-up safety and efficacy monitoring.

ii. All patients receiving therapeutic anticoagulation are expected to be monitored for any evidence of major oozing, bleeding or internal bleeding, changes in neurologic status, as well as indications of an allergic reaction. The nursing staff is to notify the prescriber if any of these adverse effects are noted.

iii. According to the Critical Result and Critical Tests/Diagnostic Procedures policy all critical laboratory values are to be reported to the prescriber within 60 minutes of notification from the laboratory except in cases whereby Physician/AHP orders/policies for treatment of the critical results were previously available. Relevant critical laboratory results that will require Physician/AHP orders/policies for treatment of the critical results were previously available. Relevant critical laboratory results that will require Physician/AHP notification include: INR greater than 5, hemoglobin less than 7gm/dL, platelet count less than 50 K/microliter, and PTT>200 seconds.

b. Medication specific monitoring parameters are listed below.

i. Unfractionated Heparin Infusion:
1) PTT 6 hours after each heparin dose change and every 6 hours while stable unless otherwise dictated per policies.
2) Nursing staff to report any fall in platelet count to less than 100K/microliter to the Physician/AHP.
3) CBC every 1-3 days (default is daily).

ii. Low Molecular Weight Heparin:
1) CBC every 1-3 days (default is daily).
2) Nursing staff to report any fall in platelet count to less than 100K/microliter to the Physician/AHP.
3) BUN and serum creatinine every 1-3 days (default is daily).

iii. Warfarin:
1) CBC every 1-3 days (default is daily).
2) For acute care patients, PT/INR every morning. This may be reduced to once weekly after 7 consecutive INR's within the therapeutic without requiring warfarin dose adjustments are obtained.
3) Nutrition Services will identify all new inpatient warfarin patients on a daily basis and make necessary menu adjustments as needed.

iv. DOAC's
1) CBC every 1-3 days (default is daily)
2) BUN and SCr every 1-3 days (default is daily)

6. Patient Education:

a. Overview:

i. TCHD staff will provide "patient/family education that includes the importance of follow-up monitoring, compliance issues, dietary restrictions, and potential for adverse drug reactions and interactions".

ii. For all therapeutic anticoagulation, the patient and their family members will be educated about the name, indication, dosage, administration procedure, side effects, and monitoring of all anticoagulant therapies. The patient and family will be instructed to alert nursing staff of any bleeding or bruising during anticoagulation therapy.

iii. Additional discharge education will be provided as per **Patient Care Services Policy: Medication Administration** ~~TCHD policy~~.

C. INPATIENT PROGRAM MONITORING:

1. Overview:

a. Results of anticoagulation monitoring in adults will be reviewed by Pharmacy and Therapeutics annually, in order to reassess the safety and effectiveness of the Pharmacy Procedure: Anticoagulation Dosing Protocol and allow for re-assessment and modification, as needed.

2. Specific Monitoring Parameters
   a. Safety:
      i. Percentage of PTT values that ~~fall into critical range~~ **are critical** ~~(greater than 100~~**200** ~~seconds)~~ in patients receiving heparin infusions.
      ii. Percentage of INR values that fall into critical range ~~(greater than 5)~~ in patients receiving warfarin therapy.
      iii. Review of vitamin K and protamine usage as trigger tools for potential bleeding complications.
      iv. Percentage of patients initiated on anticoagulation therapy with appropriate baseline laboratory measures (as described above).
      v. Analyze medication errors and adverse drug events associated with the use of anticoagulation therapy
   b. Efficacy:
      i. Frequency of goal PTT measures (73-110 seconds, encompassing both heparin nomograms) in patients receiving heparin infusions.
      ii. Frequency of goal INR measures (2 – 3.5) in patients receiving warfarin therapy.
   c. Education Compliance:
      i. Percentage of staff pharmacists and staff nurses that have completed anticoagulation competency training.

D. <u>**RELATED DOCUMENT(S):**</u>
1. Pharmacy Procedure: Anticoagulant Dosing Protocol
2. Patient Care Services Policy: Medications, High Risk/High Alert/Look Alike Sound Alike
~~2.~~**3.** Patient Care Services Policy: Medication Administration

Tri-City Health Care District
Oceanside, California

RETIRE – Incorporated into Workplace Violence Policy

ADMINISTRATIVE POLICY ~~MANUAL~~
DISTRICT OPERATIONS

ISSUE DATE: 03/94

SUBJECT: Assault and Battery Reporting Process

REVISION DATE: 06/95, 10/99, 05/03, 02/09, 06/11, 06/14, 07/17

POLICY NUMBER: 8610-241

Administrative Content Expert Approval~~Department Review~~:	~~05/17~~06/22
Administrative Policies & Procedures Committee Approval:	~~06/17~~08/22
Environmental Health & Safety Committee Approval:	09/22
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	03/23
Professional Affairs Committee Approval:	~~07/17~~ n/a
Board of Directors Approval:	07/17

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

~~1. To establish a uniform system for the reporting of all assaultive behavior (Section 240, California Penal Code) and battery (Section 242, California Penal Code) occurrences against on-duty Tri-City Healthcare District (TCHD) personnel, or other covered individuals under Cal/OSHA Workplace Violence Prevention regulations, which results in threats of injury, physical injuries or involves the use of a firearm or other deadly weapon. Refer to Administrative Policy: Mandatory Reporting Requirements 236.~~

~~B. **DEFINITION(S):**~~

~~1. Assaulted Employee: Any employee (or covered individual) of TCHD who is reasonably put in fear of being imminently struck by a patient, visitor, co-worker, physician or other individual either by a menacing gesture, sudden move alone, or accompanied by a threat (California Penal Code Section 240, Cal/OSHA Title 8, California Code of Regulations, Sec. 3203 (b); 5120€(1)(B); 3342(h)(3)).~~

~~Battered Employee: Any employee (or covered individual) of TCHD who experiences actual uninvited physical contact from a patient, visitor, co-worker, physician or other individual whether or not a physical injury occurs. (California Penal Code Section 242, Cal/OSHA Title 8, California Code of Regulations, Sec. 3203 (b); 5120€(1)(B); 3342(h)(3)).~~

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

~~1. It is the policy of the TCHD Security Department that all occurrences involving an assault or battery against any TCHD employee (or covered individuals) be properly documented and all pertinent information forwarded to the local law enforcement agency of jurisdiction within 48 hours of the time of the incident.~~

~~2. Pursuant to TCHD Administrative: Security Department Incident Notification Policy #234, when either an assaultive behavior or battery is committed against any on-duty TCHD employee (or covered individuals) , the Security Department will be notified immediately of the incident by the employee or immediate supervisor and respond with necessary personnel.~~

~~3. The primary responding security officer will be responsible to ensure that all processes described per the Security: Safety and Security Incident Investigation 233 Policy, are immediately implemented and properly documented. In addition, the responding security officer will be responsible for the following items:~~

~~a. Insure the individual has been offered medical services and document the extent of injuries if present.~~

b. Immediately notify the on-duty Security Supervisor/designee of all available facts relating to the incident.

c. If needed, the responding security officer will request the immediate notification and request for assistance of the Oceanside Police Department (OPD).

d. The responding security officer will be responsible for the completion and submission of all required TCHD Security Department Reports (as per Security: Security Department Reports #111 Policy) pertaining to the occurrence by the end of the primary responding officer's designated shift. The reports shall include, evidentiary photos, witness statements, perpetrators disposition, and any damage to TCHD property during the altercation.

4. The Security Supervisor/designee will be responsible to ensure the following is completed on the next working day after the occurrence:

   a. Review of all submitted departmental reports and evidentiary material by the responding security officer that, pertain to the occurrence.
   b. Conduct and document any additional follow-up investigation.
   c. Ensure Employee Health (EH) is notified by dialing "7050" and either speaks directly with the EH staff or leave a message with the basic details (example: Employee name, date, time and location of incident, extent of the injuries if known). EH will complete the necessary reporting to Cal/OSHA.
   d. Ensure that TCHD Administration and the Risk Manager are briefed regarding all available facts pertaining to the occurrence.
   e. Ensure that written notification of the occurrence is forwarded to the law enforcement agency of jurisdiction within 48 hours of the time of occurrence. In addition, a copy of the notification will also be attached to the responding security officer's report and forwarded to the Medical Center Risk Manager for review and recommendations.

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

1. Administrative Policy: Mandatory Reporting Requirements 236 Policy
2. Administrative Policy: Security Department Incident Notification 234 Policy
3. Security: Safety and Security Incident Investigation 233 Policy
4. Security: Security Department Reports 111 Policy

E. **REFERENCES:**

1. California Penal Code Section 240 & 242
2. Cal/OSHA Title 8, California Code of Regulations, Sec. 3203 (b); 5120€(1)(B); 3342(h)(3)

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY
DISTRICT OPERATIONS

RETIRE – incorporated into Emergency Operations Procedure Policy: Active Shooter and Hostage

ISSUE DATE:	**05/91**	**SUBJECT:**	**Code Gray: Hostage Response Plan**
REVISION DATE:	**12/03, 09/05, 09/10, 02/14, 03/17 12/20**	**POLICY NUMBER:**	**8610-283**

Administrative Content Expert Approval:	**~~09/2008/22~~12/22**
Environmental Health and Safety Committee Approval:	**12/22**
Administrative Policies & Procedures Committee Approval:	**~~10/20~~03/23**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~12/20~~03/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/20**

~~A. **PURPOSE:**~~
1. ~~To provide a rapid, organized and thorough response at Tri-City Healthcare District (TCHD) to an incident where there is an individual**(s)** being held against their will or in a hostage situation while in the facility**hospital** or in**on** the immediate surrounding parking areas.**campus.**~~

~~B. **POLICY:**~~
1. ~~It is the policy of TCHD while responding to a hostage**(s)** or barricaded suspect situation that the primary aim of personnel is to ensure the safety of all people on the premises, as well as, preserve life and protect property.~~

~~C. **PROCEDURES:**~~
1. ~~The TCHD personnel who witnesses or comes upon a hostage situation shall:~~
   a. ~~Warn others of the situation by calling out for everyone to "take cover" and also take cover as well.~~
   b. ~~Dial "66" via the telephone and report "Code Gray" to the PBX Operator, and advise of the incident location, and any other pertinent information, such as the number of hostages, a complete description of the hostage taker(s), and the description of any weapons.~~
      i. ~~The PBX/Operator will announce "Code Gray" three (3) times overhead, followed by the unit, department or location.~~
      ii. ~~The PBX/Operator will immediately notify the Security Department of the Code Gray and the location of the incident.~~
      iii. ~~The PBX/Operator will also notify Oceanside Police Department via "911" and advise of the current situation.~~
   c. ~~TCHD Security Personnel will respond to the incident location and it will be the responsibility of the Security Supervisor or designee to assume the primary Officer designation.~~
      i. ~~The Security Supervisor shall remain in this capacity until such time that they are relieved of command by Oceanside Police Department personnel...~~
      ii. ~~The Security Supervisor will be responsible to brief Oceanside Police Department personnel of the hostage situation and will supply any requested support or additional personnel.~~
      iii. ~~The Security Supervisor will also advise for the facility to be placed into a security lockdown mode until further orders.~~
   d. ~~The PBX/Operator will initiate the following call-out process.~~
      i. ~~The on-duty Administrator / Administrative Supervisor.~~
      ii. ~~The Environment of Care/Safety Officer.~~

iii. The on-call Administrator if after hours.
1) The Chief Executive Officer (CEO) will notify;
a) Board of Directors
b) Chief of Medical Staff
iv. The Public Information Officer.
v. The Director of Risk Management.

e. Security Department personnel will proceed to the incident location and begin to safely remove all patients, visitors, and staff members to a safe location and properly ensure that all approaches into and exits out of the immediate situation area are secured.

f. The Emergency Department and Surgery staff shall be advised of the hostage situation and prepare for possible trauma patients.

g. During or after the evacuation processes any capable witnesses will be interviewed by Security personnel for pertinent information regarding the hostage situation.

h. A secure area will be established for use as a command center and central location for the hostage negotiation team. A floor plan of the incident area will be obtained from the Facilities Department and a secured communications system will be established.

i. The Administrator or Designee along with Oceanside Police Department will obtain any pertinent information from the Department Leader of the affected area or department, regarding the hostage and hostage taker.

j. TCHD medical personnel will be reassigned as needed to this area in order to ensure proper staffing and continuance of the necessary medical services if possible.

k. At no time during the hostage situation will any TCHD personnel attempt to rescue a hostage or disarm a hostage taker. Open communications with the hostage taker can be attempted to deescalate the incident or obtain information, but at no time will any TCHD personnel offer any promises or concessions to the hostage taker.

l. It will be the responsibility of the primary Security Officer to document all pertinent circumstances related to the hostage situation. This documentation should include but not limited to the date, time, location, actions taken and personnel involved.

m. At the completion of the Hostage situation, all involved personnel will remain available for interviewing by local law enforcement personnel and will only return to normal operations after first receiving authorization to do so from the Security Supervisor or Designee.

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

1. Emergency Operations Procedure: Code Silver Person with Weapon or Active Shooter

Tri-City Healthcare District
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATIONS

ISSUE DATE: 11/90

SUBJECT: Disposal of Drugs and Drug Paraphernalia

REVISION DATE~~(S)~~: 11/90, 10/99, 05/03, 12/05, 03/09, 02/11, 06/14

POLICY NUMBER: 8610-217

Administrative ~~District Operations~~ Content Expert Approval:	~~10/18~~11/20
Administrative Policies & Procedures Committee Approval:	~~12/18~~11/22
Pharmacy & Therapeutics Committee Approval:	01/23
Medical Executive Committee Approval:	02/23
Administration Approval:	03/23
Professional Affairs Committee Approval:	~~06/14~~ n/a
Board of Directors Approval:	06/14

A. **PURPOSE:**

1. To set forth the District's procedure for handling and disposing ~~of~~ confiscated and/or discovered drugs~~,~~ and/or drug-use paraphernalia.

B. **DEFINITION(S):**

1. Drugs:
    a. Substances recognized as drugs in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States or **the** official National Formulary or any supplement to any of them~~-~~.
    b. Substances intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or ~~animals and~~ **animal.**
    c. Substances (other than food~~), i.e., alcohol,~~) intended to affect the structure or any function of the body of man or ~~animals~~**animal**.
2. Drug-~~use paraphernalia:~~ **Use Paraphernalia:**
    a. All equipment, products, and materials of any kind which are designed **for use** or ~~marketed~~**marked** for use in planting, propagating, ~~cultivating~~**cultivation**, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, injecting, ingesting, inhaling, or otherwise introducing into the human body a controlled substance.

~~2.~~**3.** **Workforce Member: Employees, Medical Staff, Allied Health Professionals (AHP), volunteers, trainees, Business Visitors, Covered Contractors and other persons whose conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.**

C. **POLICY:**

~~3.~~**1.** Any **Workforce Member** ~~District employee~~ who finds or confiscates any ~~drugs~~**drug** or drug paraphernalia on District property shall immediately notify the Security Department.

D. **PROCEDURE:**

1. Upon receiving ~~notification~~**information** of found drugs or drug paraphernalia, the Security Department will immediately dispatch a Security Officer to the location~~-and~~, take possession

of such items~~.~~ **and establish a chain of custody.** The Security Officer will then obtain the necessary information needed to complete the appropriate Security Department report.

2. The collecting Security Officer will then immediately notify the ~~security supervisor/designee. He/she will then immediately notify~~**Security Supervisor and / or the Lead Security Officer and** the Oceanside Police Department **(OPD.)**~~-and-~~.

3. **The officer will** request that ~~a patrol officer~~ **OPD.** be sent to retrieve the discovered or confiscated drugs ~~and/or drug~~ /paraphernalia~~.~~**, or the officer will request disposition instructions from OPD.**

a. Upon **the** arrival of the **OPD.**~~Oceanside Police Department~~, the Security Officer will turn over all **seized** items and inform the ~~officer~~**Police Officer** of all pertinent facts involved ~~and make note of~~**with** the ~~officer's~~**seizure. The Security Officer will be responsible for obtaining the Police Officer's** name, badge number, and the time ~~all~~**the** items were released.

~~2.~~**4.** The collecting Security Officer will be responsible for **the** proper completion of all necessary reports ~~and will forward these reports to the Security Supervisor on the next working day. The collecting officer will also complete a corresponding daily security report entry of all pertinent facts involved with this seizure~~. **The Security Officer will further be responsible for noting all facts in his/her Daily Security Report**.

~~4.~~**5.** The Oceanside Police Department shall handle the investigation and subsequent follow-up according to applicable laws.

a. If the drug is deemed to be the property of an employee, an investigation will follow in accordance with:

i. Administrative District Operations Policy: Mandatory Reporting Requirements 8610-236

ii. Administrative Human Resources Policy: Coaching and Counseling for Work Performance Improvement 8610-424

iii. Administrative Human Resources Policy: Alcohol and Drug Testing for Employees 8610-429

~~B.~~**E.** <u>RELATED DOCUMENT(S):</u>

~~3.~~**1.** Administrative District Operations Policy: Mandatory Reporting Requirements 8610-236

~~4.~~**2.** Administrative Human Resources Policy: Coaching and Counseling for Work Performance Improvement 8610-424

~~5.~~**3.** Administrative Human Resources Policy: Alcohol and Drug Testing for Employees 8610-429

Tri-City Healthcare District
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATIONS

ISSUE DATE: **07/85** **SUBJECT:** **Doctor Strong**

REVISION DATE~~(S)~~: **05/88, 10/96, 10/98, 10/99, 04/02, 05/03, 04/06, 06/09, 06/11, 06/12, 05/15, 03/19** **POLICY NUMBER:** **8610-221**

Administrative District Operations Content Expert Approval:	**~~11/18~~01/22**
Administrative Policies & Procedures Committee Approval:	**~~12/18~~11/22**
Environmental Health & Safety Committee Approval:	**12/22**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~02/19~~02/23**
Administration Approval:	**~~03/19~~03/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**03/19**

A. **POLICY:**
1. To assure a timely response to situations involving an actual or potential physical threat to patients, Workforce Members, visitors or property. It is the purpose of this Hospital's security program that when dealing with a confrontational and/or combative patient, personnel and/or visitor with or without a weapon, the Security Department will be notified.
2. All personnel will be encouraged to recognize activities leading to actual or potential physical threats to patients, physicians, volunteers, students, personnel, visitors or property.
3. Prompt action will be taken to secure assistance needed to stabilize situations that could leave bodily harm and/or property damage.

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

C. **PROCEDURE:**
1. When any **Workforce Member**~~employee, volunteer or physician~~ perceives that the situation may/or has become threatening verbally or physically, they should notify the hospital operator at ext. 66 and state Dr. Strong, then give their location. The operator will page overhead three times "Dr. Strong" with the location. The operator will repeat the Dr. Strong announcement on the hand-held two-way radios as well. Security Officers will respond to the location on a "stat" basis.
2. Employees at all off-site facilities will call 911 first and inform the Local Police Department of the situation. The off-site facilities will contact the hospital Security Department after the Dr. Strong has concluded to inform of the situation.
3. When the Security Department personnel arrive at the scene, they will obtain information regarding the incident from the person who has initial contact with the individual(s) who are causing the actual or potential threat. Security Department personnel will assess the situation to see if it can be handled appropriately and safely with the number of personnel at the scene. If assistance is required, Security will contact the **appropriate personnel for assistance**~~Engineering Department to their location~~.

a. **For Doctor Strong activation due to a patient's behavior, security and other responders will confer with the RN prior to patient interaction unless there is an actual physical harm incident. All patient care provided during the Dr. Strong will be under the direction of the RN caring for the patient.**

4. Security Department personnel may take additional action, which may be to call Local Police Department to respond and assist in restraining the individual or arrest if the involved persons and/or property is at risk
5. Staff will follow Administrative Human Resources Policy: Workplace Violence 8610-463 and complete the Workplace Violence Incident Report to document the situation per Occupational Safety and Health Administration (OSHA) guidelines.

D. **FORM(S):**

1. Workplace Violence Incident Report

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

1. Administrative Human Resources Policy: Workplace Violence 8610-463

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
HUMAN RESOURCES

ISSUE DATE: 03/04 **SUBJECT:** Compensation for Education

REVISION DATE~~(S)~~: 06/04; 10/05; 01/09; 09/13, 09/16 **POLICY NUMBER:** 8610-474

Administrative Content Expert Approval:	07/22
Administrative Policies & Procedures Committee Approval:	08/22
Medical Executive Committee Approval:	n/a
Administration Approval:	03/23
Professional Affairs Committee Approval:	n/a
~~Human Resources Department Approval:~~	~~09/16~~
~~Human Resources Committee Approval:~~	~~09/16~~
Board of Directors Approval:	09/16

A. **PURPOSE:**
1. To establish a compensation plan to support training and education programs for Tri-City Healthcare District (TCHD) employees.

B. **POLICY:**
1. TCHD is committed to maintaining a work environment that encourages self-development and learning for all employees. As part of that commitment, TCHD has established a compensation plan to support opportunities for self-development through internal and external training and education programs. The compensation plan encompasses three major types of educational programming in order to accomplish these goals.
2. Mandatory Training~~ and Continuing Education Programs –~~
   ~~TCHD requires that each employee continue his/her~~ **their** ~~own education to maintain a high level of job related competence and to ensure compliance with required education/certification.~~
   ~~2.~~**a.** Attendance by employees at lectures, meetings, training programs, required skill certifications (e.g. ACLS, B~~C~~LS, PALS, and NRP) and similar activities will be paid as hours worked if the following apply:
      ~~a.~~**i.** Attendance is mandatory.
      ~~b.~~**ii.** Management approval is received in advance for the class itself and the time commitment expected.
      ~~i.~~**iii.** Skills and knowledge are directly related to essential job functions.
   b. **See** Compensation for Mandatory Education, Pay Practice 474.01.
   c. **Failure to successfully complete required educational programs may result in an employee's termination of employment in accordance with Administrative Policy: Coaching and Counseling for Work Performance 424.**
3. ~~Professional/Personal Growth~~**Continuing Education**~~–~~
   a. TCHD encourages employees to pursue professional and personal growth through attendance at workshops, seminars, and conferences.
   b. If job-related and management approval is received in advance, TCHD may, at the discretion of the department director, pay related fees and/**or** the attendance time as hours worked.
   ~~d. If non-job-related, attendance time will not be paid and related fees may be eligible for reimbursement under the programs outlined in 4 below.~~
   c. **Criteria for Continuing Education Reimbursement**
      i. **Benefited employees who have completed six months of employment and who are actively employed at Tri City Healthcare District (TCHD) at the time**

of enrollment may be eligible for course fee reimbursement.

ii. **Courses/classes which provide continuing education (CE) credits (including those offered by TCHD)**

~~Non-job-related attendance time will not be paid.~~

~~Job related attendance time is eligible for reimbursement if approved by your Manager or Director.~~

iii. **Continuing education courses/classes are eligible for ~~tuition~~ reimbursement up to a maximum of $200 per fiscal year (July – June) and require Manager/designee level approval.**

iv. **Advance specialty certifications and their renewal fees may~~can~~ be applied to the $200 per fiscal year continuing education reimbursement.**

v. **Employee must submit an application ~~packets are available on the intranet and in~~ to the Education Department/designee within 90 days of course/class completion.**

~~i.~~**1) Applications must be submitted to the Education Department no later than June 1st to be eligible for the current fiscal year.**

~~3.~~**4.** Tuition Reimbursement Loan Program –

a. This program is established by TCHD to increase the applicant pool for certain critical positions and to provide opportunities for current employee career development **by enhancing and improving staff knowledge and skills by ~~taking~~completing college courses required for an approved degree**.

~~a.~~**b. See Tuition Reimbursement Loan Program Guidelines.** ~~Bachelors, Masters and Doctoral programs are also supported if approved by the Department Director.~~

~~b. All employees who have completed six months of employment may be eligible to receive education reimbursement loans. The employee must be actively employed at TCHD at the time of enrollment in the course of study. The employee will be eligible for loan forgiveness if he/she continues to work for TCHD one year for each year of benefit received. Eligible employees must be enrolled in an accredited program that will lead to licensure or certification in a position that TCHD has identified as requiring special recruitment efforts.~~

~~c. Targeted positions and their specific eligibility requirements, maximum funds, and employment commitment required for loan forgiveness are established by the Vice President of Human Resources, with approval by the Chief Executive Officer, based upon organizational staffing needs and budget considerations.~~

5. The ~~Chief Operating Officer~~ **Head of Human Resources**, with approval from the Chief Executive Officer, has authority and responsibility for administration of this policy. ~~Practices, procedures, and budget to support the administration of this policy will be developed by the Vice President of Human Resources in concert with the Director of Education, and Clinical Informatics.~~

~~4.~~**6. To the extent that any applicable collective bargaining agreement that is consistent with applicable law conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement prevails.**

C. **RELATED DOCUMENT(S)~~Compensation for Education~~:**

1. ~~Compensation for Mandatory Education, Pay Practice 474.01.~~
~~2. Compensation for Education Activities Related to Professional/Personal Educational Activities, Pay Practice 474.03.~~
~~3.~~**2.** Tuition Reimbursement Loan Program **Guidelines**~~, Pay Practice 474.04~~.
3. Tuition Reimbursement Loan Checklist
4. Tuition Reimbursement Application
5. Tuition Reimbursement Worksheet
6. Tuition Reimbursement Loan Agreement
7. Staff CE and Tuition Reimbursement Loan Program Procedure
~~4.~~**8. Tuition Repayment Agreement Form**

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE
HUMAN RESOURCES~~—PAY PRACTICE~~

ISSUE DATE:	**10/04**	**SUBJECT:**	**Compensation for Mandatory Education**
REVISION DATE~~(S)~~:	**12/14, 06/19, 03/20**	**POLICY NUMBER:**	**8610-474.01**

Human Resources Department Approval:	**~~02/20~~07/22**
Administrative Policies & Procedures Committee Approval:	**~~02/20~~08/22**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~03/20~~03/23**
Professional Affairs Committee:	**n/a**
Board of Directors:	**03/20**

A. **PURPOSE:**
1. To establish compensation practices for mandatory training and education.

B. **POLICY:**
1. All fulltime, part time, and per diem employees will be compensated for attendance at approved mandatory meetings, training programs, and/or similar activities (e.g., renewal of required certifications).
~~1.~~**2.** **All employees who have a job description that requires certification of any AHA certification~~class~~ must be entered into the Resuscitation Quality Improvement (RQI) program when they are renewing their certification.**
   a. **See RQI Program for description**
~~2.~~**3.** Employees will not be reimbursed for expenses related to the re-certification or renewal of expired certificates or professional licenses.
~~3.~~**4.** Registered Nurses under the CNA contract must code mandatory training using the appropriate Kronos workrule~~—MandClass~~.

C. **FORMS/TABLES/SCHEDULES:**
1. Approved hours for Required Education/Certification:

Class/Course Certification	**Payment Schedule**
Advanced Cardiac Life Support (ACLS)	Initial Certification: **Time spent up to 8**~~16~~ Hours~~.~~ Renewal **every 2 years**: **Time spent up to 6**~~8~~ Hours **t**~~.~~ **Quarterly session: completed during regular shift**
Basic Life Support (BLS)	Initial Certification: **Time spent** ~~U~~up to **3**~~4~~ Hours~~.~~ Renewal **every 2 years**: **Time spent** ~~U~~up to **2**~~3~~ Hours~~.~~ **Quarterly session: completed during regular shift** ~~Online Renewal: Up to 2 Hours total.~~
Pediatric Advanced Life Support (PALS)	Initial Certification: **Time spent up to 8**~~16~~ Hours~~.~~ Renewal **every 2 years**: **Time spent up to 6**~~8~~ Hours **Quarterly session: completed during regular shift**

Class/Course Certification	Payment Schedule
Neonatal Resuscitation Program (NRP)	~~Certification: 4 Hours.~~ **Initial Essential Provider: Time spent up to 2 hours one time** **Initial Essential with Advanced Provider: Time spent up to 2 hours** **Essential/Advance Provider renewal every 2 years: Time spent up to 2 hours** **Essential/Advanced Provider quarterly session: completed during regular shift**
Nonviolent Crisis Intervention (NVCI)	Initial Certification: **Time spent** ~~U~~up to 8 Hours. Renewal: **Time spent** ~~U~~up to 4 Hours. Flex Certification: **Time spent up to** 3 Hours ~~total~~.
Fetal Monitoring	Initial: **Time spent** ~~U~~up to 16 Hours. Renewal: **Time spent** ~~U~~up to 8 Hours.
Safety, Joint Commission, and/or Annual NetLearning Education	Paid for actual time required.
Other	VP Approval Required.

C. <u>RELATED DOCUMENT(S)</u>:

1. **Resuscitation Quality Improvement (RQI) Program**

Resuscitation Quality Improvement (RQI) Program

Tri-City Medical Center has implemented the American Heart Association's Resuscitation Quality Improvement (RQI) program. This is a groundbreaking new approach to maintaining competence in CPR through low dose, high frequency training. The innovative competency based training program for high-quality CPR improves patient outcomes.

- **RQI provides the optimum quality of care to our patients and to maintain regulatory compliance requires all staff who as part of their job requirements for BLS, ACLS, or PALS certification to be enrolled in the Resuscitation Quality Improvement program.**
- **Resuscitation Quality Improvement (RQI) is a hands on, return demonstration, comprehensive program of basic and advanced resuscitation skills and competencies through the use of the RQI mannequin and modules.**
- **Completion of the RQI for NRP Essential Provider assignment initiates the perpetual learning cycle that is renewed on a quarterly basis. All employees who have a job description that requires certification in NRP must register in RQI for NRP's learning platform and renew their Essential Provider credentials quarterly.**
- **In addition to the Essential Provider quarterly renewal, all employees who have a job description that requires certification as an NRP Advanced Provider will attend an instructor led event every two years.**

Process

- Initial certification for ACLS, BLS and PALS must be completeddone in a classroom setting from an AHA provider.
- All employees who have a job description that requires certification of any AHA class must be entered into the RQI program when they are renewing their certification. Completion of the RQI initial assessment will extend the recommended renewal date 3 months.
- Notification of a new quarterly assignment will be issued via the employee's Tri-City Healthcare District (TCHD) email account at the beginning of each quarter and will appear on the employees To Do List in TCHDTri-City's learning platform.

Tri-City Medical Cente

Oceanside, California

Pay Practice Manual

RETIRE – Incorporated into Administrative Human Resources Policy: Compensation for Education

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SUBJECT: Compensation for Professional & Personal & Personal Education Activities

Effective Date: 10/03/04

Number: 474.03

Revision Date:

Administrative Content Expert Approval:	**07/22**
Administrative Policies & Procedures Committee Approval:	**08/22**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**03/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**09/16**

~~**Policy Reference: Compensation for Education AP&P #474**~~

~~**Responsible Party: Director of Education**~~ ~~**Approval: VP of Human Resources 12/14**~~

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

~~1. To establish guidelines for reimbursement for attendance at workshops, seminars and conferences.~~

~~B. **PROCEDURE:**~~

~~1. Benefited employees who have completed six months of employment and who are actively employed at Tri City Health Care District (TCHD) at the time of enrollment maybe eligible for course fee reimbursement.~~

~~2. Non-job-related attendance time will not be paid.~~

~~3. Job related attendance time is eligible for reimbursement if approved by your Assistant Nurse Manager/Manager/Director.~~

~~4. Continuing education courses are eligible for tuition reimbursement up to a maximum of $200 per calendar year and require Assistant Nurse Manager/Manager level approval.~~

~~5. Advance specialty certification and renewal fees can be applied to the $200 per fiscal year educational reimbursement.~~

~~6. Application packets are available on the intranet and in the Education Department.~~

Move to Related Document Human Resources Policy: Compensation for Education

~~Pay Practice Manual~~

ISSUE DATE: 10/03/04

SUBJECT: Tuition Reimbursement Loan Program

REVISION DATE(S): 01/13

POLICY NUMBER: 474.04

~~Policy Reference: Compensation for Education AP&P #474~~
~~Responsible Party: Director of Education~~

Department Approval:	~~09/17~~07/22
Administrative Policies and Procedures Committee Approval:	~~09/17~~08/22
Administrative Approval:	03/23
Professional Affairs Committee Approval:	n/a
~~Human Resources Committee Approval:~~	~~12/14~~
Board of Directors Approval:	12/14

TUITION REIMBURSEMENT LOAN PROGRAM GUIDELINES

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

1. **This program is** ~~E~~established by Tri City Health District (TCHD) to increase the applicant pool for certain **critical** positions and to provide opportunities for **current employee** career development ~~to current employees~~ by enhancing and improving staff knowledge and skills by ~~taking~~ **completing** college courses **required for approved degree programs**.

~~B.~~ **PROCEDURE:**

1. ~~Benefited and non-benefited~~ **All** employees who have completed six months of employment may be eligible to receive ~~clinical~~ education reimbursement loans. **The employee must be actively employed at TCHD at the time of enrollment in the course of study. The employee will be eligible for loan forgiveness if they continue to work for TCHD one year for each year of benefit received.** Eligible employees must be enrolled in an accredited program that will lead to licensure or certification in a position that TCHD has identified as requiring special recruitment efforts. ~~Bachelors, Masters and Doctoral programs~~ **Degree programs on the Program Grid below** are ~~also~~ supported **if approved by the Department Director/Representative**.
2. Additional requirements:
   a. Courses must be ~~started and~~ **started and** completed while employed at TCHD
   b. The program must consist of at least 3.0 units for each semester/quarter
   c. The employee must maintain a 2.5 grade point average for each semester/quarter that reimbursement is being requested
   d. The employee must ~~maintain "meets standards" on all TCHD performance appraisals~~ **be in good standing and not engaged in progressive discipline.**
   e. The educational course **must be** ~~is~~ taken on the employee's own time, at a degree or certificate granting institution relating to a position at TCHD
   f. Loan proceeds ~~should be spent on~~ **are intended to reimburse employee for** tuition, books and supplies required for the program.
3. Requirements for Distribution of Loan:
   a. Proof of enrollment must be submitted to Education within 90 days of **last** course/semester/quarter ~~completion~~ **completed within the current fiscal year.** ~~unless submission is for entire year multiple semesters.~~

b. Completion of an employee Loan Agreement

~~b.~~**c.** **Applications must be submitted to the Education Department no later than June 1st to be eligible for the current fiscal year.**

4. Repayment or Forgiveness of Loan:
   a. ~~After completion of the training~~ **From the date funds are received,** an employee must work at TCHD ~~**consecutive**~~ one year ~~**terms**~~ for each year funds are received ~~in the position for which the training applies if the position is available~~.
5. Amount of Loan:
   a. Yearly available amounts are listed on the chart below.
   b. The total lifetime maximum ~~of~~ **is** up to $5000 per category/**program type**.
6. Additional required documents:
   a. Tuition Reimbursement Application signed by employee and ~~manager~~ **Department Director/Representative**.

~~Signature of the Director of Education.,~~

~~b. Cclinical Iinformatics and **Staffing**staffers.~~

~~c.~~**b.** ~~Official c~~College transcripts for the classes requesting reimbursement related to the degree.

~~d.~~**c.** ~~Any~~ **R**~~r~~eceipts for books, supplies and tuition.

7. Targeted positions and their specific eligibility requirements, maximum eligible funds and employment commitment required for loan forgiveness are established by the ~~Vice President~~ **Head** of Human Resources, with approval by the Chief Executive Officer, based upon organizational staffing needs and budget considerations. Current approval levels schedule:

Program Type	Employment Status	Funds per Fiscal year	Commitment
ADN (Associate Degree in Nursing**)**	At least per diem with minimum of 416 hours per year	$2000	1 year work for each year that funds are received
LVN to RN	At least per diem with minimum of 416 hours per year	$2000	1 year work for each year that funds are received
BSN (new graduate RN)	At least per diem with minimum of 416 hours per year	$2000	1 year work for each year that funds are received
RN to BSN	Benefited	$2500	1 year work for each year that funds are received
MSN/MN	Benefited	$5000	1 year work for each year that funds are received
Allied Healthcare Provider **Licensed by the state**	At least per diem with minimum of 416 hours per year	$2000	1 year work for each year that funds are received
Bachelor's Program	Benefited	$2000	1 year work for each year that funds are received
Master's Program	Benefited	$5000	1 year work for each year that funds are received
Doctoral	Benefited	$5000	1 year work for

Program			each year that funds are received

~~1.~~8. The E~~e~~ducation Department will review all tuition reimbursement loan requests for eligibility. **If eligible, the Education Representative will prepare and submit a Check Request and the Application packet to Administration Representative for approval and signature on the Check Request and Tuition Reimbursement Loan Agreement.** ~~If all the required documentation is submitted and the request is~~ If approved, **the Check Request and**~~, it~~ **Application packet** will be ~~sent to the Accounting Department~~**forwarded to Accounts Payable** for processing.

9. **Requirements for repayment of Tuition Reimbursement loans by Student.**
   a. **Repayment Conditions: Student changes School status**
      i. **If Student is expelled or drops out of the course(s) for which the loan has been issued, Student will repay the loan.**
      ii. **Student will notify ~~Education Department~~ the HR Department of status change and arrange for repayment of loan.**
      iii. **Education Department Representative (Rep) will give Student the Repayment Agreement form and arrange a payment schedule with Student.**
   b. **Repayment Conditions: Employment status changes**
      i. **Both Tri-City Healthcare District (TCHD) and Student have the right to terminate Student's employment, either during the School term, clinical training or thereafter, with or without cause at any time.**
      ~~i.~~ii. **If either party exercises its rights under this clause, Student shall be required to repay TCHD any portion of the loan paid thereof if employment with TCHD is terminated for any reason (other than involuntary layoff) prior to the fulfillment of the employment commitment as outlined in the Tuition Reimbursement Loan Agreement.**
   c. **HR will review the information and contact Student, give Student the Repayment Agreement form and arrange a payment schedule with Student.**
   d. **Rehire status will be put to "Not Eligible for rehire."**

10. **Education Department Representative will ~~regularly check~~ review the monthly TCHD Termination list and ~~will~~ notify Human Resources (HR) ~~that the employee received tuition reimbursement~~if employee termed prior to completing the mandatory employment commitment required by the Loan Agreement.**

~~8.~~11. **To the extent that any applicable collective bargaining agreement that is consistent with applicable law conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement prevails.**

RELATED DOCUMENT(S):

~~1.~~ 1. **Administrative Policy: Compensation for Education 474**
2. **Tuition Reimbursement Loan Checklist**
3. **Tuition Reimbursement Application**
4. **Tuition Reimbursement Worksheet**
~~2.~~ 5. **Tuition Reimbursement Loan Agreement**

Tuition Reimbursement Loan Checklist

To be considered for the current fiscal year, your Application must be received in the Education Department by June 1st. Only one Application and Loan Agreement shall be accepted per fiscal year (July 1 – June 30). Please make sure all items listed below are included in your application packet. Forms must be typed or printed in ink and completely filled out, including appropriate signatures. The following must be submitted to Education within 90 days of last semester/quarter completed per application:

_______ Reimbursement Application completed and signed by Manager.

_______ Completed Tuition Reimbursement Worksheet with receipts for tuition, books, or supplies. Copy of check or credit card statement/receipt used to pay for classes.

_______ Tuition Reimbursement Loan Agreement completed and signed by employee.

_______ College transcripts for the classes requesting reimbursement related to the degree.

Tuition Reimbursement Loan Program FAQS

Employee Eligibility

- Benefited and non-benefited employees who have completed 6 months of employment. Please see Loan Program grid to determine eligibility. Total lifetime maximum of up to $5000 per category.
- Per Diem status requires 416 hours of work per year.

Requirements

- **Employee must be in good standing and not engaged in progressive discipline.**
- Course must be started and completed while employed at TCHD.
- The accredited program must consist of at least 3.0 units for each semester/quarter.
- Employee must maintain a 2.5 grade point average for each semester/quarter that reimbursement is being requested.
- The educational course is taken on the employee's own time, at a degree granting institution relating to a position at TCHD.

Forgiveness or Repayment of Loan

- ~~After completion of the training,~~ **From the date funds are received,** an employee must work at TCHD ~~consecutive~~ **one** year ~~terms~~ for each year funds are received.
- ~~If employee does not work one year for each year of funding, the employee will be required to repay TCHD under terms of the Loan Agreement.~~

Tuition Reimbursement Loan Program

Program Type	Employment Status	Funds Per Fiscal Year	Commitment
ADN (Associate Degree in Nursing)	At least per diem with minimum of 416 hours per year	$2000	~~After completion of the training,~~ 1 year work for each year that funds are received
LVN to RN	At least per diem with minimum of 416 hours per year	$2000	~~After completion of the training,~~ 1 year work for each year that funds are received
BSN (new graduate RN)	At least per diem with minimum of 416 hours per year	$2000	~~After completion of the training,~~ 1 year work for each year that funds are received
RN to BSN	Benefited	$2500	~~After completion of the training,~~ 1 year work for each year that funds are received
MSN/MN	Benefited	$5000	~~After completion of the training,~~ 1 year work for each year that funds are received
Allied Healthcare Provider	At least per diem with minimum of 416 hours per year	$2000	~~After completion of the training,~~ 1 year work for each year that funds are received
Bachelor's Program	Benefited	$2000	~~After completion of the training,~~ 1 year work for each year that funds are received
Master's Program	Benefited	$5000	~~After completion of the training,~~ 1 year work for each year that funds are received
Doctoral Program	Benefited	$5000	~~After completion of the training,~~ 1 year for each year that funds are received

TUITION REIMBURSEMENT

APPLICATION

Please submit a completed application to the Education Department **by June 1st, to be considered for the current fiscal year**. ~~In order to be considered,~~ Applications and associated forms must be typed or printed in ink and completely filled out.

I am requesting funds for the following:

Program Type: ______________________________

Program Institution: ______________________________

Dates of class/program (within current fiscal year): ______________________________

Amount $ ______________________________

Expected Program Completion Date: ______________________________

Employee Information:

Name ______________________________ Date ______________

Address ______________________________ City ______________ Zip Code __________

Home/Cell Phone # ______________________ Work Phone # ______________________

Credentials/Degrees ______________________________

Employee Number ______________________ Date of Hire ______________________

Employment Status: [ ] Full-time Unit/Dept.: ______________________

[ ] Part-time Unit/Dept.: ______________________ Hours/Pay Period ____

[ ] Per Diem Unit/Dept.: ______________________

Please provide a brief description of your long-term educational plans and goals.

____

____

____

____

____

Please list any tuition education funds you have received from Tri-City Medical Center (including Foundation grants).

____

____

____

____

____

____

Employee Name (print)	Department
Employee Signature	Date:

Employee is in good standing and not engaged in progressive discipline per Administrative Policy #424.

MANAGER'S NAME (please print)	MANAGER'S SIGNATURE	DATE

Tri-City Medical Center
ADVANCED HEALTH CARE...FOR YOU

Tuition Reimbursement Worksheet

Instructions: Please complete form and attach copies of receipts.

Employee Name ______________________ Employee Number ____________________

Department __________________________

Item (Tuition/fees/textbooks)	Amount	Date
TOTAL:		

TRI-CITY HEALTHCARE DISTRICT

TUITION REIMBURSEMENT LOAN AGREEMENT

This Agreement is entered into between Tri-City Healthcare District ("TCHD") and ____________________________ ("STUDENT").

Because TCHD has determined that it would be beneficial to the institution to encourage current employees to pursue a course of training in ___________________("QUALIFYING PROGRAM") as a ______________ ("QUALIFIED SPECIALIST"); and

Because STUDENT wishes to pursue a QUALIFYING PROGRAM and become a QUALIFIED SPECIALIST;

NOW, THEREFORE, THE PARTIES DO HEREBY AGREE AS FOLLOWS:

1. TCHD will loan STUDENT the gross amount of $_________ ("LOAN"), for attendance at ___________________ School ("SCHOOL") during school year _____—_____ ("SCHOOL TERM"). The tuition reimbursement loan check will be provided, as soon as the applicable requirements described in Paragraph 4 are met.
2. Use of Loan Amount: STUDENT agrees to use the above-referenced loan for education-related expenses during the SCHOOL TERM. This includes expenses for tuition, fees, textbooks, and other education-related expenses.
3. Employment Status While Attending School: As a condition precedent to receiving the loan described, STUDENT must maintain active employment status at least on a per diem basis for a minimum of six months. STUDENT must maintain per diem status throughout training with a minimum of 416 hours per year. Exceptions: RN to BSN, MSN/MN, bachelor, master's and doctoral degree programs, STUDENT must be a benefited employee. Course/program must be started and completed while employed at TCHD.
4. Submittal of Documents: Proof of enrollment into the accredited QUALIFYING PROGRAM, or courses must be submitted to Education within 90 days of course completion. STUDENT must submit the following documents before a tuition reimbursement loan check is issued:
    a. Proof of enrollment in at least 3.0 units for each semester/quarter for which funds are requested;
    b. A transcript and grade report, at the end of the each semester or quarter, whichever is applicable, reflecting course work completed during that semester or quarter;
    c. Maintenance of a minimum 2.5 grade point average or better for each semester/quarter for which funds are requested, in addition to meeting all

other requirements established by the SCHOOL or by federal or state laws as requirements for becoming a QUALIFIED SPECIALIST;

d. Written approval of Manager to determine program eligibility for tuition reimbursement;

e. Copies of receipts for eligible reimbursable items (i.e., tuition, books, supplies, etc.);

f. Completion of the Tuition Reimbursement Application;

g. Completion of the Tuition Reimbursement Loan Agreement.

5. Eligibility for Position as QUALIFIED SPECIALIST: TCHD will make an effort to provide QUALIFIED SPECIALISTS with positions in their specialty; however, the District cannot guarantee such positions will be available.

6. Forgiveness of Repayments: TCHD will forgive LOAN under the following circumstances, and to the extent identified:

   a. Employment Forgiveness: ~~After completion of the training an~~**In consideration for the above-mentioned loan, from the date funds are received** employee must work at TCHD ~~**consecutive**~~ one year ~~**terms**~~ for each year funds are received ~~in the position for which the training applies~~.

   b. Disability Forgiveness: If STUDENT is totally disabled, within the meaning of Internal Revenue Code Section 22(e)(3), at the time any loan becomes due hereunder, said loan payment will be forgiven. To qualify for this disability forgiveness, a STUDENT must submit medical proof of total disability satisfactory to Employee Health Services.

7. Income Tax Implications: STUDENT will be responsible for all income tax obligations resulting from STUDENT's participation in this Employee Loan Program.

8. Repayment Conditions: If STUDENT is expelled or drops out of the course(s) for which the loan has been issued, STUDENT will repay the loan. Both TCHD and STUDENT have the right to terminate STUDENT's employment, either during the SCHOOL TERM, clinical training or thereafter, with or without cause at any time. If either party exercises its rights under this clause, STUDENT shall be required to repay TCHD any portion of the loan paid thereof if employment with TCHD is terminated for any reason (other than involuntary layoff) prior to the fulfillment of the employment commitment as outlined in policy.

9. Participation is Voluntary. STUDENT's participation in the Tuition Reimbursement Loan Program is completely voluntary. The education and coursework which will be pursued pursuant to this Agreement are not in any way necessary for STUDENT to continue in STUDENT's current employment with TCHD, and if STUDENT had decided not to participate in this program, this would not have affected STUDENT's employment.

10. No Promise of Continued Funding: STUDENT understands that this agreement to provide STUDENT with a LOAN for this SCHOOL TERM does not indicate or evidence any promise that additional loans will be issued for further school terms.
11. Promissory Note: If STUDENT does not meet the eligibility for Forgiveness of Repayments (Paragraph 6) or is expelled or drops out of the applicable courses/program (Paragraphs 8) STUDENT promises to make repayments on the LOAN.
    a. STUDENT agrees to pay the actual expenditures in any attempt to collect the amount due under this Note, including all costs and attorney's fees incurred by` TCHD in any action to collect this Note. STUDENT hereby waives demand and presentment for payment, notice of non-payment, notice of protest and protest of this Note.
    b. All payments called for hereunder shall be paid in lawful currency of the United States of America.
    c. Nothing in this Promissory Note shall interfere with the right of TCHD or Borrower to terminate Borrower's employment at TCHD with or without cause at any time.
12. Entire Agreement: This Agreement is the parties' entire agreement regarding the LOAN. This Agreement may only be amended or changed if such change or amendment is in writing and signed by both parties and dated subsequent to this Agreement.

In exchange for the mutual promises contained in this Agreement, both parties execute this Agreement on the _____ day of _______________, 201__, at Oceanside, California.

_______________________________	_______________________________
Administrative Representative Name (print) ~~Kathy Topp, Director of Education,~~ ~~Clinical Informatics & Staffing~~	Student's Name (print):
_______________________________	_______________________________
Administrative Representative Signature	Student's Signature:
Date: ____________________	Date: ____________________
	Department: ____________________
	Title: ____________________

Repayment Agreement Form
Tuition Reimbursement Loan Program (HR Policy 474)

Repayment Conditions: If STUDENT is expelled or drops out of the course(s) for which the loan has been issued, STUDENT will repay the loan. Both TCHD and STUDENT have the right to terminate STUDENT's employment, either during the SCHOOL TERM, clinical training or thereafter, with or without cause at any time. If either party exercises its rights under this clause, STUDENT shall be required to repay TCHD any portion of the loan paid thereof if employment with TCHD is terminated for any reason (other than involuntary layoff) prior to the fulfillment of the employment commitment as outlined in policy.

I____ hereby acknowledge an indebtedness to

Tri-City Medical Center (Tri-City Healthcare District) in the amount of $ ____________________________

In order to liquidate said indebtedness, I hereby agree to repay Tri-City Medical Center:

$_________________ in full/lump sum (or) per week/month/year (circle one) payable on the
1st/15th of month (circle if applicable).

Tri-City Medical Center shall apply said amount to the above indebtedness.

Check Payable to: Tri-City Medical Center (note: Tuition Loan Repayment)
Mail to: Education Department
Tri-City Medical Center
4002 Vista Way
Oceanside, CA 92056

Employee Name (print) ____

____ ____________________
Employee Signature Date

Address: ____

____

Phone (home): ____________________ Cell: ____________________

****
****

____ ____________________
Representative Date

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
HUMAN RESOURCES

ISSUE DATE:	07/71	SUBJECT:	Dress and Appearance Philosophy
REVISION DATE~~(S)~~:	05/88~~;~~, 07/97~~;~~, 04/00~~;~~, 03/03; 02/05, 07/05, 12/08, 07/09, 04/10, 09/10 09/16	POLICY NUMBER:	8610-415

Human Resources Department Approval:	~~09/16~~09/22
Administrative Policies & Procedures Committee Approval:	~~07/20~~09/22
Administration Approval:	03/23
Professional Affairs Committee Approval:	n/a
~~Human Resources Committee Approval:~~	~~09/16~~
Board of Directors Approval:	09/16

A. **POLICY:**

1. The Tri-City Healthcare District ("TCHD") is a professional organization, and patients, visitors, vendors, and the general public frequently form their initial impressions of professional credibility based solely on employee appearance. ~~Through this policy,~~ TCHD seeks to ensure that every employee's appearance is in compliance with health and safety regulations, ~~reflects TCHD's commitment to its service excellence initiative,~~ conveys a positive image of the organization, and provides a comfortable environment for patients.
2. Employees shall exercise good judgment in personal dress, appearance, and the use of fragrances to present a professional appearance **that is** appropriate to their job classification~~s~~. Department Directors or ~~their~~ designee~~s~~ shall ensure that employees are dressed appropriately, are groomed, and meet the fragrance control guidelines.
3. This policy is intended to provide standards for dress and appearance and is not meant to address all situations. The **Head of** ~~Chief~~ Human Resources ~~Officer~~ retains authority to determine whether an individual is meeting the professional appearance standards as set forth in this policy.

B. **GUIDELINES:**

1. Employee Attire
   a. Employees will be required to wear the designated department uniform or appropriate business attire. Clothing should be clean, neat, without tears, ~~business-like/~~business casual and of appropriate fit.
   b. The following clothing is unacceptable and therefore prohibited:
      i. Casual attire, including but not limited to~~,~~: denim **(exception: denim pass holder)**, athletic clothing, **non-TCHD logo hooded sweaters (plain colors hooded sweaters must be approved by department leadership),**- sweats, shorts, **non-TCHD** logo T-shirts/tank tops and similar items.~~;~~
      ii. Revealing, low cut, see-through or tight clothing that presents an unprofessional appearance.~~;~~
      iii. Pants shorter than calf-length, skirts more than 3 inches above the knee, and midriff-revealing clothing.
   c. Undergarments must be worn~~&~~ **and** chosen appropriately regarding color of the uniform/clothing worn so as not to be visible through the outer clothing.
2. Accessories and Jewelry

a. Photo identification badges must be worn above the waist line by all employees and the identification information must be visible in accordance with ~~TCHD~~ **Administrative** Policy**: Identification of Employees and Non-TCHD Employees** ~~#~~436.

b. Nothing but post piercings (for example earrings) should be worn in patient care areas.

~~b. All employees must remove facial, tongue and other piercings during working hours. Employees are limited to displaying two piercings per ear, unless wearing such piercings pose a safety or health risk for the employee or the patients.~~

c. All jewelry must be appropriate, not detract from a professional appearance, and not constitute a potential safety hazard for the employee or others due to its characteristics or the manner in which it is worn. Such a determination shall rest in the discretion of the Department Director or ~~Chief~~ **Head of** Human ~~Resources~~**Resources** ~~Officer~~.

d. Pursuant to Center for Disease Control (CDC) guidelines, TCHD employees who deliver direct patient care cannot wear artificial fingernails or nail jewelry. Nails must be less than one fourth inch in length, clean and trimmed.

~~d.~~**e. Sunglasses, unless medically prescribed must not be worn during work hours or while at work.**

3. Shoes
   a. Pursuant to safety requirements and TCHD policy, closed-toe shoes may be required. Open-toe shoes (including **heels,** sandals**, etc.**) may be worn when approval is obtained from the appropriate Director or ~~Chief~~ **Head of** Human ~~Resources~~**Resources** ~~Officer~~.
4. Grooming
   a. All employees must maintain a clean, presentable appearance.
   b. All employees should undertake to bathe regularly and to control body odor, including using deodorant or other odor controlling products as necessary.
   ~~c. All employees must cover tattoos when possible, including wearing long sleeves, turtlenecks or opaque hose.~~
   ~~d.~~**c.** Hair, beards, and moustaches must be trimmed, groomed**,** ~~and~~ clean**, and** ~~.~~**length may be determined per position for safety requirement.**
5. Hats/Head Coverings
   a. Personal hats and other personal head coverings are deemed not to be acceptable attire for TCHD employees.
   b. Unless approved by management, only hats or head coverings that are a part of a TCHD approved employee uniform, or that are worn for health or safety reasons may be worn during working hours.
   c. Management may approve head garb worn for religious reasons, so long as patient and/or employee safety is not compromised by the wearing of such head garb.
6. Fragrances
   a. When used, fragrances shall be applied in moderation. For purposes of this section, fragrances shall include any products that produce a scent strong enough to be perceived by others.

C. **GENERAL:**

1. Employees who are inappropriately dressed may be sent home and directed to return to work promptly, once suitably attired. Such employees will not be paid for this time. Disciplinary action, pursuant to **Administrative** Policy**:** ~~#~~ **Coaching and Counseling for Work Performance** 424 will be taken with repeated violations of this policy.
2. TCHD-supplied uniforms or scrub attire for use in designated areas (Operating Room, Angiography Lab, ~~Lift Team,~~ etc.) are not to be worn for general purposes or as a substitute for personal attire.
3. TCHD employees shall not wear uniforms or scrub attire from other healthcare institutions on TCHD premises.
4. Individual departments may, with the approval of the department Director, establish more

specific dress guidelines, which are appropriate to their unit.

5. The **Head of** ~~Chief~~ Human Resources ~~Officer~~ or designee may grant exceptions to this policy for Special Hospital Initiatives or upon request as required by law to accommodate an employee's protected status.

~~This policy shall be provided to all new hires for review prior to the completion of the hiring process.~~

6. ~~7.~~ TCHD will comply with all applicable laws relating to religious dress and grooming practices, including California Government Code sections 12926 and 12940.

7. To the extent that any applicable collective bargaining agreement that is consistent with applicable law conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement prevails.

D. RELATED DOCUMENT (S):

~~6.~~ **1. Administrative Policy: Coaching and Counseling for Work Performance 424**

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE ~~POLICY~~
HUMAN RESOURCES

ISSUE DATE: 06/87

SUBJECT: Paid Time-Off Program

REVISION DATE(S): 04/12, 02/13, 01/16

POLICY NUMBER: 8610- 433

~~Department~~ Administrative Content Expert Approval:	10/17
Administrative Policies & Procedures Committee Approval:	~~10/17~~09/20
Medical Executive Committee Approval:	n/a
~~Human Resources Committee Approval:~~	~~10/17~~
Administration Approval:	03/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	10/17

A. **PURPOSE:**

1. The Paid Time-Off Program is designed to provide eligible Tri-City Healthcare District (TCHD) employees with compensated time away from their regular assignment in order to ensure their physical and mental well-being. It is also designed to encourage advance scheduling of time off in order to provide for optimum staffing.

B. **POLICY:**

1. The Paid Time-Off Program provides for the utilization and compensation of accrued time off.
2. Paid Time Off is to be used for absences to cover vacations, holidays, illnesses or injuries of employees or their immediate family members, and personal reasons.

C. **PAID TIME-OFF (PTO) ELIGIBILITY, ACCRUAL AND USE:**

1. All benefitted full-time, part-time and weekend professional employees are eligible to accrue Paid Time Off (PTO) hours each pay period in accordance with the **Paid Time Off (PTO) Accrual Grid**~~following accrual schedule below:~~.

~~FULL TIME EMPLOYEE ACCRUAL RATE~~			~~80% TIME EMPLOYEE (64-79 hrs/week) ACCRUAL RATE~~			~~60% TIME EMPLOYEE (48-63 hrs/week) ACCRUAL RATE~~		
~~Years of Tenure***~~	~~Pay Period Accrual~~	~~Maximum Hours~~	~~Years of Tenure***~~	~~Pay Period Accrual~~	~~Maximum Hours~~	~~Years of Tenure***~~	~~Pay Period Accrual~~	~~Maximum Accrual~~
~~0-3~~	~~7.38~~	~~384~~	~~0-3~~	~~5.91~~	~~307.2~~	~~0-3~~	~~4.43~~	~~230.4~~
~~4-9~~	~~8.92~~	~~464~~	~~4-9~~	~~7.14~~	~~371.2~~	~~4-9~~	~~5.35~~	~~278.4~~
~~10-14~~	~~10.46~~	~~544~~	~~10-14~~	~~8.37~~	~~435.2~~	~~10-14~~	~~6.28~~	~~326.4~~
~~15-19~~	~~10.77~~	~~560~~	~~15-19~~	~~8.62~~	~~448~~	~~15-19~~	~~6.46~~	~~336.0~~
~~20+~~	~~11.08~~	~~575~~	~~20+~~	~~8.86~~	~~460.8~~	~~20+~~	~~6.65~~	~~345.6~~

2. Per Diem Week-End Professionals accrue PTO at a rate of 1.23 hours/pay period.
3. Tenure is defined as the number of years worked since the most recent benefit eligibility date.
4. Eligible employees begin to accrue PTO on the first of the month following thirty (30) days of employment in a benefited status and are eligible to use PTO upon its accrual. In compliance with the CA Paid Sick Leave Law (PSL), benefited employees are eligible to utilize up to three days of their accrued PTO for PSL. (See Administrative Policy: Leave of Absence 435).
5. PTO is used for the first sixteen (16) consecutive hours of any absence.
6. PTO is used to compensate employees for both scheduled and unscheduled absences.

a. Scheduled PTO – In order to provide for optimum staffing, absences must be planned and scheduled in advance. An employee must have ~~his/her~~ **their** Department Director/Manager/designee's prior approval to schedule PTO. Vacations, holidays, personal business, doctors' appointments, or other similar absences, will be paid through PTO provided appropriate, prior approval has been obtained. The amount of advance notice required is two weeks prior to the affected schedule.

b. Unscheduled PTO – Absences due to illness or emergencies are not possible to predict but may be compensated through unscheduled PTO. An employee who will be unable to report to work must notify ~~his/her~~ **their** immediate supervisor, two (2) hours prior to the scheduled starting time of ~~his/her~~ **their** workday, in accordance with Administrative Policy: Absences and Tardiness 408.

c. For absences related to the employee's own illness, see the Administrative Policy: Annual and Extended Leave Bank Policy 489.

d. An employee who misses work due to an illness or injury may be required to obtain a physician's statement.

e. Employee Health Services is available to assist with situations involving illness or injury, **and** fitness for duty.~~, and reasonable accommodations.~~

f. Requests for PTO may be denied based upon departmental operational requirements.

7. TCHD requires the use of PTO to supplement other payments such as State Disability Insurance (SDI) and Family **Paid Leave (FPL)**~~Temporary Disability Insurance (FTDI)~~. PTO may be used to supplement workers compensation payments, if the employee chooses.

8. The maximum amount that an employee can accrue in ~~his or her~~ **their** PTO account is two (2) times the employee's annual accrual rate as determined by designated FTE (see **Paid Time Off (PTO) Accrual Grid**~~Table in Section C.1. above~~). When an employee's PTO account reaches this cap, accrual will stop until such time as the employee reduces ~~his or her~~ **their** PTO balance.

9. The payment of accrued PTO hours is automatic for scheduled and unscheduled except in flex/float activity occurrences and is intended to compensate the employee at the level of ~~his or her~~ **their** regularly scheduled hours.

10. In accordance with Administrative Policy: Absences and Tardiness 408, an employee may not use PTO for a "No Call, No Show" absence.

11. In the event that an employee suffers a severe financial hardship resulting from an unforeseeable emergency, TCHD may in its sole and absolute discretion, permit the employee to withdraw from their PTO account the amount necessary to eliminate the hardship. Use of PTO Hours for Hardship procedure can be found in Use of PTO Hours for Hardship Guidelines.

D. **PTO- CASH OUT~~BUY-BACK~~:**

1. Employees are given the opportunity to be paid for a portion of their PTO once each year under conditions designed to comply with Internal Revenue Service requirements regarding constructive receipt~~. PTO Cash Out procedure can be found in~~ **see Paid Time Off (PTO) Cash Out Guidelines.**~~:~~

~~a. The employee must complete an irrevocable election form during the designated election period, indicating the number of PTO hours to be paid. The employee may elect to be paid a minimum of twenty (20) hours and a maximum of eighty (80) hours. To be eligible to be paid PTO, the employee must maintain a minimum balance of forty (40) PTO hours following subtraction of the designated hours from his/her accrued PTO.~~

~~b. Once an employee has elected to be paid PTO hours, the designated hours are subtracted from his/her PTO balance and cannot be used for scheduled/unscheduled absences. The designated hours will be paid at the employee's base hourly pay rate in effect at the time of the payment.~~

~~c. Generally, irrevocable elections will be made during the last calendar quarter of the year for payout during the last quarter of the following year.~~

E. **CHANGE IN STATUS:**

1. When changing from benefited to non-benefited status, an employee will be paid all eligible accrued PTO hours at ~~his/her~~ **their** benefited base rate of pay.
2. When changing from full time to part time status, an employee will be paid the number of eligible accrued PTO hours required to reduce ~~his/her~~ **their** PTO balance relative to the part time maximum accrual.

F. **TERMINATION:**

1. Upon termination of employment, an employee will be paid all eligible accrued PTO hours at ~~his/her~~ **their** base rate of pay.

G. **ADMINISTRATION:**

1. The~~-~~ **Head of** ~~Chief~~ Human Resources ~~**leadership**~~ ~~Officer (CHRO)~~, with approval from the Chief Executive Officer, has authority and responsibility for administration of this policy. Practices and procedures to support the administration of this policy will be developed by ~~the CHRO~~**the Head of Human Resources** ~~**leadership**~~. Exceptions to this policy must be approved by **the Head of Human Resources** ~~**leadership**~~ ~~the CHRO~~ and Chief Executive Officer.

~~1.~~**2. To the extent that any applicable collective bargaining agreement that is consistent with applicable law conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement prevails.**

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

1. Administrative Policy: Absences and Tardiness 408
2. Administrative Policy: Annual and Extended Leave Bank Policy 489
3. Administrative Policy: Leave of Absence 435
4. PTO Cash Out Guidelines
5. Use of PTO Hours for Hardship Guidelines
~~3.~~**6. Paid Time Off (PTO) Accrual Grid**

I. **REFERENCE(S):**

1. ~~Paid Sick Leave Law, Cal. AB-1522 (2014).~~**Healthy Workplace Healthy Family Act of 2014 (AB1522, amended with AB304)**
~~1.~~**2. Wage Theft Protection Act of 2011 (AB469)**

~~**Department Approval: 10/17**~~
~~**Administrative Policies & Procedures Committee Approval: 10/17**~~
~~**Human Resources Committee Approval: 10/17**~~
~~**Board of Directors Approval: 10/17**~~

Paid Time Off (PTO) Accrual Grid

FULL TIME EMPLOYEE ACCRUAL RATE			80% TIME EMPLOYEE (64-79 hrs/week) ACCRUAL RATE			60% TIME EMPLOYEE (48-63 hrs/week) ACCRUAL RATE		
Years of Tenure***	Pay Period Accrual	Maximum Hours	Years of Tenure***	Pay Period Accrual	Maximum Hours	Years of Tenure***	Pay Period Accrual	Maximum Accrual
0-3	7.38	384	0-3	5.91	307.2	0-3	4.43	230.4
4-9	8.92	464	4-9	7.14	371.2	4-9	5.35	278.4
10-14	10.46	544	10-14	8.37	435.2	10-14	6.28	326.4
15-19	10.77	560	15-19	8.62	448	15-19	6.46	336.0
20+	11.08	575	20+	8.86	460.8	20+	6.65	345.6

Note: Tenure is defined as the number of years worked since the most recent benefit eligibility date

Tri-City Medical Center
Oceanside, California

Move from Pay Practice Manual to related document to Administrative Policy: Paid Time Off 433

~~TRI-CITY MEDICAL CENTER PAY PRACTICE MANUAL~~

-

~~TITLE: PTO Buyback~~
~~NUMBER: 433.01~~
~~POLICY REFERENCE: Paid Time Off AP&P#433~~

~~EFFECTIVE DATE: 10/3/04~~
~~REVISION DATE:~~

APPROVAL: ______________________

PAID TIME OFF (PTO) CASH OUT GUIDELINES ~~PURPOSE:~~

1. **Employees are given the opportunity to be paid for a portion of their PTO once each year under conditions designed to comply with Internal Revenue Service requirements regarding constructive receipt:**
2. **The employee must complete an irrevocable election form during the designated election period, indicating the number of PTO hours to be paid. The employee may elect to be paid a minimum of twenty (20) hours and a maximum of eighty (80) hours. To be eligible to be paid PTO, the employee must maintain a minimum balance of forty (40) PTO hours following subtraction of the designated hours from their accrued PTO.**
3. **Once an employee has elected to be paid PTO hours, the designated hours are subtracted from their PTO balance and cannot be used for scheduled/unscheduled absences. The designated hours will be paid at the employee's base hourly pay rate in effect at the time of the payment.**
4. **Generally, irrevocable elections will be made during the last calendar quarter of the year for payout during the last quarter of the following year.**

~~To describe procedures used for payment of PTO buyback to eligible employees. Eligible employees may cash out up to 80 hours of their accumulated PTO annually. Employees must meet TCHD eligibility criteria which are required by the IRS.~~

PROCEDURE~~S~~:

1. **The payroll department will send out a notice regarding PTO Cash Out that will include PTO Cash Out deadlines.**
2. **Eligible PTO Cash Out forms will be available in Lawson Employee Self Service on designated date provided by payroll.**

~~1. Payment is made by check not direct deposit.~~

3. ~~2.~~ Eligibility is based on sufficient PTO balance as of qualifying date.
   a. **If you wish to receive a PTO Cash Out for the end of next calendar year (e.g. December), you must fill the form available in Employee Self Service.**
   b. **Indicate the PTO hours requested to cash out for the end of next calendar year (e.g. December), sign and return the form by emailing it to PTObuyback@tcmc.com or drop it off in the secured lockbox outside of the payroll window no later than 5:00 p.m. on due date.**

   ~~a. Sufficient PTO balance is 60 hours or more as of the qualifying date.~~

   ~~b. The qualifying date is the last day of the first pay period that ends in January.~~

   a. ~~c.~~ A minimum of 20 hours and a maximum of 80 hours may be cashed out annually provided that the employee's PTO balance does not go below 40 hours.

   ~~3. An election form will be sent to all eligible employees in January.~~

   ~~a. Employees must sign and return the letters to Human Resources by the due date on the letter.~~

   c. ~~b.~~ The PTO hours elected for ~~buyback~~ **cash out** are removed from the employee's PTO balance after the election form has been signed and turned in to ~~HR.~~ **Payroll.**
4. **Pay will be made using the current pay method you have on file. (Direct deposit or check**

Move from Pay Practice Manual to related document to Administrative Policy: Paid Time Off 433

will be MAILED to the address on payroll file – No Exceptions for pick up)

c. EXAMPLEExample PAY OUT pay out usingUSING 200419 datesDATES.

Notes:

Red not included in Policy 433, do we need specific instructions for PTO buyback process other than what is included policy 433? If so should there be an additional document for 433.

1. Employee Jane Doe has a PTO balance of 150 hours as of JanuaryDecember 106, 200419.
2. **Payroll just announced the PTO Cash out from is available on Employee Self Service.**
   January 10 is the last day of the first pay period that ends in January.
3. The election form is sent out on January 15 with a due **on December 27, 2019 by 5:00 p.m**date of January 30. Jane Doe decides to cash out 80 hours of PTO, then signs and returns the form to **payroll by sending an email to ptobuyback@tcmc.com** HR by the due date.
4. Jane Doe's PTO balance will then be reduced from 150 hours to 70 hours, reflecting her buyback election of 80 hours.
5. Jane Doe receives a check **direct deposit on pay date December 17, 2020** for 80 hours of PTO.

PTO Buyback – 10/03/04 2 of 2

Move from Pay Practice Manual to related document to Administrative Policy: Paid Time Off 433

~~TRI-CITY MEDICAL CENTER PAY PRACTICE MANUAL~~

~~TITLE: Use of PTO Hours for Hardship EFFECTIVE DATE: 1/2011 NUMBER: 433 REVISION DATE: 1/2011 POLICY REFERENCE: Paid Time Off – AP #433 RESPONSIBLE PARTY: Chief Human Resources Officer APPROVAL:~~

USE OF PTO HOURS FOR HARDSHIP GUIDELINES

PURPOSE:

1. In the event that an employee suffers a severe financial hardship resulting from an unforeseeable emergency, Tri-City Healthcare District (TCHD) may in its sole and absolute discretion, permit the employee to withdraw from ~~his or her~~**their** -PTO account the amount necessary to eliminate the hardship.

PROCEDURES:

1. Hardship withdrawals are limited to unforeseeable emergency circumstances such as sudden or unexpected illness or accident, which results in uninsured, severe financial hardship. -Employee must be able to demonstrate that the hardship is not otherwise covered by insurance or that the liquidation of the employee's assets would not reasonably cure the hardship. -If a hardship distribution is granted, the employee may only withdraw the amount reasonably necessary to satisfy the emergency hardship.
2. Hardship withdrawal distributions are treated as taxable income and all applicable federal and - state tax will be withheld. -An employee must have a minimum PTO balance of forty (40) hours- remaining after the withdrawal and is limited to two (2) circumstances per calendar year.
3. Hardship withdrawal forms are available from the Human Resources Department. The completed form with all supporting documentation is submitted to the Department Director for approval and then to the ~~Chief~~ **Head of** Human Resources ~~Officer~~ for approval.

~~1.~~**4.** Upon approval of the hardship pay, the **Head of** ~~Chief~~ Human Resources ~~Officer~~ or designee -forwards the documentation to the Payroll Office for check preparation. The hardship request is -to be filed in the employee's personnel file.

FORMS/TABLES/SCHEDULES:

~~Form for Hardship Withdrawal from PTO Account~~

PTO Hardship Withdrawal Request Form

~~Pay-Practice Manual – Effective 1.21.2011~~

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE
HUMAN RESOURCES

ISSUE DATE:	**NEW**	**SUBJECT:**	**Timekeeping and Break Policy**
REVISION DATE:		**POLICY**	**NUMBER: 8610-NEW**

Administrative Content Expert Approval:	**12/22**
Administrative Policies & Procedures Committee Approval:	**01/23**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**03/23**
Professional Affairs Committee:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**
1. In order to ensure Tri-City Healthcare District (TCHD) provides the highest quality of services, each employee is responsible for accurate timekeeping and approving their individual time cards. This policy establishes uniform policy and procedures for all non-exempt employees. This policy further establishes policies for non-exempt employee meal and rest periods in accordance with applicable law. All non-exempt employees must clock in and out for every shift worked on a consistent and timely basis.

B. **POLICY:**
1. TCHD provides rest and meal periods for all non-exempt employees in accordance with applicable laws and regulations.
2. Meal Periods
   a. Non-exempt employees who work shifts of more than five (5) hours are entitled to an unpaid and uninterrupted meal period of at least 30 minutes during which they are relieved of all duties. If the employee work six (6) hours or less in a workday, the employee and manager may mutually agree to waive the meal period by completing a meal period waiver in writing.
   b. Non-exempt employees who work more than ten (10) hours are entitled to a second unpaid and uninterrupted meal period of at least 30 minutes during which they are relieved of all duties. If the employee ~~works no more than twelve (12) hours in a workday and~~ has taken the first meal period, the employee and manager may mutually agree to waive the second meal period ~~choose to waive their second meal break~~ by completing a meal waiver **electronically**~~in writing~~.
   c. Meal periods are intended to provide non-exempt employees an opportunity to be away from work, and they are not permitted to perform any work during meal periods.
   d. Meal breaks will be automatically deducted from time cards.
   e. If the employee is unable to take any un-waived meal break due to being required to work, the employee will receive one additional hour of pay at the regular rate of compensation for each shift that the meal period is not provided.
3. Rest Periods
   a. Non-exempt employees are entitled to a paid and uninterrupted rest break based on the total hours worked daily at the rate of 15 minutes net rest time per four hours worked or major fraction thereof. During rest breaks the employee is free from all work duties and is free to leave the premises.
   b. To the extent possible, rest breaks should be taken in the middle of the employee's work period.

c. Rest periods are intended to provide non-exempt employees an opportunity to be away from work, and they are not permitted to perform any work during rest periods.

d. If the employee is unable to take a rest break due to being required to work, the employee will receive one additional hour of pay at the regular rate of compensation for each shift that the rest period is not provided.

e. Nonexempt employees who do not take meal or rest periods, take unauthorized meal or rest periods, or do not return on time from meal or rest periods may be subject to discipline, up to and including termination of employment.

i. Any non-exempt employee who performs work during their meal or rest period must notify their manager so that appropriate time-entry adjustments can be made.

4. Timekeeping

a. Exempt Employees are expected to be present for their assigned work schedule.

b. Non-Exempt Employees

i. All non-exempt employees are responsible for timely and accurately recording all time worked using an automated timekeeping system.

ii. Unless employees have received advance approval from their department manager or designee, employees are expected to be at their work station and ready for work when they clock in for their scheduled shift.

iii. Employees are expected to clock in and out at the clock or computer closest to their department or work station.

iv. Employees are required to clock in at the beginning of each shift prior to performing any work.

v. Employees are also required to clock out at the end of every shift. Employees must not perform any work after clocking out for the day.

vi. Employees are required to clock in and out for meal breaks if the meal break period is longer than 30 minutes or if you're leaving your work location. Employees should not clock out for paid rest periods.

vii. Failure to clock in or out pursuant to this policy will count as missed punch occurrence. Refer to Absences and Tardiness Guidelines.

viii. When clocking out at the end of a shift, employees will be required to answer an affirmation that they have/have not received all meal and rest breaks for their shift.

ix. If attestation is left blank, the answer will be considered a confirmation of all breaks received correctly.

x. Other than during authorized rest periods, employees must clock out when they stop work and clock back in when they resume work.

xi. Employees must receive prior approval from manager to work additional shifts or overtime hours.

xii. All employees are required to approve their time cards at the end of the pay period for submission to management for final review.

xiii. Any time card edits must solely and accurately be documented in the genie logs. Genie logs are a legal document located in every department.

xiv. Time card corrections will be confirmed and approved by the supervisor/manager and payroll.

5. Any violation of this policy may result in disciplinary action, up to and including termination.

6. To the extent that any applicable collective bargaining agreement that is consistent with applicable law conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement prevails.

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

1. Administrative Policy: Absences and Tardiness Policy 8610-408
2. Absences and Tardiness Guidelines

3. Administrative Human Resources Policy: Leave of Absence 8610-435
4. Administrative Human Resources Policy: Paid Time-Off Program 8610-433
5. Administrative Human Resources Policy: Coaching and Counseling for Work Performance 8610-424
6. Kin Care Fact Sheet: http://tricityintranet.com/tcmc/kin-care-fact-sheet/
7. Meal Waiver

Tri-City Healthcare District
Oceanside, California

ADMINISTRATIVE
HUMAN RESOURCES

ISSUE DATE: 01/00	**SUBJECT: Workplace Violence Prevention Plan**
REVISION DATE~~(S)~~: 10/12, 12/15, 09/18	**POLICY NUMBER: 8610-463**

Administrative ~~Human Resources~~ Content Expert Approval:	**~~07/1808/22~~09/22**
Administrative Policies & Procedures Committee Approval:	**~~07/18~~09/22**
Environmental and Safety Committee Approval:	**10/22**
Medical Executive Committee Approval:	**~~08/18~~01/23**
~~Organizational Compliance Committee Approval:~~	**~~n/a~~**
Administration Approval:	**~~09/18~~03/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**09/18**

A. **DEFINITION(S):**
1. **Workforce Member: Employees, Medical Staff, Allied Health Professionals (AHP), volunteers, trainees, Business Visitors, Covered Contractor and other persons whose conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.**
2. ~~Definition of~~ Workplace Violence:
   a. Workplace Violence: means any act of violence, threat of violence or aggressive behavior that occurs in the work setting. The term workplace violence shall not include lawful acts of self-defense or defense of others. Workplace violence includes the following:
      ~~a.~~**i.** The threat or use of physical force against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury.
      ~~b.~~**ii.** An incident involving the threat or use of a firearm or other dangerous weapon, including the use of common objects as weapons, regardless of whether the employee sustains an injury.
      ~~c.~~**iii.** Examples of violent~~ce~~ acts may include, but are not limited to assault, battery, beatings, stabbings, shooting, rape, psychological traumas, threatening or obscene phone calls, verbal abuse, stalking, sw**earing**~~orn~~ or shout**ing**~~ed~~ at, intimidation or harassment of any kind.
3. Four workplace violence types:
   a. **"Type 1 violence"** means workplace violence committed by a person who has no legitimate business in the worksite, and includes violent acts by anyone who enters the workplace with the intent to commit a crime
   b. **"Type 2 violence"** means workplace violence directed at employees by customers, clients, patients, students, inmates, or any other for whom an organization provides services
   c. **"Type 3 violence"** means workplace violence against an employee by a present or former employee, supervisor, or manager
   d. **"Type 4 violence"** means workplace violence committed in the workplace by someone who does not work there, but has or is known to have had, a personal relationship with an employee

B. **EXECUTIVE SUMMARY:**
1. Violence is occurring all throughout the world and over time has filtered in**to** the workplace.

Overall, violent assaults remain fairly rare, although healthcare workers may be at higher risk for attacks compared to other professions. With this in mind, Tri-City Healthcare District (TCHD) is committed to providing a work environment that is safe and every effort is made to reduce or eliminate threats or acts of workplace violence.

2. ~~The California Occupational Safety and Health Administration (Cal/OSHA) Standards Board adopted SB 1299,~~ **It is** ~~**required by**~~**required** ~~. California~~**by California OSHA (Cal/OSHA) to have a written workplace prevention program which is evaluated for effectiveness annually. The program must include specific elements (listed below) and must be based on TCHD**~~**TCMC**~~**'s potential threats taking into account the population, historical experience etc.** ~~a new health care workplace violence prevention regulation that mandates the assessments of the workplace, hazards identified, corrective measures put into place, and staff trained.~~**The Workplace Violence Prevention Plan (WVPP) is always in effect in every unit including outpatient areas,, services and operations. The** Workplace Violence Prevention Plan (WVPP) is part of the organization's Injury and Illness Prevention Plan (IIPP). ~~The WVPP is in effect at all times in every unit (including Outpatient areas), services and operations.~~

3. Key Elements of the WVPP include:
   a. Identifying management positions with the responsibility for administering the WVPP
   b. Coordination with other employers of employees (contractors, registries, vendors) regularly working at TCHD
   c. Identifying and evaluating safety and security risks
   d. Investigating acts of violence/violent incidents
   e. Hazards corrections/mitigations
   f. Communication plan with employees and others
   g. Designing, coordinating and implementing the training
   h. Incident reporting by employees, contracted labor, registries, and regularly on-site vendors
   i. Incident reporting to Cal/OSHA
   j. Recordkeeping/Incident Log
   k. Annual Program Review
   ~~k.~~**l. To the extent that any applicable collective bargaining agreement that is consistent with applicable law conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement prevails.** ~~**Employees represented by a Collective Bargaining Agreement must follow the terms and conditions of that agreement.**~~

4. Zero Tolerance: Violence of any kind as defined above will not be tolerated in the workplace.

C. **SCOPE:**

1. All Departments, Units, Service Lines, Employees, Medical Staff, Registry or Traveler staff, On-site Vendors/Contractors, Patients, Family members and Visitors

D. **RESPONSIBILITIES:**

1. The Manager of Safety/Environment of Care ~~Safety Officer~~ is responsible to initiate, implement, maintain and administer the WVPP. The Manager of Safety/ Environment of Care ~~Safety Officer~~ may delegate duties, tasks and assignments via the ~~Workplace Violence Prevention (~~WVPP~~)~~ **Committee** (sub-committee of the Environmental Health & Safety Committee).
2. The Manager of Employee Health is responsible to initiate, implement, maintain and administer the IIPP.
3. Each Department Director/Manager/Supervisor and Employers (On-site Contractors/Vendors) of other employees is responsible for implementing, complying **with** and supporting the WVPP.
4. Each employee and other employees (contractors/vendors) are responsible for implementing, complying **with** and supporting the WVPP.
5. The WVPP Committee has been created to coordinate the activities necessary to maintain a safe and workplace free of violence and violent behaviors. The committee is

comprised of an interdisciplinary team including, at least, 5 RNs appointed by the Union. This committee meets on a regular basis and is responsible for the following:

- **a.** **potential hazards or actual incidents that have occurred since the time of the last meeting**
- **b.** **updating and discussing the hazard assessments specific to each unit, service line and operation**
- ~~a.~~**c.** **communicating gaps or previously unidentified hazards to the Environmental Health and Safety Committee (EHSC) so that improvements can be made**

E. **PLAN DEVELOPMENT:**

1. WVPP development requires a multidisciplinary team approach, which includes Leadership, ~~Management,~~ along with employees a~~nd their representatives~~ in developing, implementing, and reviewing the plan.

~~2. The development, implementation, and annual review of the plan will be coordinated through the Workplace Violence Prevention sub-committee in conjunction with active involvement of employees and their representatives.~~

2. **Employees** ~~and their representatives~~ **are asked, informally, via**~~as in~~ **department meetings and communications, and formally, through committee meetings and organization communications, to help develop, implement, and review the plan, including participating in the following:**
   - **a.** **Identifying, evaluating, and correcting workplace violence hazards**
   - **b.** **Designing and implementing training, and reporting and**
   - **c.** **Investigating workplace violence incidents**

F. **COMMUNICATION:**

1. WVPP information and updates are communicated through the following means:
   - a. Annual WVPP evaluation and review
   - b. Annual training (type of training is dependent on the roles, departments and specific risks associated with the job duties or environment)
   - c. Department Specific Training (example: CPI Non-Violent Crisis Intervention)
   - d. Net Learning self-learning module
   - e. Power Minutes or Hot Topic educational flyers
   - f. Workplace Safety Poster (Information on how to contact ~~Safety/~~Security Officers and report concerns via **incident reporting system**~~RL Solutions~~)
   - g. Department Staff Meetings
2. Employees are encouraged to report safety concerns to the Safety Officer, Security, Risk Management, Employee Health and their Director, Manager or Supervisor

~~3. Attempts will be made throughout the year to solicit active participation of employees and their representatives in the review, creation, design and implementation of the WVPP and all training materials and sessions. The following methods will be used to solicit active participation:~~
   - ~~a. Power Minutes or Hot Topic educational flyers~~
   - ~~b. Net Learning modules~~
   - ~~c. Training session debriefings~~
   - ~~d. Staff meetings~~
   - ~~e. Safety Symposiums~~
   - ~~f. Safety fairs~~

G. **TRAINING:**

1. All employees working in the facility, units, service lines, or operations shall be provided initial training, followed by annual refresher training on the WVPP.

~~1.~~**2.** **Training material appropriate in content and vocabulary to the educational level, literacy, and language of employees shall be used**

~~2.~~**3.** In addition to District employees, WVPP training is required for:
   - a. Registry Staff/Travelers

b. On-Site Contractors that conduct regular business on TCHD property (example: Aramark, Cardinal Health, Stericycle)

~~3.~~**4.** Allied Health Professionals not employed by the district and volunteers are not required to be trained by Cal/OSHA, but are highly encouraged to be familiar with the WVPP

~~4.~~**5.** The level of training on WVPP depends on the roles, departments and specific risks associated with the job duties or environment:
- a. Low risk: Net Learning self-learning module
- b. High risk: Non-Violent Physical Crisis Intervention (NVCI) training

~~5.~~**6.** Employees/supervisors performing patient care contact activities in higher-risk areas (example: Emergency Department [ED], ~~Behavioral Health Unit [BHU], Crisis Stabilization Unit [CSU],~~ and **Patient Mobility Technicians**~~Lift Team~~) are required to attend annual formal Non-Violent Physical Crisis Intervention (NVCI) training.

~~6.~~**7.** Employees assigned to respond to alarms or other notifications of violent incidents or whose assignments involve confronting or controlling persons exhibiting aggressive or violent behavior (example: Security Officers) shall be provided training prior to initial assignment and at least annual thereafter.

~~7.~~**8.** Non Violence Crisis Intervention training shall include:
- a. General and personal safety measures;
- b. Aggressive and violent predicting factors;
- c. The assaults cycle;
- d. Characteristics of aggressive and violent patients and victims;
- e. Verbal and physical maneuvers to defuse and prevent violent behavior;
- f. Strategies to prevent physical harm;
- g. Restraining techniques;
- h. Appropriate use of medications as chemical restraints;
- i. An opportunity to practice the maneuvers and techniques included in the training with other employees they work with, including a meeting to debrief the practice session.

~~8.~~**9.** An annual review of the educational training materials and programs will be conducted with active engagement of employees and their representatives.

~~9.~~**10.** Employees will be provided a means of asking questions, providing feedback or suggestions related to all training programs during face-to-face training and also with online training where a response will be provided~~ within one business day~~.

H. RISK ASSESSMENTS:

1. A risk assessment is required for all departments, units, service lines, (including Outpatient areas), and services that include:
   - a. Environmental risk factors;
   - b. Community-based risk factors;
   - c. Area surrounding the facility such as employee parking areas and other outdoor surroundings;
   - d. ~~Include a r~~Review of workplace violence incidents that have occurred ~~in each facility, department, unit, operations, (including Outpatient areas), and services~~ within the previous year, whether or not an injury occurred;

~~e.~~**2.** Risk assessments will be conducted annually or whenever conditions change that could affect safety;

~~a.~~**3.** The risk assessment shall be used to identify locations and situations where violent incidents are more likely to occur;

~~b.~~**4.** Active engagement of employees ~~and their representatives~~ **is encouraged and solicited.**

~~2.~~**5. Assessment tools, environmental checklists, rounding, and committee meetings are used to identify locations and situations where violent incidents are more likely to occur.**

~~3.~~**6. Environmental risk assessments take place at least annually and more frequently through the activities listed per the policy**~~in 5. above~~. **Environmental risk factors included in the assessment are:**

a. **Poor illumination or blocked visibility of areas where possible assailants may be present**
b. **Lack of physical barriers between employees and persons at risk of committing workplace violence**
c. **Lack of effective escape routes**
d. **Obstacles and impediments to accessing alarm systems**
e. **Locations within the facility where alarm systems are not operational**
f. **Entryways where unauthorized entrance may occur, such as doors designated for staff entrance or emergency exits**
g. **Presence of furnishings or any objects that can be used as weapons in the areas where patient contact activities are performed**
h. **Storage of high-value items, currency, or pharmaceuticals**

~~4.~~**7. For home health care and home-based hospice: Procedures to identify and evaluate - during intake procedures, at the time of the initial visit, and during subsequent visits whenever there is a change in conditions - environmental risk factors such as the presence of weapons, evidence of substance abuse, or the presence of uncooperative cohabitants.**

I. **HAZARD CORRECTION:**

1. Engineering and work practice controls shall be used to eliminate or minimize employee exposure to the identified hazards to the extent feasible.
2. TCHD shall take measures to protect employees from imminent hazards immediately, and shall take measures to protect employees from identified serious hazards within seven business days of the discovery of the hazard.
3. When an identified corrective measure cannot be implemented within the seven business day timeframe, (such as a project that requires Office of Statewide Health Planning and Development [OSHPD] approval), TCHD shall take interim measures to abate the imminent or serious nature of the hazard while completing the permanent control measures.
4. Active engagement of employees and their representatives will be included in the hazard corrective measures whenever feasible.
5. Examples of Hazard Corrections include, but are not limited to the following:
   a. Emergency Department:
      i. Electronic access control
      ii. Panic buttons
      iii. Closed Circuit Television (CCTV) cameras
      iv. Security Officer Station – Posted 24 hours per day
      v. Zero Tolerance Posters
   ~~b. Behavioral Health Unit / Crisis Stabilization Unit:~~
      ~~i. Electronic access control~~
      ~~ii. CCTV~~
      ~~iii. Panic Buttons~~
      ~~iv. Security Officer posted on unit 24 hours per day~~
   ~~c.~~**b. Women and Newborn Services**~~Maternal Child Health Units~~:
      i. Electronic access control
      ii. Access Control System
      iii. CCTV
      iv. The **WNS**~~Maternal Child Health~~ units are protected with active video surveillance systems on entrances and exits of the units. Additionally, the unit has electronic access control systems for entrances and exits that alarm if unauthorized entry or exit occurs
      ~~iv.~~**v.** Department policy in place for identifying visitors
      ~~v.~~**vi.** Department procedure for uniquely identifying mother-infants
      ~~vi.~~**vii.** ~~Teaching program to e~~Educate parents or guardians **about**~~to explain~~ the **safety and** security processes

vii.**viii.** Unique identification for staff members
viii. Unique visitor badge system with automatic time sensitive "VOID" process
d. Neonatal Intensive Care Unit:
i. Electronic access control
ii. The Maternal Child Health units are protected with active video surveillance systems on entrances and exits of the units. Additionally, the unit has electronic access control systems for entrances and exits that alarm if unauthorized entry or exit occurs
e.**c.** Pharmacy Department:
i. Electronic access control
i.**ii.** **CCTV**
ii. Infrared Security System
f.**d.** Business Office:
i. Electronic access control
ii. Panic button
iii. Local area surveillance system
g.**e.** Human Resources department:
i. Panic buttons
ii. Access Control System
iii. CCTV
h.**f.** Adult Critical Care Unit:
i. Electronic access control
ii. Local camera system
i.**g.** Patient Representative Office:
i. Panic button

J. **PATIENT AND VISITOR ASSESSMENT:**

1. Patients are assessed upon Admission to all areas except the Progressive Care Unit (PCU) and the Neonatal Intensive Care Unit (NICU) to identify and evaluate patient-specific risk factors. The assessment history is aimed at identifying factors that may indicate the patient has a higher likelihood for workplace violence, such as use of illicit drugs or alcohol, psychiatric condition or diagnosis associated with increased risk of violence, any condition or disease process that would cause confusion and/or disorientation, or history of violence. The Expanded Aggressive Behavior Risk Assessment Tool (e-ABRAT) is being used. These patients will have a violet horseshoe magnet that is placed on their door to alert others that there may be a potential for increased violent behaviors.
2. Additionally, clinicians order an Interdisciplinary Plan of Care (IPOC) with applicable goals and interventions for patients that have been identified as a higher risk for potential violence. The IPOC is called Adult Safety/Violence/Restraints.
3. If a violent event occurs, it will be documented in the electronic health record in IView.
4. Visitors that have demonstrated or have a potential for demonstrating violent behaviors will be immediately reported to management, security and the Administrative Supervisor. Staff will be informed of visitors of concern during their handoff report on their patients.

K. **VIOLENT INCIDENT REPORTING (INTERNAL AND EXTERNAL TO CAL/OSHA):**

1. Internal reporting of workplace violence incidents shall be accomplished by several means:
   a. Non-emergent Incident
   a.**i.** During normal business hours Monday – Friday, **Workforce members**employees shall **report incidents**contact Employee Health (EH) by dialing the Incident Reporting Hotline "7050" or **submitting an incident report electronically**visiting the EH office.
   b. After hours and weekends, incidents shall be reported by dialing the Incident Reporting Hotline "7050" and notifying the Administrative Supervisor.

b. **Emergent situation in progress**
 i. **Contact Security for assistance or call a Dr. Strong**

c. For serious incidents, such as a death or injury requiring hospitalization **contact the Administrative Supervisor (AS). The AS will notify** the employees' supervisor, manager or director ~~shall be contacted~~ and ~~that individual will~~ immediately contact the administrator on-call and the Manager of Safety/EOC~~ Safety Officer~~.

d. Employees shall report incidents of violence or unsafe conditions and complete **an incident report**~~ Quality Review Report~~.

2. External reporting of workplace violence incidents to Cal/OSHA shall be completed for incidents involving any of the following:
 a. The use of physical force against a hospital employee by a patient or a person accompanying a patient that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury.
 b. An incident involving the use of a firearm or other dangerous weapon, regardless of whether the employee sustains and injury.
 c. An incident involving the death of an employee, hospitalization greater than 24 hours, one or more days away from work (which includes the day of the incident), restricted work or transfer to another job, medical treatment beyond "First Aid", loss of consciousness, significant injury, or psychological trauma or stress as a result of the workplace violence incident.

3. Timeframes for reporting to Cal/OSHA:
 a. Shall be reported online to Cal/OSHA within 24 hours if the incident involves:
  i. A fatality or an injury that requires inpatient hospitalization for a period in excess of 24 hours.
  ii. Any incidents involving a firearm, dangerous weapon, loss of limb, or serious degree of permanent disfigurement.
  iii. An urgent or emergent threat to the welfare, health, or safety of hospital personnel (potential exposure to death or serious physical harm).
 b. Shall be reported online to Cal/OSHA within 72 hours if the incident involves:
  i. All other incidents not listed above in section 3.a.i,ii, iii
  ii. The hospital shall submit an initial report with all information available within the allotted timeframe. There are no obligations by Cal/OSHA for the hospital to update the report online if additional information is made available at a later date.
 c. Telephone reports to Cal/OSHA
  i. The Cal/OSHA WVPP regulations states that employers must continue to report immediately by telephone to the nearest District Office of the Division of Occupational Safety & Health any serious work-connected injury, illness or death as required by Title 8, California Code of Regulations, Section 342(a).
   1) Local District Office:
    a) San Diego District Office
    7575 Metropolitan Drive, Suite 207
    San Diego, CA. 92108
    Telephone: 619-767-2280
   2) Cal/OSHA does not accept telephone reporting in place of the online reporting noted in 3.a.b. The telephone reporting is a separate requirement for incidents involving the death or serious work-connected injury.
   3) Immediately means as soon as practically possible, but no longer than 8 hours after the hospital knows of the death or serious injury. In extreme exigent circumstances the timeframe for reporting to Cal/OSHA may be extended up to 24 hours maximum.
   4) Information required when completing a telephone report:
    a) Time and date of accident/event

b) Employer's name, address and telephone number
c) Name and job title of the person reporting the accident
d) Address of accident/event site
e) Name of person to contact at accident/event site
f) Name and address of injured employee(s)
g) Nature of injuries
h) Location where injured employee(s) was/were taken for medical treatment
i) List and identity of other law enforcement agencies present at the accident/event site
j) Description of accident/event and whether the accident scene or instrumentality has been altered.

L. **VIOLENT INCIDENT LOG/RECORD KEEPING:**

1. Records of workplace violence hazards identification, evaluation, and correction shall be created and maintained in accordance with California Code of Regulations, Title 8.
2. Training records shall be created and maintained for a minimum of 1 year, per California Code of Regulations, Title 8. The records must include details with date of training, contents or summary of the training sessions, names and qualifications of persons conducting the training, and the names and job titles of all the persons attending the training sessions. In addition, California Code of Regulations, Title 22 states that orientation and competency validation must be documented in the employees file for the duration of their employment.
3. Violent Incident Logs must be maintained for a minimum of five years California Code of Regulations, Title 8.
4. All records required by this subsection shall be made available upon request to the Chief of the Division of Occupational Safety and Health or his/her representative (Cal/OSHA Investigators) for examination and copying.
5. All records required by this section shall be made available to employees and their representatives, on request, for examination and copying (at no charge to the employee).

M. **VIOLENT INCIDENT INVESTIGATION:**

1. A post-incident response and investigation shall be completed for any employee, contractor, or other individuals that are covered by the WVPP, and have been involved in an act of violence or threat of violence. Steps that shall be taken in the event of a incident of violence (not limited to):
   a. Provide immediate medical care or first aid to employees or covered individuals who have been injured in the incident;
   b. Conduct a post-incident debriefing as soon as possible after the incident with all employees, supervisors, and security involved in the incident;
   c. Completion of the Workplace Violence Incident Report form *(titled: Workplace Violence Incident Report;*
   d. The Security Department will conduct a Security Crime/Incident Report for any incidents that cause injury or have a high probability of causing injury, psychological trauma or stress;
   e. **The Violent Incident Log (the Log) shall record information about every incident, post-incident response, and workplace violence injury investigation performed and shall include the following information:**
      i. **The date, time, specific location, and department of the incident**
      ii. **A detailed description of the incident**
      iii. **A classification of who committed the violence, including whether the perpetrator was a patient/client/customer, family/friend of a patient/client/customer, stranger with criminal intent, coworker, supervisor/manager, partner/spouse, parent/relative, or other perpetrator**
      iv. **A classification of circumstances at the time of the incident, including whether the employee was completing usual job duties, working in**

poorly lit areas, rushed, working during a low staffing level, in a high crime area, isolated or alone, unable to get help or assistance, working in a community setting, working in an unfamiliar or new location, or other circumstances

v. **A classification of where the incident occurred, including whether it was in a patient or client room, emergency room or urgent care, hallway, waiting room, restroom or bathroom, parking lot or other area outside the building, personal residence, break room, cafeteria, or other area**

vi. **The type of incident, including whether it involved**
1) **Physical attack, including biting, choking, grabbing, hair pulling, kicking, punching, slapping, pushing, pulling, scratching, or spitting**
2) **Attack with a weapon or object, including a gun, knife, or other object**
3) **Threat of physical force or threat of the use of a weapon or other object**
4) **Sexual assault or threat, including rape/attempted rape, physical display, or unwanted verbal/physical sexual contact**
5) **Animal attack**
6) **Other**

vii. **Consequences of the incident, including**
1) **Whether medical treatment was provided to the employee**
2) **Who, if anyone, provided necessary assistance to conclude the incident**
3) **Whether security was contacted and whether law enforcement was contacted**
4) **Amount of lost time from work, if any**
5) **Actions taken to protect employees from a continuing threat, if any**

viii. **Information about the person completing the Log including their name, job title, phone number, email address, and the date completed**

ix. **Information about each incident shall be based on information solicited from the employees who experienced the workplace violence.**

x. **Any element of personal identifying information sufficient to allow identification of any person involved in a violent incident, such as the person's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the person's identity, is omitted.**

~~**Information about the person completing the Log including their name, job title, phone number, email address, and the date completed**~~

xi. **The Log shall be reviewed during the annual review of the WVPP Plan.**

~~d.~~**f.** All violent incidents will be reviewed through the WVPP sub-committee and reported up to the EHSC, and finally up to the Board of Directors (annually).

N. **ANNUAL REVIEW OF THE WVPP:**

1. An annual review of the WVPP must be completed at the end of each fiscal year. The goal of the annual evaluation is to evaluate the effectiveness of the plan and any actions implemented throughout the plan year. The annual review of the WVPP shall include:
   a. Staffing, including staffing patterns and patient classification systems that contribute to, or are insufficient to address, the risk of violence;
   b. Sufficiency of security systems, including alarms, emergency response, and security personnel availability;
   c. Job design, equipment, and facilities;

d. Security risk associated with specific units, areas of the facility with uncontrolled access, late-night or early morning shifts, and employee security in areas surrounding the facility such as employee parking areas and other outdoor areas;
e. Review of the Violent Incident Log.

2. Additional limited review may be required following new procedures, processes or information. An updated review of the plan shall be completed whenever necessary, as follows:
a. To reflect new or modified tasks and procedures, changes in staffing, engineering controls, construction or modifications of the facilities, evacuation procedures, alarm systems and emergency responses;
b. To include newly recognized workplace violence hazards;
c. To review and evaluate workplace violence incidents that result in a serious injury or fatality; or
d. To review and respond to information indicating that the WVPP is deficient in any area.

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

1. Environment of Care Policy: Security Management Plan
2. Workplace Violence Incident Report
3. **Environment of Care Policy: Safety Management Plan**
4. **Expanded Behavior Risk Assessment Tool (EBRAT)**
5. **Security Crime Incident Report**
~~2.~~6. **Violent Incident Log**

P. **REFERENCE(S):**

1. The Joint Commission: EC.01.01.01, 02.01.01, 03.01.01, 04.01.01
2. Cal/OSHA Workplace Violence Prevention in Healthcare **Title 8 Section 3342**
3. California Code of Regulations, Title 8, Section 3203(b); 5120(e)(1)(B); 3342(h)(3).
4. California Code of Regulations, Title 22, Section 70214
5. California Hospital Association, Healthcare Workplace Violence Prevention: How to comply with the Cal/OSHA regulations, January 2017.

Work Place Violence Closure Form

Date: ______________________

Reporting Member: ________________________

Date of Incident: ____________ WPV Reporting Number ______________________

You recently reported a Workplace Violence situation to which you had witnessed or were victim to. This situation has been reviewed and the investigation into this has been concluded. The results to this investigation and the recommendations are as follows:

Environment Control Modifications:

- ☐ Physical layout (accessible escape routes, unimpeded line of sight)
- ☐ Physical access control
- ☐ Physical barriers or obstacles
- ☐ Lighting
- ☐ Removing/securing objects that have weapon potential

Work Practice Control Modifications:

- ☐ Increased staff levels
- ☐ Added/Increase Security Staff
- ☐ Additional Staff Training
- ☐ Implementation of buddy system
- ☐ Improved communication among staff regarding aggressive/violent patients or visitors
- ☐ Other work practice modification (see comments)
- ☐ Local Authorities contacted/involved
- ☐ N/A – No continuing threat to staff or visitors
- ☐ Other (see comments)

Comments:

____

____

____

Copies of the Workplace Violence form along with these findings have been sent to:

- ☐ **Risk Management**
- ☐ **C-Suite**
- ☐ **Admin Supervisor**
- ☐ **Department Manager**
- ☐ **EHS**

If you have any further information you'd like to contribute or would like to schedule a meeting, please contact me at ~~surowiecja@tcmc.com~~*MJackson@tcmc.com*.

~~Jeff Surowiec~~**lori Jackson** / Safety ~~Officer~~**Manager**

WORKPLACE VIOLENCE INCIDENT REPORT

Completion of each section is required.

Section 1: *(To Be Completed by Victim if able)*

Hospital facility: **TRI-CITY MEDICAL CENTER**

Date of incident:

Employee: **Emp#**

Department: **Extension:**

Hospital representative and contact information: ~~Jeff Surowiec~~**Ilori Jackson**, ~~surowiecja@tcmc.com~~IMJackson@TCMC.Com 760-940-3076

Time of incident:

1. Who was the aggressor? *(check one)*

- ☐ Patient(s)
- ☐ Spouse /partner of patient (current or former)
- ☐ Family of patient
- ☐ Friend of patient
- ☐ Stranger
- ☐ Supervisor/manager
- ☐ Spouse /partner of employee (current or former)
- ☐ Family of employee
- ☐ Friend of employee
- ☐ Co-worker
- ☐ Licensed independent medical provider
- ☐ Former employee
- ☐ Outside vendor
- ☐ Aggressor not listed above____________________

2. Was a risk assessment completed (EBRAT)?

☐ Yes ☐ No ☐ N/A (aggressor was not a patient)

3. Where did the incident occur? *(check as many as apply)*

- ☐ Emergency room ~~Room #~~ _____
- ☐ Urgent care
- ☐ Cardiac rehabilitation
- ☐ Surgical services
- ☐ Labor & delivery
- ☐ Radiology & imaging
- ☐ Onsite ambulatory outpatient clinic
- ☐ Offsite ambulatory outpatient clinic
- ☐ Inpatient **DEPT:**____________ **Rm** _____
- ☐ Admissions/registration
- ☐ Pharmacy
- ☐ Seclusion/restraint room
- ☐ Administrative offices
- ☐ Cafeteria
- ☐ Kitchen
- ☐ Storage room/area
- ☐ Lobby/reception area
- ☐ Hallway
- ☐ Stairway
- ☐ Waiting room
- ☐ Restroom/bathroom
- ☐ Break room
- ☐ Parking lot
- ☐ Outside premises
- ☐ Location not listed above________________

4. What type of incident occurred? *(check all that apply)*

- ☐ Biting by aggressor
- ☐ Choking
- ☐ Grabbing
- ☐ Hair pulling
- ☐ Kicking
- ☐ Punching/slapping
- ☐ Pushing/pulling
- ☐ Scratching
- ☐ Shooting
- ☐ Spitting at/on
- ☐ Stabbing
- ☐ Striking
- ☐ Rape/attempted rape
- ☐ Unwanted physical sexual contact
- ☐ Type of physical force not listed above____________________
- ☐ Use of (i.e., assault with) firearm or other dangerous weapon:
  - ☐ Gun
  - ☐ Knife
  - ☐ Furniture/furnishings (e.g., lamp)
  - ☐ Medical equipment
  - ☐ Other weapon______________________________

Section 2: *(To be completed by Security/Leadership)*

1. How many employees were injured?

2. Was Medical Attention Obtained: Yes _____ No _______ Will Seek Private Physician _______

3. What types of injuries were known to be sustained? *(check all that apply)*

- ☐ Death
- ☐ Amputation
- ☐ Asphyxiation/suffocation
- ☐ Burns
- ☐ Bruising/abrasion
- ☐ Cut/puncture
- ☐ Dislocation/fracture
- ☐ Head injury
- ☐ Internal injury
- ☐ Open wound
- ☐ Sprain/strain
- ☐ Stress/psychological impairment
- ☐ Injury type not listed above____________________
- ☐ Injury type unknown by the hospital at this time
- ☐ N/A –No known injured employees at this time (Restriction: if checked, no other boxes can be checked)

4. At the time of the incident were any of the injured employees: *(check all that apply-*

- ☐ On break/lunch
- ☐ Arriving/leaving the facility
- ☐ Working past scheduled shift
- ☐ No special circumstances apply (Restriction: if checked, no other boxes can be checked)
- ☐ Don't know specific circumstances (Restriction: if checked, no other boxes can be checked)
- ☐ N/A –No known injured employees (Restriction: if checked, no other boxes can be checked)

5. If another employer's employees are affected, describe that employer(s): *(check all that apply)*

☐ N/A –No employees of other employers affected (Restriction: if checked, no other boxes can be checked)

☐ Contractor providing services to the hospital
If known: Company name__________________ Company phone number________________ **(not required)**

☐ Vendor
If known: Company name__________________ Company phone number________________ **(not required)**

☐ Don't know the type of employer

WORKPLACE VIOLENCE INCIDENT REPORT

6. Did the use of physical force or a dangerous weapon begin while an employee was alone with the aggressor?
☐ Yes ☐ No

7. Did the use of physical force or a dangerous weapon begin while an employee(s) was in an isolated area?
☐ Yes ☐ No

8. Did the use of physical force or a dangerous weapon begin in a *location* that was unfamiliar or new to the employee(s)? ☐ Yes ☐ No ☐ Don't know if location was unfamiliar or new to employee(s)

9. At the time of the use of physical force or a dangerous weapon was any employee *doing a task* that was unfamiliar or new to them? ☐ Yes ☐ No ☐ Don't know if task was unfamiliar or new to employee(s)

10. During the use of physical force or a dangerous weapon, was the employee(s) assisted by: *(check all that apply)*

☐ Internal security
☐ Assistance provided that is not listed above
☐ Hospital emergency response team
☐ Nearby employees
☐ Local law enforcement in response to 911 call
☐ Employee received no assistance

11. If local law enforcement was contacted via 911, what assistance did they provide? *(check all that apply)*

Responding Agency ________________________ **Incident Number** ________________________-

☐ N/A local law enforcement not called (Restriction: if checked, no other boxes can be checked)
☐ Local law enforcement did not respond
☐ Officers provided assistance via phone
☐ Officers deployed to the scene
☐ De-escalated the situation without physically subduing the aggressor
☐ Physically intervened and subdued the aggressor(s)
☐ Arrested the aggressor(s)
☐ Assistance provided that is not listed above________________________
____

12. Is there a continuing threat to employees due to unresolved engineering, work practice, and/or administrative controls that need to be addressed? ☐ Yes ☐ No

13. Which of the following are planned or under consideration for addressing the continuing threat? *(check all that apply)*

☐ **Engineering control modifications**

If known, please provide type of engineering control:
☐ Physical layout (incl. accessible escape routes, unimpeded line of sight)
☐ Physical access control
☐ Physical barriers
☐ Alarm system
☐ Lighting
☐ Monitoring systems (e.g., metal detectors, closed circuit video, mirrors)
☐ Removing/securing objects with weapon potential
☐ Reducing overcrowding in waiting room
☐ Other engineering control modification

☐ **Work practice control modifications:** ________________________

If known, please provide the type of control:
☐ Increased staffing levels
☐ Added/increased security personnel
☐ Additional employee training
☐ Implementation or change in buddy system
☐ Improved communication among staff about aggressive/violent patients
☐ Reduced waiting times
☐ Other work practice modification

☐ **Other type of modification**
~~☐ Further~~☐ Further **investigation to identify appropriate exposure control measures is in progress** (investigation includes speaking with involved employees).
☐ **N/A –No continuing threat to employees** (Restriction: if checked, no other boxes can be checked)

14. To whom else in the organization was this event reported: ☐ Risk Management ☐ C-Suite ☐ Admin Supervisor ☐ Department Manager

Reporting Staff Name: ________________________ Emp. ~~#~~ :#: __________ ~~Date~~_ :_Date: __________

** E-mail completed form to ~~Safety Officer~~ Workplace Violence- ~~Jeff Surowiec / surowiecja@tcmc.com~~wpv@TCMC.Com

Safety Officer Review: ________________________ **Date:** ________ **Completed:** __ **Follow Up: Y** __ **N** __

1. Was the incident reported to the nearest Cal/OSHA Enforcement District Office under Title 8, CCR, Section 342? ☐Yes ☐ No
(COMPLETED BY SAFETY OFFICER)
Reported by ________________________ **Date:** ________________

2. Which district office was the incident reported to? If the incident was not reported to a district office, please select N/A.

(COMPLETED BY SAFETY OFFICER) ________________________ **DATE:** ________________

Tri-City Medical Center

Oceanside, California

EMERGENCY PREPAREDNESS MANAGEMENT

~~EFFECTIVE~~ISSUE DATE:11/88

SUBJECT: Disaster Procedure for V.I.P. Hospital Wide

REVIEW DATE: 04/91
REVISION DATE: 09/93, 03/97, 06/00, 04/03, 12/05
~~CROSS REFERENCEREVIEW DATE: 4/91APP~~

POLICY NUMBER: 4008 ~~Page 1 of 1~~

Department Approval:	**12/22**
Environmental Health and Safety Committee Approval:	**12/22**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**03/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/05**

A. POLICY:

1. Tri-City Medical Center recognizes that all patients are treated equally. However, due to the notoriety of certain patients, special measures will be implemented to ensure the safety and security of a Very Important Patient **(VIP)** during a disaster. Diversion Status will be communicated via QA Net and Dispatchers.

B. DEFINITIONS:

1. For purposes of this policy, a V~~.~~I~~.~~P is defined as any patient who may generate additional media or security attention due to the nature of their position and/ or public notoriety.

C. PATIENT CARE:

1. In the event of a code blue or emergent medical need, Emergency Resuscitation staff will be readied ~~with the following personnel~~**per Patient Cares Services Policy: Code Blue Response Plan**
   - ~~a. Emergency Physician on duty, other Specialty Physicians as requested, including those serving the person in a medical capacity.~~
   - ~~b. Three Emergency Department (ED) Staff RNs.~~
   - ~~c. One Emergency Department Technician on duty.~~
   - ~~d. One RCP~~
   - ~~e. Ancillary staff as ordered~~
2. The Emergency Department management may be notified by the Secret Service personnel as to when the VIP will be in the area.
   - a. Secret Service will put telephones in the ED private physician dictation room and man the scene.
3. Close all doors to secure the Treatment Room and the ED.
4. Station Security along with VIP security team around perimeter
5. Members of the Media are kept out of the ED at all times. The Public Information Officer will coordinate all Media communications.
6. Operating Room (OR) will be notified to ready room and to standby.
7. Laboratory will secure eight pints of appropriate blood type.
8. Consult with security both internal and public to outlines parameters for treatment areas to be used by regular patients needing emergency treatment
9. If the V~~.~~I~~.~~P requires inpatient admission, the **Administrator Supervisor**~~Patient Placement Coordinator~~ will assign a secure room, inform security personnel, and a designated member of the Executive Team.

Tri-City Medical Center
Oceanside, California

RETIRE – follow Emergency Department Procedure: Hospital Emergency Operations Plan, Emergency Department Response

EMERGENCY OPERATIONS PROCEDURE MANUAL

REVIEWISSUE DATE: 11/91

SUBJECT: ER Base Hospital Disaster Triage and Treatment Responsibilities

REVISION DATE: 01/94, 03/97, 06/00, 04/03, 10/05

POLICY NUMBER: 4027 Page 1 of 3

Department Approval: 12/2201/23
Environmental Health and Safety Committee Approval: 01/23
Medical Executive Committee Approval: n/a
Administration Approval: 03/23
Professional Affairs Committee Approval: n/a
Board of Directors Approval: 10/05
CROSS REFERENCAPPROVAL:

A. INTRODUCTION:
1. Due to the varying types and magnitudes of emergency events, Tri-City Medical Center has adopted the command structure of Hospital Emergency Incident Command Systems (HEICS). Once the decision has been made to activate the disaster plan, the HEICS becomes the standard operating procedure. The complete plan is located in the TCMC Safety and Disaster Plan Manual located in the Radio Room adjacent to the nurse's station.

B. PURPOSE:
1. To provide guidelines for emergency evacuation of patients, visitors and staff during a disaster – Code Orange/Code Yellow.

C. PROCEDURE:
1. Field Triage/Treatment Plan:
a. The first competent authority (EMT-1) reporting will assume the field medical command and triage duties until relieved. The triage officer and teams will be responsible for field triage medical casualties in the disaster scene area.
b. Normal medical management responsibilities continue for paramedics even under disaster conditions. Paramedics are not authorized to perform paramedic skills without radio authorization from the base station physician or nurse. Paramedics may be assigned by their agency to a disaster scene outside of their normal operational area.
c. A triage/treatment team of at least one physician and one R.N. is to be identified by each hospital. The closest team may be requested by the rescue agency (first responder) according to the County of San Diego disaster plan. The team will be transported from the hospital by ASTREA (Sheriff) or a California Highway Patrol vehicle to the disaster site. Other transport means may be necessary, such as the use of an ambulance returning to the scene or using a hospital vehicle. Triage team should take the following material with them to the disaster scene:
i. Disaster field triage bag
ii. Orange Disaster, which contains triage supplies.
iii. Orange Disaster Carts are brought up by MDC
iv. 50 Disaster Triage Tags

D. FUNCTIONS OF THE TEAM AT THE SCENE:
1. At the Scene the initial triage/treatment team shall immediately assess the amount of medical support needed and request appropriate support such as additional triage teams, treatment teams, Red Cross, blood banks, etc. Available triage personnel shall be divided into sectors of the emergency scene

~~qualified personnel responsible for each sector rather than using the "grand rounds" approach to one large triage team.~~

~~a. Portable Communication Radio:~~

~~1) IC will distribute the Radios. The triage/treatment team carries three portable radios for the physician, for the RN., and for the medical scene commander.~~

~~b. Radio Communication:~~

~~1) Radio communication with adjacent hospitals shall be established on the Station X Console B located in the Radio Room in the Emergency Department. Station X should be ordered to establish an open channel patch between Scripps Encinitas and Camp Pendleton Naval Hospital. Additional hospitals also may be requested.~~

~~**E. SORTING AND TAGGING CASUALTIES:**~~

~~1. Immediate: (Red tag) has the highest priority for evacuation and includes victims with life threatening problems needing immediate treatment such as major lacerations with extensive hemorrhage, correctable mechanical respiratory difficulties, open fractures of major bones, critical injuries to the respiratory or central nervous system, eviscerations, severe burns, or victims of ionizing radiation.~~

~~2. Delayed: (Yellow tag) is given second priority for evacuation. Examples include fractures, non-critical injuries of the central nervous system, minor burns and major lacerations without extensive hemorrhage.~~

~~3. Dead and Non-Salvageable Dying: (Black) State Law requires a body cannot be moved, searched, or undressed until released by the coroner unless it presents a hazard or hinders care of others.~~

~~4. Minor Care: (Green tag) They are sent to an area cleared for bus loading. They will then be transferred to casualty collection points.~~

~~**F. TRIAGE RESPONSIBILITIES:**~~

~~1. Assemble hospital triage/treatment team.~~

~~2. Pick up triage tags and field triage kit from Base Hospital.~~

~~3. Transport to scene from hospital by law enforcement, ASTREA, or returning ambulance.~~

~~4. Check in with scene commander and previous medical commander. Assume scene medical command if indicated.~~

~~5. Establish field and hospital communications (via transport officer).~~

~~6. Determine number of injured and assess needs. Notify scene commander.~~

~~7. Determine if additional triage/treatment teams are needed. Notify scene commander.~~

~~8. Divide area into sectors and divide teams to begin triage/treatment. Obtain volunteers for tagging and recording.~~

~~9. Sweep triage of all casualties before rendering any treatment: (immediate, urgent, dead or non-salvageable).~~

~~10. Coordinate movement of "immediate" then "urgent" to ambulance staging area.~~

~~11. Designate last triage officer or paramedic to ambulance staging area for treatment and stabilization.~~

~~12. Upon completion of triage, assume responsibilities of treatment officer(s) at scene. Request supplies (IV's, etc.) from hospital if required.~~

~~13. Ensure base hospital and medical command center are kept advised of scene medical situation (via scene commander or transport officer).~~

~~**G. FUNCTIONS OF THE TREATMENT TEAM:**~~

~~1. The treatment officer will be responsible for field stabilization and the initiation of the casualty collection points (CCP) as required. The treatment officer normally will be the third medical authority reporting to the scene. This should be the last position filled at the scene.~~

~~**H. TREATMENT OFFICER OR DESIGNEE RESPONSIBILITIES:**~~

~~1. Responsible for coordination of team at casualty collection points (CCP).~~

~~2. Report to hospital for transportation via law enforcement to CCP.~~

~~3. Pick up CCP treatment officer kit.~~

~~4. On arrival at CCP, establish communications with scene and base hospital via law enforcement radio or ham operator and assess needs.~~
~~5. Coordinate Red Cross team and assign responsibilities.~~
~~6. Determine need for opening first aid station.~~
~~7. Request volunteers to open, staff and setup station as needed.~~
~~8. Divide available personnel into sectors and set up treatment area.~~
~~9. Set up station for patient records system.~~
~~10. Triage arriving patients and establish care priorities and complete treatment tags on each patient.~~
~~11. Anticipate and request additional supplies and personnel.~~
~~12.~~**A.** ~~Request ambulance transportation for emergency situations.~~

Tri-City Medical Center
Oceanside, California

EMERGENCY OPERATIONS PROCEDURE MANUAL

~~EFFECTIVE~~ISSUE DATE:11/88	SUBJECT: Emergency Preparedness Management (Disaster) Plan: ~~ED~~ Emergency Department (ED) Registration Department Specific
REVISION DATE: 09/93;0 3/97; 05/00; 10/02; 10/04; 12/05	POLICY NUMBER: 4080 ~~Page 1 of 2~~

Department Approval: 08/21
Environmental Health and Safety Committee Approval: 12/22
Medical Executive Committee Approval: n/a
Administration Approval: 03/23
Professional Affairs Committee Approval: n/a
Board of Directors Approval: 12/05
~~CROSS REFERENCE:~~
~~REVIEW DATE:~~ ~~APPROVAL:~~

A. **PURPOSE:**
1. To ensure proper registration procedures are followed. Assist in identifying disaster patients and insuring that all victims have been identified and logged. Maintaining adequate staffing for registration in the event of a disaster.

B. **DEFINITIONS:**
1. **Emergency Types:**
   a. **External emergency facing the community**
   b. **Internal emergency involving the functions of the hospital, or the treatment and care of patients are no longer sustainable at the hospital**
2. **Department Leaders: Directors, Clinical Manager, Supervisors, Educators, Charge Nurse on duty**
3. **Workforce Member: Employees, Medical Staff, Allied Health Professionals (AHP), volunteers, trainees, Business Visitors, Covered Contractors and other persons whose conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.**

C. **INTRODUCTION:**
1. Do to the varying types and magnitudes of emergency events; Tri-City **Hospital District (TCHD)** ~~Medical Center~~ has adopted the command structure of the Hospital ~~Emergency~~ Incident Command Systems (H~~E~~ICS). Once the decision has been made to activate the ~~disaster~~ **Emergency Operations Plan (EOP)**~~plan~~, H~~E~~ICS becomes the standard operating procedure. The complete plan is located in the TCMC **Emergency Operations** ~~Disaster~~ Manual located on the lower shelf in the ED Registration work area.

D. **NOTIFICATION:**
1. **In the event of an internal or external emergency, departments will be notified via the overhead paging system announcing the "Code Orange"**
2. **Management of staff**
   a. **Staff will be notified by their respective area lead staff via telephone / text**

24 hours per day, 7 days per week.

3. **Management (department/unit leaders) responsibilities following the activation of the Emergency Management plan or drill include, but is not limited to the following:**
   a. **Department Leaders: On Campus (within facility)**
      i. **Respond to ICC and assume responsibilities as directed by the Incident Commander (IC)**
      ii. **Department Leaders: Off Campus (not within facility)**

~~The Ed Registration area will be notified of the PBX Operator announcing the "Code Orange" using the overhead paging system.~~

E. **PROCESS:**

~~2.~~1. ~~Desk 4 or~~ Shift Charge Responsibilities:
   a. Contact the ED Charge nurse to assess the nature of the disaster. Identify the possible staffing needs.
   b. **Contact Leadership On-Call.**
   c. Pull the Disaster Manual ~~on the lower shelf in the~~**on the counter in the ED Registration** work area and retrieve the HEICS Message form. Duplicate copies of the form are located in the front sleeve of the manual.
   d. Complete the message form stating the staff available at this time.
   e. Assign a "Runner" to the Command Center with the Message Form.
   f. Assign a "Caller". Pull the "Call Tree" and begin calling additional Staffing. The "Call Tree" is located in the front of the Disaster Manual.
   g. When additional staffing arrives. Fill out the HEICS Message form and have the "Runner" assigned go to the Command Center with the additional information. This will continue as the staffing increases.
   h. ~~On~~ **In** the ~~top shelf~~ **bottom shelf** in the work area center cabinet is the official "Disaster Packets" and boxes of armbands, if needed.
   i. Contact the Charge Nurse and ask where the Triage Nurse will be assigned.
   j. Take the "Disaster Packets" and proceed with the Triage Nurse to the appropriate area for triage and registration.
   k. If there is no electricity, Use the "HEICS Section Personnel Time Sheet". Have all staff sign in. Time in and Time out hours must be completed.

~~B.~~F. **REGISTRATION PROCESS:**

1. ~~5.1~~ The patient will be sent to the designated triage area. Each victim will be assigned a "Disaster Packet". Inside of the packet are nursing forms and registration forms. The triage nurse will do nursing forms. The packets are numbered. Use the labels on the armband to identify the patient. Downtime account numbers will correspond with the packet. Label all papers in packet.
2. **NOTE**: depending on the severity of the disaster registration will be guided by Triage as to when the actual full registration will be done. In the triage area or at the bedside. If Registration is assigned to a "Secondary Triage". A short registration, Account number listed on packet, Patient Name, Date of Birth, Telephone Number and the area in which the patient has been sent. (~~i.~~i.e., ~~OR~~**Surgery**, ED~~R~~, **Acute Rehabilitation Unit (**Rehab), **Behavior Health Unit (**BHU), **Intensive Care Unit (**ICU) will be taken. Once the patient reaches their final destination, Registration will be notified to complete the registration process. Registration will use "DIS" (Disaster Service Code)

G. **WORKFORCE MEMBERS RESPOSIBILITIES**

1. **Staff**
   a. **On duty workforce members**

i. Assign duties to staff as directed by IC/ IC Designee
ii. Re-prioritize tasks as directed based on the nature of the emergency:

b. Off duty workforce members
i. On arrival to the hospital, report to the Labor Pool

2. Leadership
a. Leadership
i. Orient and educate staff to the department's and hospital's Emergency Operations Plan
ii. Maintain and update the department's emergency management plan
iii. Maintain and update department's call-back emergency list
3. Contact off duty staff, if required, using the call back emergency list
4. Ensure staff are familiar with their responsibilities

H. RELATED DOCUMENT(S).
1. Emergency Operations Procedure Manual: Emergency Operations Plan

Tri-City Healthcare District
Oceanside, California

EMERGENCY OPERATIONS PROCEDURE MANUAL
~~Emergency Operations Procedure Manual~~
~~Special Circumstances~~

ISSUE DATE: 07/15~~NEW~~

SUBJECT: ~~CODE SILVER~~ Active Shooter and Hostage (Code Silver and Code Gray)~~Person with Weapon or Active Shooter~~

~~REVIEW DATE(S):~~
REVISION DATE~~(S)~~: 07/15

Department Approval~~-Date(s)~~:	~~06/15~~10/22
Environmental Health and Safety Committee Approval~~-Dates(s)~~:	~~07/15~~12/22
Medical Executive Committee Approval~~-Dates(s)~~:	n/a
Administration Approval:	03/23
Professional Affairs Committee Approval~~-Date(s)~~:	~~07/15~~ n/a
Board of Directors Approval~~-Date(s)~~:	07/15

A. PURPOSE:
1. To provide all work force members response information to address an active shooter or hostage situation within the Tri-City Healthcare~~Hospital~~ District (TCHD).
2. To provide a safe and secure environment for all workforce members, patients, and visitors in the event one or both of the following incidents are occurring:
   a. Person with a weapon
   b. Active shooter
   c. Hostage situation
3. To provide a rapid, organized and thorough response to an incident where there is an individual being held against their will or in a hostage situation while in the facility or in the immediate surrounding parking areas.
~~1.~~4. To assure a timely response to situations involving an actual or potential physical threat to patients, volunteers, students, physicians, workforce visitors or property

B. DEFINITION(S):
1. Active Shooter - "An individual or persons actively engaged in killing or attempting to kill people in a confined and populated area; in most cases, active shooters use firearm(s) and there is no pattern or method to their selection of victims".
2. Active Shooter Situation - Situations that "are unpredictable and evolve quickly and typically the immediate deployment of law enforcement is required to stop the shooting and mitigate harm to victims".
3. Hostage Situation – "A person being held by force by one or more individuals in a conflict with security until specific terms are met".
4. Code Gray – An alert code name to identify and inform workforce members of a witnessed hostage situation within or near TCHD.
5. Code Silver – An alert code name to identify and inform workforce members an active shooter has been identified within or near TCHD.
6. Workforce Member: Employees, Medical Staff, Allied Health Professionals (AHP), volunteers, trainees, Business Visitors, Covered Contractors and other persons whose conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD, whether or not they are paid by TCHD.

~~A.~~C. POLICY:

1. It is the policy of the Tri-City Healthcare~~Hospital~~ District (TCHD) to take all reasonable measures to minimize the negative impacts of a situation involving a person with a weapon, an active shooter or a hostage situation.
2. It is the policy of TCHD while responding to a hostage or barricaded suspect situation that the primary aim of personnel is to ensure the safety of all people on the premises, as well as, preserve life and protect property.
3. Workforce members encounter a person with a gun, actively shooting or witness hostages being taken, should run to escape, hide in a secured place and barricade or lock the door of their hiding place, and fight as a last resort.

~~To assure a timely response to situations involving an actual or potential physical threat to patients, volunteers, students, physicians, employees, visitors or property.~~

~~1. It is the policy of the hospital to take all reasonable measures to minimize the negative impacts of a situation involving a person with a weapon, an active shooter or a hostage situation.~~

D. WORKFORCE ROLE:

1. When an active shooter or a person with a gun is identified implement the following:
   a. Protect self – quickly determine the most reasonable way to protect your own life and alert others within your immediate vicinity. Protect yourself by implementing the following
      i. Run to escape and hide.
         1) Individuals ~~around you~~ will follow the lead of employees during an active shooter or hostage situation
      ii. Warn others by calling the hospital Private Branch Exchange~~Operator~~ (PBX), when it is safe to do so, State Code Silver.
      iii. Do not make contact with the shooter or the person with the gun
   b. Once in a safe place or space, if possible call the hospital PBX operator and state the code type e.g., Code Silver (Active Shooter) or person with a gun
      i. Location – department, area, or room number.
      ii. Suspects – number and any physical descriptions.
      iii. Any known hostages or victims.
      iv. Any relevant information (weapons, demands)
      v. Law enforcement personnel authorized to carry a weapon should be identified if they are not in a distinctive uniform.
   c. Workforce members not in the area of the Code Silver should:
      i. Stay away from the location stated
      ii. Close all patient and unit exit doors
      iii. Take cover and barricade yourself behind locked doors
      iv. Provide assistance as requested by an authorized person
   d. v. Implement unit / department active shooter plans
2. Triage Response:
   a. Wait for law enforcement to declare the scene "safe for triage" before any clinical personnel enter to triage patients / victims.
   b. If staff or physicians must enter or leave the building or a patient has an emergency that requires movement, law enforcement must be notified. If appropriate, an armed escort by law enforcement should be provided.
   c. All incoming patients should be diverted to other nearby healthcare facilities. The facilities will be notified of the active shooter situation.

E. HOSTAGE SITUATION:

1. Workforce members that witnesses a hostage situation shall:
   a. Warn others of the situation by calling out for everyone to "take cover".
   b. Dial "66" via the telephone and report "Code Gray" to the PBX Operator
      i. Location – department, area, or room number.
      ii. Suspects – number and any physical descriptions.

iii. Any known hostages or victims.
iv. Any relevant information (weapons, demands)

c. The Emergency Department and Surgical Services workforce members shall be advised of the hostage situation and prepare for possible trauma patients.
d. A designated hospital leader and along with Oceanside Police Department will obtain any pertinent information from the department leader of the affected unit / department, regarding the hostage and hostage taker.
e. Workforce members will be reassigned duties as needed.
f. At no time during the hostage situation will any TCHD workforce members attempt to rescue a hostage or disarm a hostage taker.
g. Open communications with the hostage taker can be attempted to deescalate the incident or obtain information, but at no time will any workforce member offer any promises or concessions to the hostage taker.

F. PRIVATE BRANCH EXCHANGE (PBX) OPERATOR ROLE:

1. Answer the call and remain calm
2. PBX Operator will:
a. Immediately initiate the appropriate shooter policy by specifying the location within the facility.
b. Announce via the overhead system the name of the e.g., Code Silver or Code Gray three (3) times twice along with location of the situation.
c. Notify law enforcement by calling 9-1-1
d. Initiate the appropriate code list
e. If required hide and barricade as outlined in this policy

G. TCHD SECURITY PERSONNEL ROLE:

1. Security Personnel will:
a. Respond to the incident command location while maintaining personal safety
b. Assume responsibility of the Security Supervisor or designee as primary Officer designation until such time that they are relieved of command by Oceanside Police Department (OPD) personnel.
c. Brief OPD personnel of the situation and supply any requested support or additional personnel.
d. Advise for the facility to lockdown until further orders.
e. Proceed to the incident location and begin to
i. Safely remove all patients, visitors, and staff members to a safe location and properly ensure that all approaches into and exits out of the immediate situation area are secured.
f. Established a secure area for use as a command center and central location for the hostage negotiation team.
g. Obtain a floor plan of the incident area from the Facilities Department
h. Assist with establishing a secured system
i. Document all pertinent circumstances related to the hostage situation. This documentation should include but not limited to the date, time, location, actions taken and personnel involved.
j. At the completion of the Hostage situation, all involved personnel will remain available for interviewing by local law enforcement personnel and will only return to normal operations after first receiving authorization to do so from the Security Supervisor or Designee
k. During or after the evacuation processes any capable witnesses will be interviewed by Security personnel for pertinent information regarding the hostage situation.

2. Incident Command will be established per ~~policy~~Emergency Operations Procedure Manual Policy: Emergency Operations Plan

~~B. PROCEDURE:~~
~~1. Discovery:~~

~~1. Anyone encountering a person brandishing a weapon should:~~
~~i. Seek cover and warn others of the situation.~~
~~ii. Clear immediate danger area of all personnel.~~
~~iii. Staff is to call "66" with all known information.~~
~~1) Location – department, area, or room number.~~
~~2) Suspects – number and any physical descriptions.~~
~~3) Any known hostages or victims.~~
~~4) Any relevant information (weapons, demands)~~
~~5) Law enforcement personnel authorized to carry a weapon should be identified if they are not in a distinctive uniform.~~
~~2. Private Branch Exchange (PBX) Operator will:~~
~~i. Immediately initiate Active Shooter procedures specifying the location within the facility.~~
~~ii. **The PBX operator will announce via the overhead system "Code Silver" three (3) times twice along with location of the situation.**~~
~~iii. Due to the nature of the incident, the PBX operator will also notify law enforcement by calling 9-1-1.~~
~~2. Response (Code Silver):~~
~~1. Any staff members in the location affected by the Code Silver should:~~
~~i. Evacuate if possible.~~
~~ii. Seek cover/protection and warn others of the situation.~~
~~iii. Do not panic and stay alert. Remain calm.~~
~~iv. Do not make contact with the shooter(s).~~
~~2. Any staff members not in the area of the Code Silver should:~~
~~i. Upon hearing the overhead announcement of a Code Silver, stay away from the location stated.~~
~~ii. Close all patient and unit exit doors.~~
~~iii. Take cover and barricade yourself behind locked doors.~~
~~iv. Provide assistance as requested by an authorized person.~~
~~3. Triage Response:~~
~~1. Wait for law enforcement to declare the scene "safe for triage" before any clinical personnel enter to triage patients / victims.~~
~~2. If staff or physicians MUST enter or leave the building or a patient has an emergency that requires movement, law enforcement must be notified. If appropriate, an armed escort by law enforcement should be provided.~~
~~4. Hospital Command Center:~~
~~1. The administrator-on-call (AOC) or Administrative Supervisor will assume the role of Incident Commander or delegate the responsibility to the most qualified individual.~~
~~2. The Incident Commander will activate the Command Center (CC) in an area not affected by the situation.~~
~~3.~~**i.** ~~The Incident Commander will activate those positions within Hospital Incident Command System (HICS) that is necessary as the situation determines.~~
~~4. All incoming patients should be diverted to other nearby healthcare facilities. Those facilities must be notified regarding the Code Silver situation.~~

~~5.~~**3.** Law Enforcement Arrival:

- **a.** When law enforcement arrives, **they will** ~~it will become their incident and they will~~ assume full responsibility of managing the situation.
- ~~1.~~**b.** All staff **will**~~is requested to~~ cooperate fully with law enforcement.
- **c.** **Security will provide** ~~L~~law enforcement **personnel** ~~will need~~ **the following information:**
  - **i.** **Information about the active shooter and / or hostage situation**
  - **ii.** **A**~~a~~ copy of the **schematics of the hospital that includes:** facility's floor plans, indicating rooms, exits, windows, utility access~~,~~
  - **iii.** ~~k~~**K**eys
  - ~~2.~~**iv.** ~~and A~~**A**ccess badges~~.~~
- ~~3.~~**d.** Law enforcement will establish their separate incident command post outside the facility and away from the situation.

~~4.~~**e.** Victim response:
- i. Show hands **(raise your hands)** at all time when law enforcement arrives on scene
- ii. Follow **all** law enforcement instructions ~~as they are given~~
- iii. Verbally identify yourself
- iv. Advise law enforcement if you are injured and require medical attention**, when asked**
- **v.** Leave all personal belongings during the evacuation process.

~~6.~~**4.** Media:
- ~~1.~~**a.** The Public **Affairs** ~~Information~~ Officer ~~(PIO)~~ will contact families of identified hostages and serve as the liaison with the media.
- **b.** All media coverage is to be directed to the Public Information Officer and facility staff will not give out information to the media. ~~Protection of privacy is extremely important and staff should not be discussing the situation openly.~~
- ~~2.~~**c.** All official statements by the facility will be discussed with the designated law enforcement representative before being released.

~~7.~~**5.** All Clear~~:~~ **(Active Shooter No Longer a Risk and / or Hostages Released)**
- ~~1.~~**a.** The Incident Commander, after consultation with law enforcement, shall issue an "All Clear" notification to the PBX Operator to indicate termination of the situation.
- ~~2.~~**b.** The PBX Operator will announce "Code Silver **or Code Gray** All Clear" three (3) times via the overhead announcement system.
- ~~3.~~**c.** All **workforce members**~~facility staff~~ may return to their departments and normal operations at this time if permitted.

~~8.~~**6.** After-Action:
- ~~1.~~**a.** ~~Be prepared to spend considerable time with l~~**L**aw enforcement **personnel may spend several minutes to hours** reviewing the situation in detail.
- b. **Debriefing:**
  - ~~2.~~**i.** Facility administrators and staff must meet after the conclusion of the incident within a ~~24-48 hour~~**24-48-hour** time frame to review the situation from start to finish.
  - ~~3.~~**ii.** The goal of the debriefing is not to determine fault**,** but, what actions, policies and procedures could be enhanced to better respond **to future** ~~in a~~ Code Silver situation**s**.

~~9.~~**7.** Mental Health Considerations:
- **a.** It is strongly recommended that all affected persons in the Code Silver **or Code Gray** situation be required to complete an initial mental health evaluation by a professional to determine if continued therapy is required and for what duration the therapy is to continue.
- ~~1.~~**b.** ~~-~~All persons involved in the situation should be provided a written evaluation with the mental health professional's recommendation for a return to duty date.

H. EDUCATION AND TRAINING**:**

1. Training and education to ensure that all **Workforce Members** ~~staff~~ of ~~Tri-City Healthcare District (TCHD)~~ ~~is~~ ~~**workforce**~~ **are** aware of potential security hazards and how to protect themselves, co-workers and **visitors, etc.,** ~~guests~~ through established policies and procedures.
2. **Staff will be assigned computer-based learning (CBL) modules on Active Shooter and hostage situations, actions to implement annually**

~~2.~~**3. Education on unit-based actions to implement during an active shooter or hostage situation or victim will be discussed annually by unit / department leaders.**

~~10. Training for staff must include what to do if they become a hostage or victim.~~

4. Employees at all ~~(TCHD)~~ off site buildings will call 911 first and inform the local law enforcement agency of the situation.

~~3.~~

I. RELATED DOCUMENT(S):

~~11.~~**1. Administrative District Operations Policy: Business Visitor Visitation Requirements 8610-203**

~~C.~~**J.** REFERENCE(S):

1. California Hospital Association / Active Shooter ~~Guide~~**Guide (Need to update)**
2. **Healthcare and Public Health Coordinating Council. (2017). Active shooter: Planning and response. Retrieved from**
3. **United States Department of Homeland Security. (2008, October). Active shooter: How to respond. Retrieved from https://www.calhospitalprepare.org/**
4. U.S. Department of Homeland Security "How to respond when an Active Shooter is in your vicinity". **(need to find this reference)**
5. ~~2.~~ **United States Department of Homeland Security: Cyber + Infrastructure (CISA). (n.d.). Hospitals and Healthcare Facilities: Security Awareness for Soft Targets and Crowded Places. Retrieved from https://www.cisa.gov**

HOW TO RESPOND WHEN AN ACTIVE SHOOTER IS IN YOUR VICINITY

Quickly determine the most reasonable way to protect your own life. Remember that visitors and workforce members are likely to follow the lead of employees and managers during an active shooter and / or hostage situation.

Run - Evacuate If there is an accessible escape path, attempt to evacuate the premises. Be sure to:

- Have an escape route and plan in mind
- Evacuate regardless of whether others agree to follow
- Leave your belongings behind
- Help others escape, if possible
- Prevent individuals from entering an area where the active shooter may be
- Keep your hands visible
- Follow the instructions of any police officers
- Do not attempt to move wounded people
- Call 911 when you are safe

Hide - If evacuation is not possible, find a place to hide where the active shooter is less likely to find you.

- Your hiding place should:
  - Be out of the active shooter's view
  - Provide protection if shots are fired in your direction (i.e., an office with a closed and locked door)
  - Do not trap yourself or restrict your options for movement
  - pPrevent an active shooter from entering your hiding place by:
    - Lock the door
    - Blockade the door with heavy furniture
    - Turn off or silence cell phones and computer

If the active shooter is nearby:

- Lock the door
- Silence your cell phone and/or pager
- Turn off any source of noise (i.e., radios, televisions)
- Hide behind large items (i.e., cabinets, desks)
- Remain quiet If evacuation and hiding out are not possible
- Remain calm
- Dial 911, if possible, to alert police to the active shooter's location
- If you cannot speak, leave the line open and allow the dispatcher to listen

Fight - Take action against the active shooter

As a last resort, and only when your life is in imminent danger, attempt to disrupt and/or incapacitate the active shooter by:

- Acting as aggressively as possible against him/her
- Throwing items and improvising weapons
- Yelling Committing to your actions

Active Shooter Quick Reference Guide

ACTIVE SHOOTER EVENTS

When an Active Shooter is in your vicinity, you must be prepared both mentally and physically to deal with the situation.

You have three options:

1 RUN

- Have an escape route and plan in mind
- Leave your belongings behind
- Evacuate regardless of whether others agree to follow
- Help others escape, if possible
- Do not attempt to move the wounded
- Prevent others from entering an area where the active shooter may be
- Keep your hands visible
- Call 911 when you are safe

2 HIDE

- Hide in an area out of the shooter's view
- Lock door or block entry to your hiding place
- Silence your cell phone (including vibrate mode) and remain quiet

3 FIGHT

- Fight as a last resort and only when your life is in imminent danger
- Attempt to incapacitate the shooter
- Act with as much physical aggression as possible
- Improvise weapons or throw items at the active shooter
- Commit to your actions . . . your life depends on it

The first officers to arrive on scene will not stop to help the injured. Expect rescue teams to follow initial officers. These rescue teams will treat and remove injured.

Once you have reached a safe location, you will likely be held in that area by law enforcement until the situation is under control, and all witnesses have been identified and questioned. Do not leave the area until law enforcement authorities have instructed you to do so.

When law enforcement arrives:

- Remain calm and follow instructions
- Drop items in your hands (e.g., bags, jackets)
- Raise hands and spread fingers
- Keep hands visible at all times
- Avoid quick movements toward officers, such as holding on to them for safety
- Avoid pointing, screaming or yelling
- Do not ask questions when evacuating

Information to provide to 911 operations:

- Location of the active shooter
- Number of shooters
- Physical description of shooters
- Number and type of weapons shooter has
- Number of potential victims at location

For questions or additional assistance contact:
Your local law enforcement authorities or FBI Field office

Tri-City Medical Center
Oceanside, California

EMPLOYEE HEALTH AND WELLNESS ~~POLICY MANUAL~~

ISSUE DATE: 06/1999	**SUBJECT: Temporary ~~Light~~ Modified Duty for Industrial Injuries**
REVISION DATE: 05/2008, 05/2011, 09/~~20~~14	

Employee Health Department Approval:	**06/20**
Infection Control Committee Approval:	**n/a**
Environmental Health & Safety Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**03/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**09/14**

A. **PURPOSE:**
1. To provide a process to reasonably accommodate provider's restrictions for employees who are injured on the job.
2. To keep employees, who are receiving workers' compensation benefits, working in a productive capacity while protecting their **healing** injury.
~~2.~~**3.** **To provide a uniform and fair application of a program for modified duty (which includes the definitions in section C) for occupational injuries among the various departments the following policy is hereby adopted and made applicable to all employees.**

B. **PROCEDURE:**
1. After an employee has met ~~light~~ **modified** duty requirements (as verified by Employee Health Services~~Risk Manager~~ **or designee**) and as work is available, an employee will be assigned a ~~light~~ **modified** duty position.
2. The ~~light~~ **modified** duty assignment will accommodate the employee's stated restrictions **as assigned by a medical provider**.
3. Although TCHD will attempt to accommodate an employee on ~~light~~ **modified** duty (due to availability), there is no guarantee of placement.
4. ~~Light~~ **Modified** duty is considered a temporary assignment, usually lasting no longer than 90 days.
~~4. Department Managers must give consideration to the type of work assigned~~
5. In addition, no ~~light~~**modified** duty assignment will become permanent.

C. **DEFINITIONS:**
1. Light Duty – The injured employee is brought back to work and placed temporarily within an existing job that is not as physically taxing or demanding as their normal job.
2. Restricted Work - The injured employee is brought back to their normal job with restrictions assigned by the doctor.
3. Transitional Work – The injured employee is brought back to a position that has been specifically created to accommodate the restrictions of a specifically injured employee if the need for such work should arise and such an assignment does not cause a financial hardship on the organization.
4.

~~C.~~**D.** **~~LIGHT~~ MODIFIED DUTY GUIDELINES:**
1. Before an employee starts an approved ~~light~~ **modified** duty assignment, the following must occur:
2. Employee Health Services~~Risk Manager~~ **or designee** will:

~~3.~~**a.** Meet with the injured employee and review the physician's written approval for ~~light~~ **modified** duty, and the return to work policy.

~~4.~~**b.** Complete the Notice of Offer of Modified or Alternative Work Form **or Transitional Duty Agreement, if applicable**~~.~~

~~5.~~**c.** Employee will read and receive the "Employee Responsibilities While on Light Duty" Form and be able to communicate a clear understanding of expectations.

3. If it is not possible to place the injured employee within their department, Employee Health **or designee** ~~Services~~~~**Risk Manager**~~ will contact managers for placement.

4. Department Managers must give consideration to the type of work assigned for the ~~light~~modified duty person.

a. Assignments shall not put patients or staff at risk of injury~~.~~

b. Injured Security Officers, who are on ~~light~~**modified** duty, shall not be assigned responsibilities of a Security Officer. Responsibilities of this position put the Security Officer at risk of exceeding ~~light~~**modified** duty restrictions which could result in further injury.

5. If there is no meaningful work available that the injured employee is capable of performing, the injured employee will be sent home subject to being called back should appropriate modified duty become available. A modified duty assignment is not guaranteed to an injured employee, but TCHD will attempt to make work available. In no event will a position be created for the sole purpose of utilizing the injured employee in a modified duty status or shall a modification of job duties be made which allows the employee to perform in a modified duty capacity.

6. The refusal of any modified duty position shall be handled by the organization pursuant to the provisions of the worker's compensation regulations and may include the suspension of benefits for the refusal of a position within the limitations set forth by the appropriate medical provider.

7. A modified duty assignment can end when the employee has reached the 90 day maximum, is released to full duty by a medical provider, or has reached maximum medical improvement.

8. **This modified duty work shall be separate and distinct from TCHD's EEO policy which shall address issues of accommodation pursuant to the ADA, FMLA, or CFRA or other federal and state requirements that may apply to TCHD. Under no circumstances should this policy be used in situations where the EEO policy shall apply.**

~~D. **SECURITY OFFICERS:**~~

~~1. **Injured Security Officers, who are on light duty, shall not be assigned responsibilities of a Security Officer. Responsibilities of this position put the Security Officer at risk of exceeding light duty restrictions which could result in further injury**~~

~~2. **Employee Health Services Risk Manager will work with the injured Security Officer placing him in a position outside of his normal job duties and Department.**~~

~~3. **Security Officers on light duty shall not wear uniforms or any attire that identifies employees as Security.**~~

E. **COMPENSATION:**

1. Employees' **pay while** on the ~~light~~ **modified** duty program will be -**determined by W~~w~~orkers' C~~c~~ompensation regulations.** ~~paid at their regular wages prior to the injury~~ **and TCHD pay practice.**~~.~~

2. It is the responsibility of ~~Employee Health Services~~**Manager/Supervisor** -to approve the employee's time card at the end of each pay period.

F. **CRITERIA TO RETURN TO WORK:**

1. After receiving medical treatment, the employee must receive a return to work authorization form from their treating provider and ~~give~~ **return** it to Employee Health Services.

~~2. After receiving medical treatment, the employee must receive a return to work authorization form from their treating provider and give it to Employee Health Services.~~

~~3.~~**2.** The return to work authorization is specific and may include:~~.~~

- ~~4.~~**a.** A full release to work, without restrictions or limitations,~~.~~
- ~~5.~~**b.** A modified release to work with specific restrictions or limitations~~.~~,
- ~~6.~~**c.** Release to remain off work for a particular time period (Temporary Disability)

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

~~1. Notice of Offer of Modified or Alternative Work Form~~

~~2.~~**1.** Employee Responsibilities **While on the Light Modified Duty** ~~Form~~.

~~3. Clocking in on Kronos for Modified Duty Assignments~~

SAVE PRINT CLEAR

DWC-AD 10133.53 NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK

For injuries occurring on or after 1/1/04

THIS SECTION COMPLETED BY CLAIMS ADMINISTRATOR:

Employer (name of firm)______ sition of a
(name of job) ______
You may contact ______ ______
Date of offer: ______
Claims Administrator:______ :______

NOTICE TO EMPLOYEE Name ______
Date ______

You have 30 calendar days from odified or alternative work. Regardless of whether you acce anent disability payments may be decreased by 15%. However offer, you will not be entitled to the supplemental job displac

Modified Work ☐ or Alterna

A. You cannot perform the essent
B. The job is not a regular positio
C. Wages and compensation offe
D. The job is beyond a reasonabl

THIS SECTION TO BE COMPLETE

__ I accept this offer of Modified or
__ I reject this offer of Modified or A he Supplemental Job Displacement Benefit.

I understand that if I voluntarily quit be entitled to the Supplemental Job Displacement Benefit.

Signature

I feel I cannot accept this offer beca

Retire Form

If the offer is <u>not</u> accepted or reject rejected by the employee.

The employer or claims administrator ministrative Director within 30 days of acceptance or rejection. (A.D., "SJ S.F., CA 94142-0603)
If a dispute occurs regarding the abov ative Director to resolve the dispute by filing a Request for Dispute Resolu ctor.

Form DWC-AD 10133.53 (Au Page 1 of 3)
ALIFORNIA
(08/06)

DWC-AD 10133.53 NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK

For injuries occurring on or after 1/1/04

POSITION REQUIREMENTS

Actual job title:

Wages: $ pe

Is salary of modified/alternative work

Is salary of modified/alternative work job?

Will job last at least 12 months?

Is the job a regular position required

Work location: ____________

Duties required of the position:

Description of activities to be perform

Physical requirements for performing ... customary job):

Name of doctor who approved job re ... ate of report::____________

Date of last payment of Temporary T

Retire Form

Preparer's Name:

Preparer's Signature: Date

DWC-AD 10133.53 NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK

For injuries occurring on or after 1/1/04

Proof of Service By Mail

I am a citizen of t he County of

______________ not a party to the within matter.

My business address is:

______________ ______________

On ______________ of **Modified** or **Alternative Work** on the par osed in a sealed envelope with postage fully at the place so addressed.

Retire Form

I declare under penalty of per foregoing is true and correct.

Executed at ______________ ______________.

Signature:______________

Copies Served On: ______________

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL

ISSUE DATE: 03/02

SUBJECT: Infection Prevention Risk Assessment

REVISION DATE(S): 07/13, 08/14, 05/16, 03/17, 02/18 03/19, 02/20

Infection Control Department Approval:	~~06/21~~04/22
Infection Control Committee Approval:	~~07/21~~11/22
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~04/20~~02/23
Administration Approval:	~~05/20~~03/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. **PURPOSE:**
1. Tri-City Medical Center conducts an annual Infection Prevention (IP) risk assessment to identify the associated risks for the transmission and acquisition of infectious agents throughout the hospital. It pertains to patients, licensed independent practitioners, staff, volunteers, students, visitors and family. The Risk Assessment is based on the geographic location of the hospital, the program/services provided, and the characteristics of the patient population served, community needs, and the results of analysis of the hospital's infection prevention data from CY 202~~0~~2~~1~~. The Risk Assessment is formally reviewed at least annually and periodically reassessed whenever significant changes occur in any of these factors.

B. **INFECTION PREVENTION PROGRAM MANAGEMENT AND RESOURCES:**
1. The hospital identifies the individual(s) with clinical authority over the IP program. The Medical Director of the IP program has the clinical authority over the IP program. The Medical Director serves as the Infectious Disease Specialist and chair of the Infection Prevention Committee.
2. The hospital assigns responsibility for the daily management of IP activities to the Infection Preventionist. The Infection Preventionist is the individual with the clinical and administrative authority over the implementation of the daily management of the IP program. The Infection Preventionist reviews program issues with the Medical Director of the IP Program. The current FTEs assigned to the IP program is 1.6. Additional hours have been approved for the Medical Director to provide dedicated services to the IP program.
3. The Infection Preventionist has administrative duties that include the following:
    a. Developing polices governing control of infections and communicable diseases.
    b. Implementing policies governing control of infections and communicable diseases.
    c. Developing a system for identifying, reporting, investigating, and controlling infections and communicable diseases.~~,~~

C. **GEOGRAPHIC REVIEW:**
1. The geographic location of TCMC is in a suburban area, adjacent to multiple outpatient/office facilities, freeways, and shopping centers in northern San Diego County. San Diego County is the second most populous of California's 58 counties, and the fifth largest county in the United States. San Diego is currently home to 3.1 million residents, as of July 1, 2019. Located within the North County geographic region are 3 college campuses along with a Marine Corp Base (Camp Pendleton).

D. DEMOGRAPHIC REVIEW:

1. San Diego County is becoming increasingly bicultural due to its close proximity to Mexico. In addition, the county is already ethnically diverse, and will be increasingly so. As of 2019, the largest San Diego County racial/ethnic groups are White (45.6%) followed by Hispanics (33.7%) & Asian (11.6%). Approximately 21.5% of the county's populations are immigrants, including refugees, who come from other countries, speak many different languages, and have a variety of needs as they assimilate into their new environment. Approximately, 38.8% of people in San Diego County speak a non-English language. The senior and disabled populations are growing disproportionately compared to the rest of the population.

E. LOCATION OF ALL SERVICES WITHIN ACUTE CARE SETTING

1.

Lower Level

Location	Departments	Inpt/OBV	OutPt	Ambulatory
	Assembly Rooms			
	Cafeteria			
	Employee Health			
	Medical Records			
	Pharmacy			
	Sterile Processing			
	Quality/Risk/Infection Prevention			

Level 1

Location	Departments	Inpt/OBV	OutPt	Ambulatory
North Wing	Acute Rehab	X		
South Tower	ICU	X		
Pavilion	Cardiology Services		X	X
1st floor	Emergency		X	
1st floor	Laboratory			X
1st floor	Pulmonary Rehab		X	X
1st floor	Radiology	X	X	X

Level 2

Location	Departments	Inpt/OBV	OutPt	Ambulatory
North Wing	Labor and Delivery	X		
Center Tower	Mother Baby/Post Partum	X		
South Tower (2E/2W)	Patient Rooms	X		
Pavilion (2P)	Patient Rooms	X		

Level 3

Location	Departments	Inpt/OBV	OutPt	Ambulatory
Center Tower	PCU (Forensics)	X		
Pavilion (3P)	Patient Rooms	X		
South Tower (3E/3W)	Patient Rooms	X		

South Tower	NICU	X		
Level 4				
Location	**Departments**	**Inpt/OBV**	**OutPt**	**Ambulatory**
Pavilion (4P)	Patient Rooms	X		
South Tower (4E/4W)	Patient Rooms	X		

2. According to the US Census Bureau 2021~~19~~ QuickFacts, the demographic information on the three cities most often served by TCHD is listed below.

City	Median income	Total # residents	White	Hispanic	Asian	African American
Oceanside	$ 752,41169 7	174,0685,742	465.38 %	367.82%	7.34%	4.45%
Vista	$ 723,16325	101,63898,381	389.64 %	50.29%	4.32%	3.1%
Carlsbad	$ 1120,9334 78	1145,746382	6973.3 %	153.95%	98.10%	10.19%

3. Tri City Medical Center **Patient**~~Financial~~ Characteristics for Fiscal Year 2022~~10~~

~~a. The top six insurance coverage are as follows:~~

~~MEDICARE~~	~~24.8%~~
~~MEDI-CAL HMO~~	~~16.9%~~
~~Medicare SR HMO~~	~~15.1%~~
~~MEDI-CAL~~	~~12.8%~~
~~Other Governmental~~	~~12.8%~~
~~HMO~~	~~4.4%~~

~~b.~~**a.** Patient Census:

	Average. Daily Census	Average. Length of Stay*	Total Pt. Days
Acute Care (excludes all below)	108.012.4	4.65.50	41,01239,434
ICU*	124.9	3.46.23	5,4494,721
NICU	6.99.4	8.89.56	3,4392,527
Rehab Serv.	5.57.1	14.211.04	2,5892,004

i. *ICU ALOS includes discharges, transfers out, and expirations. All other areas are based only on discharges.

~~c.~~**b.** In acute care FY 2022~~10~~, the three largest age groups are **age** 60-69 ~~year olds~~ (~~18.67~~**17.75**%), 70-79 ~~year olds~~ (18.187.7%), and 80-89 ~~year olds~~ (15.353.8%).

~~d.~~**c.** **12.09**~~16.6~~ percent (~~8684/52,277~~**6,531/54,035**) of Emergency Department patients **were**~~are~~ admitted to the hospital **in FY2022**.

4. TCHD's primary focus is on basic community services. The top ten major diagnostic categories (DRGs) are the following:
   a. Obstetrics
   b. Newborns & Neonates
   c. Infectious & Parasitic Diseases
   d. Circulatory System
   e. Musculoskeletal & Connective Tissue
   f. Nervous System
   g. Respiratory

h. Digestive System
i. Kidney & Urinary Tract
j. Hepatobiliary System & Pancreas

5. Top **three**~~five~~ Inpatient Surgical Procedures (Fiscal Year 202~~0~~**2**~~1~~): Cesarean section (CSEC), spinal fusion (FUSN), ~~hip prosthesis (HPRO),~~ **esophagogastroduodenoscopy** ~~knee prosthesis~~ (~~KPRO~~**EGD**)~~.and cholecystectomy (CHOL).~~
6. Home Care Services provides skilled, intermittent care to individuals in a home setting. The restorative, rehabilitative 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, Speech Therapists and/or Dietitians. For FY 202**1**~~0~~ in Home Care:

Average LOS	**Top Payers**	**Top Primary DX Categories**
36.8 days	Medicare--52.44% HMO/PPO 42.08%	-Factors influencing Status/Sup Class -Injury/Poisoning -Circulatory (not HTN, HF or CVD) -Respiratory (COPD) -Musculoskeletal/Connective Tissue -Respiratory (not COPD) Circulatory-CVD Genitourinary 1. Other health services for specific procedures and after care 2. All Other injuries excluding fractures 3. Diseases of Cardiovascular System 4. Diseases of Respiratory System excluding complications of care 5. Complications of surgical and medical care

F. EMPLOYEE HEALTH:

1. The Employee Health department at TCMC works collaboratively with the Infection Prevention Department to minimize the spread of infectious disease to and from employees.
   a. The total number of employees **who worked at this facility in** ~~working at TCHD FY 20210~~**CY 2022 was**~~is~~ approximately **1,**~~,616~~**776.**~~2,524 with about 1,572 (62%) staff providing direct patient care. This number includes 511 employees which were terminated at some point during FY2020.~~
2. The Employee Health department contributes to the prevention and control of communicable diseases by established policies and procedures listed in TCMC policies. Together with Infection Prevention they work collaboratively in:
   a. Investigating and monitoring exposures to communicable disease and illness.
   b. Establishing pro-active policies and procedures for management of employee infection risks related to disasters, bioterrorism, and emerging pathogens.
   c. Establishing guidelines for work restrictions due to communicable disease.

~~c.~~

G. REVIEW AND EVALUATION OF FY2022~~10~~ HOSPITAL SURVEILLANCE:

1. **See related document: Infection Prevention Annual Program Evaluation**

H. RISK ANALYSIS FOR FY 2022:

1. **See related document: Infection Prevention Annual Risk Assessment Table**

~~See related document: Infection Control Annual Program Evaluation~~
~~G. RISK ANALYSIS FOR FY2021~~

Risk Issue / Incident	Has incident occurred in previous 12 months (Yes / No)	Prevention or Control Strategy In place (Yes / No)	Event likely to occur in next 12 mos. 1=low 2 = med 3 =high	Potential Impact on Patients or Facility 0=none 1=low 2=med 3=high	Risk Score =Event likely times Potential Impact	Priority Rank H,M, L
Device or Procedure related Risks						
Central line BSI	Yes	Yes	3	3	6	H
Ventilator Associated Pneumonia	No	Yes	1	2	2	L
Catheter related UTI	Yes	Yes	3	3	9	H
Surgical Site Infections	Yes	Yes	3	3	9	H
Equipment Related Risks						
Disinfection/Sterilization of medical devices-(failure)	Yes	Yes	2	3	6	M
Cleaning of common equipment—wet contact time (failure)	Yes	Yes	3	2	6	M
Pathogen Exposure Risks for Patients and Staff						
MDROs (multi drug resistant organisms)	Yes	Yes	3	3	9	H
C. difficile	Yes	Yes	3	3	9	H
Influenza –Seasonal	Yes	Yes	2	3	6	M
Infestations (Scabies, Lice, bed bugs)	Yes	Yes	3	3	9	H
Tuberculosis	No	Yes	2	3	6	M
Communicable Diseases(COVID-19)	Yes	Yes	3	3	9	H
Internal Environmental Risks						
Construction or Renovation Projects	Yes	Yes	3	2	6	M
Repairs/Maintenance that affect patient care areas	Yes	Yes	3	2	6	M
Laundry and linen problems	No	Yes	2	2	4	M
Medical Waste mishandling	No	Yes	1	1	1	L
Mold	No	Yes	1	2	2	L
Water Intrusion/ Disruption	Yes	Yes	3	2	6	M
Environmental cleanliness-terminal cleaning failure	Yes	Yes	3	3	9	H

~~H.~~

Safe Food Handling: cool down logs, labeling	No	Yes	1	2	2	L
Ice Machines – schedule for cleaning Ice containers	No	Yes	1	2	2	L
Employee Related Risks						
Hand Hygiene (non-compliance)	Yes	Yes	2	2	4	M
PPE (non-compliance)	Yes	Yes	3	3	9	H
Needlestick: Bloodborne pathogen exposure	Yes	Yes	2	3	4	M
PAPRs (non-compliance,)	No	Yes	2	3	6	M
Unidentified TB patients in Emergency department & direct admit	No	Yes	1	3	4	M
External Environment Risks						
Community outbreaks of communicable diseases with influx of infectious patients	Yes	Yes	3	3	9	H
New Emerging/Re-emerging Pathogens (e.g., pandemic flu, Avian flu, SARS-COV, etc.)	Yes	Yes	3	3	9	H
Compliance with NPSG, JC, CDPH	Yes	Yes	3	3	9	H
Mandatory Reporting and use of NHSN	Yes	Yes	3	3	9	H

Low (L) = < 3

Medium (M) = 3—6

High (H)= > 6

I. **GOALS, OBJECTIVES, STRATEGIES, EVALUATION:**

1. **The goals, objectives and strategies are described in the annual Infection Prevention Program Plan.**

~~1.~~2. Using the risk analysis and the summary of healthcare-associated infection surveillance outcomes, prioritized risks are identified based on their nature, scope, and impact on the care, treatment, and services provided.

~~2.~~3. Goals and objectives, with specific strategies are developed and implemented to address the prioritized risks. These strategies may take the form of policy and procedure, surveillance and monitoring activities, education and training programs, environment and engineering controls, or combinations thereof. Strategies may differ in approach, form, scope, application and/or duration depending on the specific risk issue, the care setting(s) and environment. **See**

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

1. Infection Control Policy: Infection Prevention Program Plan
2. Infection Control Policy: Epidemiologic Investigation of a Suspected Outbreak
3. Infection Control Annual Evaluation 2022~~1~~

K. **REFERENCE(S):**

1. County of San Diego Public Health & Human Services Agency, Public Health Services. Retrieved from http://www.sandiegocounty.gov/hhsa/programs/phs/
2. APIC Text of Infection Control and Epidemiology, 2021.
3. https://www.census.gov/quickfacts/fact/table/missionviejocitycalifornia,orangecountycalifornia/PST045217 **(Reviewed 11/22)**
4. Joint Commission, Hospital Accreditation Standards
5. CMS Conditions of Participation: IC
6. Title 22, Calif. Code of Regulations
7. Health and Safety Code
8. CDC Guidelines as listed
9. CDPH AFL 09-07
10. FDA 21 CFR Part 1271
11. County of San Diego Tuberculosis Control and Refugee Health Program.) TB Statistics-Fact Sheet 2020 (March 12, 2021). Retrieved from http://www.sandiegocounty.gov/hhsa/programs/phs/tuberculosis_control_program/
12. **https://datausa.io/profile/geo/san-diego-county-ca/**
13. **https://www.sandiegocounty.gov/hhsa/statistics_demographics.html**
14. **https://www.california-demographics.com/san-diego-county-demographics**

Tri-City Medical Center
Oceanside, California

Move to Laboratory Transfusion Medicine Manual

MEDICAL STAFF

ISSUE DATE: 2001	**SUBJECT:** Audit Criteria for Blood Utilization Review (BUR)
REVISION DATE(S): 05/08, 09/12, 09/18	**POLICY NUMBER:** 8710 – 540

Medical Staff Department Approval:	~~12/17~~07/21
Blood Utilization Review Committee Approval:	~~07/18~~02/23
Medical Executive Committee Approval:	~~08/18~~02/23
Administration Approval:	~~09/18~~03/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	09/18

A. **AUDIT CRITERIA FOR RED BLOOD CELL (RBC)TRANSFUSIONS:**
1. Red blood cell (RBC) transfusions are given to improve oxygen delivery.
2. Only transfuse in presence of compelling clinical indication in individual patients. Symptomatic anemia in a normovolemia patient, regardless of hemoglobin concentration may be indicated.
3. From the American Society of Anesthesiologist Task Force on blood Component Therapy the following recommendations are adopted:
   a. Hemoglobin greater than or equal to 10-g/dL transfusion is rarely indicated.
   b. Hemoglobin 6-8 g/dL indications for transfusion should be based on the patient's risk of inadequate oxygenation from ongoing bleeding and/or high-risk factors.
   c. Hemoglobin less than 6 g/dL transfusion is almost always indicated.
   d. Preoperative Transfusion: aim should be to identify and correct anemia with non-transfusion methods.
   e. Patients with asymptomatic anemia and hemoglobin less than or equal to 7 g/dL may need to be transfused if scheduled surgery is expected to produce significant blood loss (with or without cell saver use). The risks associated with general anesthesia are high.
4. In most healthy patients, oxygen delivery is thought be adequate even at hemoglobin of 7-8 g/dL
   a. Chronic anemia: cause of anemia should be established. See 2 above.
   b. RBC transfusion is contraindicated if specific replacement therapy is possible (e.g., iron, vitamin B12, folic acid). Transfuse only in case of emergency surgery, acute blood loss or trauma.
   c. RBC transfusion may be indicated in anemia secondary to aplasia or bone marrow suppression. In patients with no symptoms of anemia and no ~~high risk~~**high-risk** factors, hemoglobin of 6-7 g/dL may be sufficient.
   d. Evidence of cardiovascular, pulmonary or cerebrovascular disease may need to be transfused with hemoglobin greater than or equal to 7 g/dL.
   e. Special situations such as severe Thalassemia or other Congenital Anemias: the aim of transfusion in these cases is to prevent symptoms and suppress endogenous Erythropoiesis by maintaining hemoglobin at a minimum of 10 g/dL
   f. Sickle Cell Disease: Patients with a history of or at high risk for stroke or other severe complications who are not on a chronic transfusion protocol or who require acute RBC exchange may be transfused to reduce Hb S to below 30-50%.
5. Acute Blood Loss (ABL): blood volume loss of 15-30% should be treated with crystalloids colloids, not RBC in young, healthy patients.
   a. ABL 30-40% blood volume loss requires rapid volume replacement and RBC transfusion is probably necessary.

b. ABL greater than 40% is life threatening and volume replacement including RBC transfusion is required.

6. Burn patients: depending on clinical symptoms transfusion trigger should be 6-8 g/dL. At Tr-City Healthcare District (TCHD) these patients have probably been transferred post-burn unit confinement.
7. All RBC transfused at TCHD are leukoreduced.

B. PLATELETS:

1. Platelet count less than 10,000/uL in a non-bleeding patient with failure of platelet production.
   a. Note: all platelets given at TCMC are leukoreduced platelet pheresis products each containing greater than or equal to 3.0×10^{11} platelets.
2. Platelet count less than 50,000/uL and impending surgery or invasive procedure or in a patient experiencing hemorrhage.
3. Diffuse micro-vascular bleeding following cardiopulmonary bypass or during use of an intra-aortic balloon pump with no significantly abnormal coagulation parameters.
4. Diffuse micro-vascular bleeding in a patient with massive blood loss (one blood volume) in whom platelet counts are not yet available.
5. Bleeding associated with a qualitative platelet defect, regardless of platelet count.
6. Comment: A platelet count should be obtained before and 60 minutes after transfusion to evaluate refractory status.

C. FRESH FROZEN PLASMA:

1. Plasma is administered to correct bleeding due to single or, much more commonly, multiple coagulation factor abnormalities when specific therapy is unavailable.
2. Standard audit criteria for plasma transfusion may include but are not limited to the following:
   a. PT or PTT greater than 1.5 times the mean reference range in a non-bleeding patient scheduled for or undergoing surgery or invasive procedure.
   b. Diffuse micro-vascular bleeding in a patient transfused more than one blood volume and coagulation test results not yet available.
   c. Microangiopathic hemolytic anemia (e.g., TTP) being treated with plasma exchange.
   d. Emergency reversal of Coumadin effect.
   e. Specific coagulation factor deficiency when appropriate concentrates are not available (e.g. Antithrombin III).
   f. Comment: PT and PTT should be obtained pre and post transfusion to determine the need for and the effect of transfusion.

D. CRYOPRECIPITATED ANTIHEMOPHELIC FACTOR (CRYOPRECIPITALE):

1. Cryoprecipitate is administered for prevention or treatment of bleeding due to hypofibrinogenemia, dysfibinogenemia, Von Willebrand Disease (in some circumstances) and very rarely Factor VIII and IX deficiency.
2. Standard audit criteria for cryoprecipitate transfusion may include but are not limited to the following:
   a. Fibrinogen less than 80 to 100 mg/dL.
   b. Diffuse micro-vascular bleeding and fibrinogen less than 100 to 120 mg/dL.
   c. Von Willebrand Disease unresponsive to DDAVP and no appropriate concentrates available.
   d. Hemophilia A with no appropriate factor concentrates available.
   e. Uremic bleeding if DDAVP is ineffective
   f. Factor XIII deficiency

E. WHOLE BLOOD:

1. Whole blood is generally not available at any time except for autologous units.

F. <u>GRANULOCYTES:</u>

1. Neutrophil count less than 500/uL in patients with life-threatening infection who have recoverable marrow hypoplasia.
2. Severe neutrophil dysfunction (e.g.; chronic granulomatous disease).

G. <u>IRRADIATED BLOOD COMPONENTS:</u>

1. Cellular blood components are irradiated to reduce the risk of graft versus host disease (GVHD) in individuals with severely suppressed immune system.
2. Patients with the following conditions and some others on a case-by-case evaluation should receive washed blood components.
   a. Congenital immunodeficiencies
   b. Progenitor cell transplantation, either allogeneic or autologous
   c. Patients receiving HLA-matched cellular components
   d. Patients receiving directed donor units (directed units are automatically radiated at collection site)
   e. Patients with Hodgkin's Disease
   f. Less well-established indications
   g. Marrow-toxic chemotherapy/radiation
   h. Solid organ and hematologic malignancies
   i. Outside Facility Protocols that require participants to have irradiated blood components, when notified by the physician.

H. <u>WASHED BLOOD COMPONENTS:</u>

1. Washing blood components removes the suspending plasma or the cryo-protectant from frozen cellular products. These products should be given when exposure to donor plasma can be dangerous to the recipient.
2. Patients with the following conditions and some others on a case-by-case evaluation should receive washed blood components.
   a. History of anaphylactic reaction to blood components
   b. IGA deficiency with documented IGA antibodies.
   c. Severe allergic reactions not made tolerable by pre-medication.
   d. Recurrent febrile reactions not prevented by leukocyte reduction and premedication.
   e. Comment: Plasma volume reduction without washing can sometimes be effective in cases 3 and 4.

I. <u>FROZEN RED CELLS (DEGLYCEROLIZED):</u>

1. Rare blood types
2. Antibodies to high incidence antigens
3. Multiple and complex antibody patterns

J. <u>CROSS MATCHED AND/OR HLA MATCHED PLATELETS:</u>

1. Patients demonstrating documented immune refractoriness to platelet transfusion may require crossmatched or HLA-matched platelets to ensure increased numbers and functionality of transfused platelets (same criteria as above B).
   a. Platelet Crossmatch compatibility is first line to find out if antibody (HLA or platelet antibodies) are causing refractoriness.
   b. If there is a documented refractoriness due to a. then determination of the type of antibody interfering is done.
   c. Depending on the outcome of b. Platelets will be obtained from supplier to best meet conditions within the given donor population.
   d. Sometimes a biologic increment is seen with random donors. In these cases, the donors may be recalled to provide platelets for the identified patient.
2. Criteria for refractoriness

a. Poor 1-hour-post-transfusion increase in platelet count (less than 50K increase) or poor calculated platelet increment on at least two occasions in the absence of:
   i. Sepsis
   ii. DIC
   iii. ITP
   iv. TTP
   v. Splenomegaly
   vi. Active bleeding
   vii. Other conditions of accelerated platelet destruction

K. CYTOMEGALOVIRUS (CMV) RISK REDUCTION:

1. Methods:
   a. Leukoreduction: RBC and platelets provided by TCHD are leukoreduced. These products are considered to be CMV negative equivalent per current standards of practice.
   b. CMV seronegative blood donors

2. Consider CMV – reduced Risk units in the following situations:
   a. CMV seronegative recipients of allogeneic progenitor cell transplants
   b. CMV-seronegative pregnant women
   c. All routine neonatal transfusions including exchange transfusion
      i. All neonatal RBC and platelets are CMV seronegative
   d. Congenital immunodeficiencies
   e. CMV-seronegative patients with HIV infection
   f. CMV-seronegative recipient of a solid organ transplant from a seronegative donor
   g. CMV-seronegative patients undergoing chemotherapy that results in severe neutropenia

L. REFERENCE(S):

1. Standards for Blood Banks and Transfusion Services, Current Ed., 31st – 2018. AABB Bethesda, MD 20814-3304
2. Technical Manual, Current Ed., 19th – 2017. AABB Bethesda, MD 20814-3304
3. Practice Guidelines for Perioperative Blood Management. the American Society of Anesthesiologists, Inc. Wolters Kluwer Health, Inc. All Rights Reserved. Anesthesiology 2015; 122:241–00

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE:	**11/03**	**SUBJECT:**	**Standards for Endovascular Therapy for Cerebrovascular Disorders**
REVISION DATE~~(S)~~:	**09/07, 06/14, 09/19**	**POLICY NUMBER:**	**8710 – 530**

Medical Staff Department Approval:	**~~02/19~~03/22**
Department of Radiology Approval:	**~~04/19~~12/22**
Credentials Committee Approval:	**~~06/19~~01/23**
Medical Executive Committee Approval:	**~~08/19~~02/23**
Administration Approval:	**~~09/19~~03/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**09/19**

A. **PURPOSE**
   1. To provide standards for the performance of endovascular therapy (catheter based) for cerebrovascular disorders (including coil occlusion of intracranial aneurysms, treatment of cerebral arteriovenous malformation or cerebral fistula, and cerebral/carotid angiography), including required facilities/resources as well as credentialing criteria.

B. **FACILITIES/RESOURCES:**
   1. All cases involving endovascular treatment of intracranial vascular disorders must meet the following minimum criteria for adequate facilities:
      a. Digital subtraction angiography with roadmap capabilities.
      b. An appropriate sized image intensifier (12-16 inches)
      c. Power injector for contrast administration
      d. Adequate frame rate filming (4 fps minimum)
      e. Appropriate supply of balloons, guidewires, stents, coils and pharmacologic agents.
      f. Appropriate level of sterility
      g. Adequate space and facilities for anesthesia
      h. Interventional Radiology and/or Surgical Registered Nurses
      i. Interventional Radiology technologists

C. **CREDENTIALING CRITERIA**
   1. Initial Credentialing:
      a. Successful completion of an ACGME-accredited four (4) year residency in diagnostic radiology which includes training and supervision in diagnostic neuroimaging, and successful completion of one (1) year post graduate fellowship in neuroradiology, and one (1) year fellowship in endovascular surgical neuroradiology that meets ACGME standards by including training and experience in cerebral angiography performance and interpretation of 100 cerebral angiograms and performance of 100 endovascular cerebral procedures; or
      b. Successful completion of an ACGME-accredited residency in neurosurgery which includes five (5) years of training, experience and supervision in diagnostic neuroimaging, and one (1) year fellowship in endovascular surgical neuroradiology that meets ACGME standards by including training and experience in cerebral angiography performance and interpretation of 100 cerebral angiograms and performance of 100 endovascular cerebral procedures; or

c. Successful completion of an ACGME accredited residency in diagnostic radiology and successful completion of one year ACGME accredited fellowship in neuroradiology; or successful completion of an ACGME-accredited residency in neurosurgery; and documentation of participation in 50 endovascular surgical neuroradiology procedure under the supervision of a program director or equivalent; and documentation of performance of 80 intracranial endovascular surgical neuroradiologic procedures as primary operator.

d. If the above (a, b, or c) were completed more than two (2) years prior to application, additional documentation of the performance of 30 diagnostic angiographies and 30 endovascular cerebral procedures in the two (2) years preceding application is required.

2. Proctoring requirements: Two (2) cases proctored by physician who has current unsupervised TCMC privileges for Endovascular Therapy for Cerebrovascular Disorders
3. Re-credentialing requirements: Thirty (30) diagnostic cerebral angiographies and thirty (30) endovascular cerebral procedures in the two-year period with acceptable outcomes.
4. Note: Emergency Regional Stroke Thrombolysis and Intravascular infusion for treatment of vasospasm, Carotid Angioplasty and Stenting are included under credentials granted under Credentialing Standards for Catheter-Based Peripheral Vascular Interventional Procedures (TCMC Medical Staff Policy Number 8710-504).

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

1. Medical Staff Policy: Credentialing Standards for Catheter-Based Peripheral Vascular Interventional Procedures 8710-504

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: 08/96

SUBJECT: Co-treatment of Patients

REVISION DATE~~(S)~~: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 03/16, 06/19

Outpatient Behavioral Health Services Department Approval:	~~02/18~~03/22
Division of Psychiatry Approval:	~~03/19~~01/23
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~05/19~~02/23
Administration Approval:	~~06/19~~03/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	06/19

A. **PURPOSE:**

1. To provide guidelines on provision of physician Co-Treatment of patients by attending psychiatrists.

B. **POLICY:**

1. Co-treatment by attending psychiatrists will be facilitated if a patient has a primary psychiatrist in the community who will continue to manage medications while patient is attending the program. The Program physician will oversee treatment of the patient in Behavioral Health Outpatient program and will collaborate with the community physician with regard to medications, and post Program follow up. Co-treatment will be directed and certified as medically necessary by the attending program psychiatrist.

C. **PROCEDURE:**

1. Who May Perform/Responsible: Psychiatrists
    a. Patients will be admitted and followed by an attending Program psychiatrist. The Program psychiatrist will complete the admission order, and psychiatric evaluation. Monthly progress notes will be completed by the psychiatrist and/or Allied Health Professional (AHP) and will indicate medical necessity and patient's progress toward treatment goals.
    b. The Program psychiatrist and AHP will be encouraged to communicate regularly with the community psychiatrist to update him/her on the patient's progress and any medication issues.
    c. The Program psychiatrist will direct all treatment planning. The co-treating physicians are informed regarding any patient concerns and treatment progress.

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: **08/96**

SUBJECT: **Psychiatric Evaluation for Higher Level of Care**

REVISION DATE~~(S)~~: **05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 09/17, 05/20**

Department Approval:	**~~03/19~~11/21**
Division of Psychiatry Approval:	**~~03/20~~01/23**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/20~~02/23**
Administration Approval:	**~~05/20~~03/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/20**

A. **PURPOSE:**
  1. To define appropriate methods for admitting a patient to an inpatient psychiatric unit.

B. **POLICY:**
  1. When a patient is in need of inpatient treatment, the program staff and attending physician will arrange the admission.

C. **PROCEDURE:**
  1. Who may perform/responsible: Clinical and Nursing Staff
    a. The treatment team, to include the Clinical Coordinator, Operations Manager and Registered Nurse (RN) whenever possible, meets to triage the patient and determine the need for inpatient admission **or crisis stabilization unit (CSU) referral.**~~.~~
    b. The clinical staff contacts the attending psychiatrist to inform him/her of the current situation and the staff's assessment of the patient and recommendations for ~~admission~~**evaluation or inpatient treatment**.
    c. If the attending psychiatrist concurs that ~~admission~~ **a higher level of care** is necessary, the clinical staff contacts the psychiatric liaison to conduct handoff communication.
    d. If the patient refuses hospitalization **or** psychiatric evaluation in the Emergency Department (ED) **or CSU**, the attending program psychiatrist makes a determination as to whether the Sheriff/PERT should be contacted to evaluate for involuntary hold.
    e. The staff will be responsible for arranging for transport of the patient and obtaining consents from the patient/conservator, as needed. Depending on level of risk, a patient may be transported by Tri-City Medical Center van or accompanied by Staff on the van if they are voluntarily agreeing to be evaluated for hospitalization. Patients who are high risk, danger to self or others should be transported via ambulance or the Sheriff. The staff will contact the local Sheriff/PERT to assist with involuntary hold 5150 evaluation. OPBHS Staff may not place patients on involuntary hold and must utilize local law enforcement for involuntary detention evaluation.
    f. Staff will use the Situation, Background, Assessment, Recommendation (SBAR) process to conduct hand off communication with the intake coordinator, psychiatric liaison, shift Supervisor, MD, police department, or ambulance.
    g. The program staff will notify the patient's family or significant others of the transfer, in accordance with the patient's wishes. If appropriate, the patient's insurance reviewer is contacted and informed regarding the inpatient admission.

h. Patient information/records will be sent at the time of transfer. These records will include diagnosis, pertinent financial/administrative information, current medical findings, current medications and a brief summary of ~~the course of treatment~~**the reason for the referral**. Program nurse and clinical staff will ensure accuracy of medication reconciliation and hand off communication.

ISSUE DATE: 12/02 **SUBJECT:** Audiology Services

~~ISSUE DATE: 12/02~~
REVISION DATE~~(S)~~: 01/06, 01/09, 05/12, 03/16

Rehabilitation Department Approval:	~~05/18~~08/22
Department of Medicine Chiefs Approval:	~~10/19~~01/23
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~10/19~~02/23
Administration Approval:	~~11/19~~03/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/19

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

B. **REQUESTS FOR SERVICE:**
a. All requests for audiology services must be in the form of a written prescription from a licensed physician or non-physician practitioner.
b. Verbal requests for audiology services will be accepted, but must be followed by a written.
c. The speech pathology department will notify the licensed and contracted audiologist.

C. **HOURS OF SERVICE:**
1. The audiologist will respond to order within 72 hours and will set up a time to complete the evaluation.

D. **RESPONSIBILITIES:**
1. Provides audiology evaluations and treatment as prescribed by a licensed physician or non-physician practitioner.
2. Administers a pure tone audiometric assessment using standardized testing equipment and techniques to evaluate patient's hearing status.
3. Develops recommendation for each individual based upon the individual's medical condition, assessment and personal goals.
   a. Makes recommendations regarding assistive hearing devices as needed.
   b. Refer patients for further assessment or to other services and agencies as needed.
4. Documents patient treatment and treatment outcomes in patient's legal record.
5. ASHA Preferred Practice Patterns for the Profession of Audiology. Maintains ongoing reporting and consultative role with appropriate health care professionals regarding patient's current status.
6. Identifies safety hazards and equipment in disrepair, removes hazard or equipment and inputs work order.

7. Demonstrates fiscally responsible decision making including the prudent use of therapy equipment and supplies, and conservation of time and resources in a manner that maintains desired income and expense ratios.
8. Maintains appropriate operational and administrative records, may include but not limited to licensure, certifications, timecards, training records, and billing sheets as per department guidelines.

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

1. American Speech-Language-Hearing Association. (2004). *Scope of practice in audiology*. Available from www.asha.org/policy.
2. Centers for Medicare & Medicaid Services. (2015, May). *Therapy Services.* Retrieved from www.cms.gov: www.cms.gov/Outpatient_Rehabilitation_Fact_Sheet.ICN905365.pdf
3. Centers for Medicare & Medicaid Services. (2015, May). *Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6698.pdf.* Retrieved from www.cms.gov

Tri-City Medical Center
Oceanside, California

REHABILITATION ~~SERVICES~~

ISSUE DATE:	07/88	SUBJECT:	Speech Pathology Services Department Policy

~~ISSUE DATE: 07/88~~
REVISION DATE~~(S)~~: 01/91, 01/94, 03/97, 01/00, 01/03, 01/06, 01/09, 05/12, 03/16, 12/19

Rehabilitation Department Approval:	06/18
Department of Medicine Chiefs Approval:	~~10/19~~01/23
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~10/19~~02/23
Administration Approval:	~~11/19~~03/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/19

A. **DEFINITION(S):**
1. Speech: The production, intelligibility and fluency of verbalization, to include articulation of phonemes, rate of speech, prosody, phrasing and motor planning, and sequencing of speech.
   a. Disorders of speech may include:
      i. Dysarthria: Distorted articulation and/or prosody, secondary but not limited to cerebrovascular accident, brain injury, Parkinson's disease, amyotrophic lateral sclerosis, myasthenia gravis, multiple sclerosis, cerebral palsy, or oral cancer.
      ii. Apraxia of Speech: Inability to plan and sequence motor movements efficiently for speech production, secondary but not limited to cerebrovascular accident or brain injury.
      iii. Developmental Phonological or Articulation Delay or Disorder: Misarticulations, phonological processes or deficits in phonological awareness.
      iv. Dysfluency: Repetitions of sounds or words, inappropriate cessation of speech or secondary characteristics involving facial or body movements, or abnormally fast or irregular speech rate
2. Language: The arbitrary set of symbols which has meaning and which is used for interpersonal communication. Receptive language skills involve the comprehension of spoken, visual, or written language. Expressive language skills involve the formulation of verbal, gestural, augmentative or written language to communicate thoughts and needs.
   a. Disorders of Language may include:
      i. Receptive Aphasia: Impaired comprehension of verbal or written language.
      ii. Expressive Aphasia: Impaired expression of verbal or written language.
      iii. Alexia: Impaired comprehension of written language.
      iv. Agraphia: Impaired expression of written language.
      v. Developmental Language Delay: Impairment in development of language function.
      vi. Pragmatics: Interpretation and use of nonverbal language including facial expression, body language, gestures, appropriateness of actions based on setting, company and prosody
3. Voice: Phonation through respiratory support and approximation of the vocal cords, in the parameters of quality, pitch, loudness and resonance.
   a. Disorders of Voice may include impairments in the following areas:

i. Volume: Vocal loudness insufficient or excessive for the speaker's size, age, or gender.
ii. Pitch: Vocal pitch inappropriate for the speaker's size, age, or gender
iii. Quality: Altered vocal quality, including hoarseness, breathiness, harshness, or aphonia.
iv. Resonance: Imbalanced nasal resonance

4. Cognition: The skills of orientation, attention, memory and executive function.
   a. Disorders of Cognition may include:
      i. Disorientation: Inability to identify personal, temporal, spatial, and general information
      ii. Decreased attention: Inability to attend to stimuli appropriately.
      iii. Memory impairment: Decreased short-term, long-term immediate and working memory for information presented in verbal, visual, written or tactile modalities.
      iv. Executive function impairment: Decreased insight, awareness of deficits, problem-solving, safety awareness, reasoning, thought organization, insight and/or initiation, management off attention.
5. Swallowing: The functional oropharyngeal process involved in swallowing various consistencies of food, liquids, and own oral secretions.
   a. Disorders of swallowing many include:
      i. Oral or pharyngeal dysphagia: Impairment in oral or pharyngeal swallow function.
      ii. Oral feeding disorder: Inability to tolerate various consistencies of foods and/or liquids secondary to but not limited to oral weakness, dyscoordination, aversion or tactile defensiveness.

B. **POLICY:**
1. Speech-Language Pathology services will be available to inpatients, acute rehabilitation patients, and outpatients at Tri-City Medical Center.

C. **PROCEDURE:**
1. Speech Pathology service personnel are accountable per rehabilitation services leadership structure and/or the Medical Director of each program and/or the referring physician for maintaining a competent level of practice. The Department is also accountable through the appropriate administrative executive to the administrator for carrying out the policies and procedures as approved by the Governing Board.
   a. Administer appropriate assessment.
   b. Provide a written plan/report for each individual including history, results, recommendations, plan, treatment and education with designated goals based upon the individual's medical status, evaluation and test results, considering personal goals, when appropriate Provide Speech Therapy evaluation and treatment as prescribed by a licensed physician.
   c. Provide Speech Therapy treatment as the licensed therapist deems appropriate with a plan of care signed off on by a licensed physician, nurse practitioner, or physician's assistant.
   d. Implement initial and ongoing treatment program utilizing specific activities or methods to develop or restore functional communication, cognition, or swallowing, compensate for dysfunction or minimize debilitation.
   e. Modify treatment program or diet consistency recommendation based upon progress, lack of progress or regression, or as requested by the patient's physician.
   f. Provide documentation of patient's progress in medical chart on a daily, weekly and/or monthly basis.
   g. Provide patient's physician with a written summary of the patient's progress and recommended discharge plan.
   h. Maintain all therapy equipment in safe and functional condition.
   i. Secure and conserve therapeutic equipment and supplies.

j. Maintain and implement the departmental budget in a manner that maintains designated income and expense ratios.
k. Maintain appropriate operational and administrative records.
l. Maintain ongoing reporting and consultative roles with appropriate health care professionals regarding patient's current communicative and swallowing status.
m. Provide educational in-services regarding speech pathology evaluation and treatment approaches, the nature of communication and swallowing disorders, diagnostic and therapeutic approaches to the deficits, and measures to prevent or alleviate communication and swallowing disorders.

D. **REFERENCE(S):**

1. https://www.asha.org/policy/SP2016-00343
2. Business & Professions Code – BPC Division 2. Healing Arts [500 - 4999.129], (Division 2 enacted by Stats. 1937, Ch. 399.hapter 5.3. Speech-Language Pathologists and Audiologists [2530 - 2539.14], (Heading of Chapter 5.3 amended by Stats. 1992, Ch. 427, Sec. 2.)

Tri-City Medical Center
Oceanside, California

REHABILITATION ~~CENTER~~

ISSUE DATE: 12/19 **SUBJECT:** Ethical Code of Conduct

REVISION DATE~~(S)~~: 12/19

Rehabilitation Department Approval:	~~05/18~~08/22
Department of Medicine Chiefs Approval:	~~10/19~~01/23
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~10/19~~02/23
Administration Approval:	~~11/19~~03/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/19

A. **POLICY:**
1. The Tri-City Rehabilitation Center will adhere to the Tri-City Healthcare District **(TCHD)** Code of Conduct.
2. Code of Conduct defines ethical practices in patient management that may include altruism, respect and dignity, freedom from abuse/harassment, setting boundaries and restrictions on patient/professional relationships, compassionate care, legal and professional obligations. All clinical staff providing care to rehabilitation patients shall follow the conduct rules and regulations and code of ethics set forth by their professional organization and/or licensing body.

B. **RELATED DOCUMENT(S):**
1. Tri-City Healthcare District Code of Conduct

C. **REFERENCES(S):**

1. American Academy of Physical Medicine and Rehabilitation American Nurses Association
2. American Occupational Therapy Association Code of Ethics American Physical Therapy Association Code of Ethics American Psychological Association
3. American Speech and Hearing Association
4. American Therapeutic Recreation Association Code of Ethics National Association of Social Workers
5. National Therapeutic Recreational Society

Tri-City Medical Center
Oceanside, California

REHABILITATION ~~CENTER~~

ISSUE DATE: 12/19	SUBJECT: Interdisciplinary Plan of Care

~~ISSUE DATE: 12/19~~
REVISION DATE~~(S)~~: 12/19

Rehabilitation Department Approval :	~~05/18~~08/22
Department of Medicine Chiefs Approval:	~~10/19~~01/23
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~10/19~~02/23
Administration Approval:	~~11/19~~03/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/19

A. **POLICY:**

1. Every patient at the Rehabilitation Center receives a comprehensive individualized treatment program designed to meet the patient's unique needs. Programs are developed jointly by the patient, the family and team of rehabilitation specialists under the direction of the Medical Director (MD), or designee. There shall be evidence of participation from each appropriate rehabilitation discipline in the establishment of an interdisciplinary treatment plan.

B. **PROCEDURE:**

1. The physician will conduct a post-admission evaluation which identifies any relevant changes that may have occurred since the preadmission screening, as well as a review of the patient's prior and current medical and functional conditions and comorbidities in the documented history and physical examination. The post-admission physician evaluation will be completed within the first 24 hours of admission.
2. Nursing will complete their initial nursing assessment and initial goal setting within the first 24 hours of admission.
3. Patients are assessed and treatment initiated within 36 hours of admission by the therapy services (OT, PT, and SLP) that have been ordered by the attending physician.
4. The Interdisciplinary plan of care is established within 96 hours of admission with input from the interdisciplinary team. The interdisciplinary plan of care coordinated by the physician includes:
    a. Rehab problem/diagnoses
    b. Date of onset of injury or illness
    c. Specific type, number and frequency of services to be rendered by each discipline.
    d. Address current health status and recommendations for additional resources/consultations necessary to achieve predicted outcomes
    e. Treatment goals that are realistic, achievable and relevant to the patient
    f. Measures to assess effects of treatment
    g. Factors to facilitate and potential barriers for goal achievement
    h. Individual's (patient's) expressed goals
    i. Prognosis
    j. Estimated length of stay
    k. Discharge planning including expected disposition
    l. Signature of physician

Tri-City Medical Center
Oceanside, California

REHABILITATION ~~CENTER~~

ISSUE DATE: 12/19 **SUBJECT: Interdisciplinary Team Conference**

REVISION DATE~~(S)~~: 12/19

Rehabilitation Department Approval:	~~05/18~~08/22
Department of Medicine Chiefs Approval:	~~10/19~~01/23
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~10/19~~02/23
Administration Approval:	~~11/19~~03/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/19

A. **POLICY:**

1. Team conferences are held at least biweekly, ~~on Tuesdays and Thursdays at 1:00pm,~~ or as otherwise arranged by the Care Coordinator.
2. The conference schedule will be posted on the interdisciplinary schedule.
3. The patients and their family/support system shall be made aware of the interdisciplinary team conference dates.
4. The meeting consists of a brief report from each discipline on the patient's progress, goals, and expected outcomes of rehabilitation stay. Team members reporting include, but are not limited to:
   a. Registered Nurse (RN)
   b. Physical Therapist (PT)
   c. Occupational Therapist (OT)
   d. Speech Language Pathologist (SLP)
   e. Therapeutic Recreation (TR)
   f. Dietician
   g. Social Worker
   h. Medical Director (MD)
   i. Care Coordinator
5. Summary of Team members' reports are documented directly into the Electronic Health Record (EHR) by physician in attendance at the conference.
6. Estimated length of stay, discharge plan, needed equipment, and resources are reviewed and modified as needed per the patient's progress. Home evaluation and family/caregiver training if required are reviewed. Discharge date is reviewed and modified as needed.
7. Social Worker will report to patient/family after the team conference an overall summary of the conference, including functional report, estimated length of stay, and needed equipment.

ISSUE DATE:	**12/19**	**SUBJECT: Mission Statement, Goals and Objectives**
REVISION DATE~~(S)~~:	**12/19**	

Rehabilitation Department Approval:	**~~05/18~~08/22**
Department of Medicine Chiefs Approval:	**~~10/19~~01/23**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~10/19~~02/23**
Administration Approval:	**~~11/19~~03/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/19**

A. **POLICY:**

1. Tri-City Rehabilitation Center is an Inpatient Rehabilitation Facility that is dedicated to provide comprehensive, individualized and high quality healthcare to advance the health and wellness of the community we serve.
2. The Inpatient Rehabilitation Facility (IRF) is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care.
3. Goals and Objectives:
    a. To render high quality rehabilitation services to assist each patient in reaching their maximum functional potential so they may assume their rightful place in society, while learning to live within the limits of their capabilities.
    b. To enable a patient's safe return to the home or community-based environment upon discharge, the patient's treatment goals and achievements during an IRF admission are expected to reflect significant and timely progress toward this end result.
    c. To alleviate pain, restore function, and improve quality of life by using evidence based techniques and approaches in physical, occupational, speech, audiology and therapeutic recreation. These include standardized tests, measurements, procedures, modalities, treatment programs, and wellness education. Caregivers and family members are integrated into the treatment programs whenever possible. Therapeutic equipment is provided as appropriate.

Tri-City Medical Center
Oceanside, California

REHABILITATION ~~CENTER~~

ISSUE DATE: **12/19** **SUBJECT: Patient/Family Conferences**

REVISION DATE~~(S)~~: 12/19

Rehabilitation Department Approval:	**~~05/18~~08/22**
Department of Medicine Chiefs Approval:	**~~10/19~~01/23**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~10/19~~02/23**
Administration Approval:	**~~11/19~~03/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/19**

A. <u>**POLICY:**</u>

1. Patient/family conferences are held as needed to discuss patient progress toward goals and opportunities to maximize patient outcomes.
2. The patients/families will be notified by the Care Coordinator of the date and time of their conference.
3. The conference schedule will be posted on the interdisciplinary schedule.
4. The meeting consists of a brief report from each discipline on the patient's progress, goals, and expected outcomes of rehabilitation stay. Team members reporting include, but are not limited to:
    a. Registered Nurse (RN)
    b. Physical Therapist (PT)
    c. Occupational Therapist (OT)
    d. Speech Language Pathologist (SLP)
    e. Therapeutic Recreation (TR)
    f. Dietician
    g. Social Worker
    h. Medical Director (MD)
    i. Care Coordinator
5. Team members' reports are documented on the weekly conference forms.
6. After team reports, the interdisciplinary team meets with the patient and family member to discuss the patient's case.
7. Each discipline will report to the patient and family the progress, goals and expected outcomes of the rehab stay. The team will respond to patient/family questions.
8. Estimated length of stay, discharge plan, needed equipment, and resources are reviewed and modified as needed per the patient's progress. Home evaluation and family/caregiver training if required are reviewed. Discharge date is reviewed and modified as needed.
9. The conferences forms will be placed or scanned into the patient's medical record

Tri-City Medical Center
Oceanside, California

REHABILITATION ~~CENTER~~

ISSUE DATE: 12/19 **SUBJECT: Policies and Procedures**

REVISION DATE~~(S)~~: 12/19

Rehabilitation Department Approval:	**~~05/18~~08/22**
Department of Medicine Chiefs Approval:	**~~10/19~~01/23**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~10/19~~02/23**
Administration Approval:	**~~11/19~~03/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/19**

A. **POLICY:**
1. The Tri-City Rehabilitation Center will develop and maintain policies and procedures specific to the Rehabilitation Center when the Hospital (Tri-City Medical Center) policies do not cover necessary regulatory, business, or practice needs.
2. A list of all new, revised, and reviewed Rehabilitation Center Policies and Procedures shall be submitted to Rehab Leadership Team for review and for approval by the Chief Operating Officer. Rehab Policies and Procedures will be submitted according to hospital policy. Interdisciplinary Rehabilitation policies and procedures will be maintained online and be available to staff.
3. Each Rehabilitation Department (Rehabilitation Services, Nursing, Social Services, Case Management, and Diet and Nutrition) shall maintain a departmental Policy and Procedure Manual, which is reviewed and updated in accordance with applicable regulations and Tri-City Medical Center (TCMC) Policy.

Tri-City Medical Center
Oceanside, California

REHABILITATION ~~CENTER~~

ISSUE DATE: 12/19	**SUBJECT: Pre-Admission Screening**
REVISION DATE~~(S)~~: 12/19	

Rehabilitation Department Approval:	**~~05/18~~08/22**
Department of Medicine Chiefs Approval:	**~~10/19~~01/23**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~10/19~~02/23**
Administration Approval:	**~~11/19~~03/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/19**

A. **POLICY:**

1. A pre-admission assessment shall be completed for referrals to the Rehabilitation Center. Patients will be evaluated at the optimal assessment period and an admitting decision will be made based on the established admission criteria. Patients who do not meet the established admission criteria for level of care and program will be denied admission or deferred for further evaluation and reassessment. All rehab admissions must be medically accepted by the Medical Director, or designee.

B. **PROCEDURE:**

1. The rehabilitation referral is received and placed into the patient's Electronic Medical Record.
2. The Care Coordinator and Medical Director, or designees, will jointly review the referral via chart review and/or in person with the patient and/or family.
3. The patient is accepted by the Medical Director, or designee, and financial clearance is obtained.
4. The Rehab Pre-Admission screen is completed and the Medical Director, or designee covering admissions, reviews the packet.
5. The referring facility is notified of acceptance and transportation is arranged by the sending facility.
6. If the patient is not accepted, the referring facility is notified with an explanation of denial reasons.
7. The referring facility is given the nurse's station phone number so report and handoff can be received.
8. A documented preadmission assessment contains:
    a. Diagnosis
    b. Medical history
    c. Complications
    d. Comorbidities
    e. Ongoing medical management
    f. Mental status
    g. Premorbid and current level of function
    h. Support systems
    i. Prognosis
    j. Scope of services recommended
    k. Intensity of services recommended
    l. Related to the scope and intensity of services recommended:
        i. The willingness of the patient to participate
        ii. The ability of the patient to tolerate the care proposed
        iii. Medical necessity for the level of care
        iv. The potential of the patient to benefit

m. Estimated length of stay
n. Additional needs may include:
    i. Cultural
    ii. Dietary
    iii. Equipment
    iv. Medications
    v. Services
o. Funding
p. Alternative resources to address additional needs such as hiring caregivers, home modifications, or equipment procurement

Tri-City Medical Center
Oceanside, California

REHABILITATION ~~CENTER~~

ISSUE DATE: 02/20

REVISION DATE~~(S)~~: 02/20

SUBJECT: Provision of Services Not Provided by Tri-City Rehabilitation Center

Rehabilitation Department Approval:	~~05/18~~08/22
Department of Medicine Chiefs Approval:	~~10/19~~01/23
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~01/20~~02/23
Administration Approval:	~~02/20~~03/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/20

A. **POLICY:**

1. Services required that are not provided by Tri-City Rehabilitation Center will be provided through either contracted services or referral to an outside service. Contract services are provided for Physical/Occupational Therapy and Nursing through registry services. Referrals to outside services will be made by a physician and coordinated through ancillary services for the following: Orthotics and Prosthetics, Vocational Rehabilitation, Psychology/Neuropsychology, Dentistry, and Podiatry.
2. Contract Services:
   a. Registry/Traveling Service: To appropriately provide adequate staffing levels, the use of registration and/or traveling contracts may be required. Current contract are maintained and the Registries may be used in the event outside staffing is required to adequately provide quality patient care. As with all contract services, quality of patient care is subject to review.
3. Referral Services:
   a. Orthotics and Prosthetics Services: Primary services are provided by HANGER. Orthotics and prosthetics representatives consult with Tri-City Rehabilitation Center frequently and actively participate in the department's gait evaluations when needed. Current patients may be fitted prior to their discharge from therapy to monitor fit, proper function, and adequate education of orthosis and prostheses throughout their therapy. The Orthotist/Prosthetist is responsible for documenting any patient interactions and issuing equipment. Referrals to this service may be initiated by Physical or Occupational Therapy; however, a physician's referral is mandatory.
   b. Psychological/Neuropsychological Services: Referrals for Psychological/Neuropsychological services are made by a physician
   c. Vocational Rehabilitation Services: Referrals for Vocational Rehabilitation services are made by a physician. These services are available to our patients through the Department of Rehabilitation in San Diego.
   d. Dentistry Services: Referrals for Dentistry services are made by a physician
   e. Podiatry Services: Referrals for Podiatry services are made by a physician

Tri-City Medical Center
Oceanside, California

REHABILITATION ~~CENTER~~

ISSUE DATE: 02/20 **SUBJECT: Scope of Services**

REVISION DATE~~(S)~~: 02/20

Rehabilitation Department Approval:	~~05/18~~08/22
Department of Medicine Chiefs Approval:	~~10/19~~01/23
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~01/20~~02/23
Administration Approval:	~~02/20~~03/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/20

A. **POLICY:**

1. Population served: The **Acute** Rehabilitation Center (**ARU**~~Rehab Center~~) serves the members of the Tri-City Healthcare District and surrounding areas.
2. Settings: The Tri-City **Acute** Rehabilitation Center is a Diagnostic Related Group (DRG) exempt unit located in the south wing, main level of the Tri-City Medical Center.
3. Days and hours of services: 7 days per week, 24 hours per day
4. Frequency of services: Services are provided in accordance with CMS guidelines and based on an individualized plan of care.
5. Payer sources: The **Acute** Rehab**ilitation** Center accepts patients of all insurance types, including but not limited to Medicare, Medi-Cal, HMOs, PPOs, and uninsured individuals
6. Referral sources: The Rehab Center reviews, interviews, and accepts patient based on the referral or recommendation of an attending physician.
7. The purpose of the unit is to develop, implement, and evaluate, a plan of interdisciplinary care to provide restorative and maintenance programs to enable the ill or injured person to regain his/her optimal functional level of independence in order to safely and successfully discharge to the community.
8. It is the intent of the center that each patient is treated with dignity and respect. Optimal health care services are being delivered to each person regardless of size, disability, race, creed, or ethnic origin.
9. The individualized plan of care includes the patient, family/significant others, and the interdisciplinary Rehabilitation team. The strategic plan evaluates the effectiveness of the interdisciplinary care in the Rehabilitation Center.
10. The Rehabilitation Team consists of:
    a. Medical Director – provides the overall medical direction for patient care and serves as chairperson of the team conferences
    b. Nurse - develop, implement and evaluate a plan of nursing care for adult (18 years and older), acute care patients who are acutely ill or injured and are in varying stages of recuperation from diagnostic, therapeutic, or surgical intervention.
    c. Physical Therapist – the role of Physical Therapy are to relieve pain, minimize disability, prevent deformities, develop, improve and restore functioning. Physical Therapy Services shall include, but are not limited to, evaluation/assessment, development of treatment plans and goals, instruction, education and consultation services
    d. Occupational Therapist – the role of Occupational Therapy is to provide assessment, therapy and education for patients who demonstrate deficits in skills required for daily living activities. Services include evaluation and treatment for impairments of physical, psychosocial, cognitive, developmental and sensory-integrative functioning. The goal of

treatment is to improve or restore function, prevent or minimize dysfunction, and compensate for or cope with disabling conditions.

e. Speech Language Pathologist - Speech-Language Pathology Services include assessment, therapy and education for patients who demonstrate communication or oral-pharyngeal function disorders. These include, but are not limited to, impairments of articulation, language comprehension and expression, cognition, fluency, voice, reading, writing and swallowing. Education and counseling for families of patients exhibiting the aforementioned disorders are also provided.

f. Recreational Therapist - Therapeutic Recreation Services provide goal-oriented programs that promote wellness and improve the patient's quality of life through leisure. Therapeutic Recreation treatment may be individual or done in groups. Services include, but are not limited to, leisure assessment and evaluation, skill development, social programs, special events, leisure education, leisure counseling and resource development. Family education and counseling are included to improve patient's attitude, skill level and socialization.

g. Social Worker/Discharge Planner – is responsible for developing the discharge plan, ensuring appropriate caregiver intervention, and continued home care and/or outpatient services. Also, to provide psychosocial support to both patient and family in order to assist with discharge planning.

h. Dietician – involves in-depth individualized nutrition assessment; determination of the nutrition diagnosis; determination and application of the nutrition intervention personalized for the individual or group; and periodic monitoring, evaluation, reassessment and intervention tailored to manage or prevent the disease, injury, or condition.

i. Care Coordinator/Admissions Liaison – is responsible for evaluating all patients including medical review, rehabilitation potential, and preliminary review of future placement resources. Additional responsibilities include: team conference coordination, PPS Coordination including data collection and submission to CMS, Utilization Review, and marketing. Also, assists with general coordination of patient care to maximize rehabilitation potential and successful discharge

Tri-City Medical Center
Oceanside, California

STAFFING MANUAL

ISSUE DATE:	**04/03**	**SUBJECT:**	**Monitoring Registry Files**
REVISION DATE:	**04/04, 01/05, 12/05, 04/07, 12/13**		
REVIEW DATE:	**06/03, 04/10, 12/13, 08/15**		

Department Approval:	**09/22**
Administration Approval:	**03/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/15**

A. **POLICY:**

1. A file in **the Electronic System** will be maintained for all Agencies and their staff in the Staffing Resource Center.
2. Each file in **the Electronic System** will contain:
    a. All Required documentation such as, License/Certification, Credentials, Testing, Immunizations, Orientation Checklist, etc.
    b. Signed **System Access Request** Form and Pyxis)
    c. Performance evaluations from the Nursing Departments
3. Manual files will contain:
    a. Current Contract with Tri-City Healthcare District (TCHD)
    b. Current Rate Addendum with TCHD
    c. Copy of Current Agency Insurance coverage (General, Professional, and Workman's Compensation)
    d. Copy of Annual Audit and Summary Letter
    e. Any Miscellaneous Letters or Correspondence with the Agency.
    f. One year of current information must be maintained on record in the Staffing Resource Center at all times.
    g. Purged files will be maintained on record for 6 years in a data storage facility of choice.
    h. A list of files in storage, their contents, and box # will be maintained on file in the Staffing Resource Center.

Tri-City Medical Center
Oceanside, California

Staffing Manual

ISSUE DATE: 12/13 **SUBJECT: Registry Badge Process**

REVISION DATE(S): 08/15, 07/16

Department Approval Date(s): 08/15 09/22
Administration Approval: 03/23
Professional Affairs Committee Approval Date(s): 08/15 n/a
Board of Directors Approval Date(s): 07/16

A. **PURPOSE:**
1. It is the policy of Tri-City Healthcare District (TCHD) that all Supplemental Staff are required to wear the TCHD issued identification badge ("badge") at all times while present at any TCHD facilities.

B. **POLICY:**
1. Badges must be maintained in good condition. The placement of pins and unauthorized stickers on the badge is prohibited.
2. In no instance should a TCHD issued badge be loaned to someone else or be out of the possession or control of the person the badge was issued to.
3. Violation of this policy may result in discipline in accordance with applicable TCHD Hospitals Human Resource policies.
4. Badges are the property of TCHD and must be returned to the Staffing Resource Office at the end of each shift or upon request.
5. Security has the right to confiscate badges classified as lost, expired or in possession of an individual other than the person to whom the badge is issued.

C. **BADGE DISPLAY:**
1. Badge holders **Supplemental staff** must wear the ID badge at all times while on property owned or under the control of the institution.
2. The badge must be worn on the upper chest and be clearly visible to someone facing the wearer. The badge must be worn horizontally so that patients, guests and fellow employees can easily read it.
3. Badges are non-transferable and are to be used only by the person to whom it is issued.

D. **PROCEDURE:**
1. Registry Staff
   a. Staff will report directly to the staffing office to sign in and obtain a facility badge.
   b. Registry staff shall wear their TCHD issued badge along with their Registry issued badge with a personal photo displayed.
   c. Registry RN's will use the TCHD badge with scanning capability for the care of patients.
   d. Upon completion of the shift, registry staff shall return to the Staffing Resource Office to sign-out in Shiftwise and return the TCHD issued badge.
   e. Staffing Office shall maintain a log of TCHD issued badges and document the checking-out and checking-in of issued badges.
   f. Should Registry Staff not return the TCHD issued badge, the terms of the registry contract shall be enforced **and the registry agency notified.** Registry staffs are responsible for complying with the TCHD badge process.
   f.

2. Traveler Staff
    a. Upon completion of compliance requirements as stated in the contractual agreement with the Travel agency, travelers will obtain a TCHD issued badge from the Employee Health Department.
    b. Traveler will return the badge to the Staffing Office **Administrative Supervisor or unit ~~n~~Nursing ~~l~~Leadership** ~~or Manager or Director~~ of the Department the traveler is assigned to at the end of the assignment or upon request.

E. **RELATED DICUMENT(S):**
1. Badge Log Form

Tri-City Medical Center
Oceanside, California

Staffing Manual

ISSUE DATE:	**04/03**	**SUBJECT:**	**Registry Contracts, Rate Addendums, Orientation Packets and Audits**
REVISION DATE:	**04/04, 01/05, 12/05, 04/07**		
REVIEW DATE:	**06/03, 01/05, 04/10, 12/13, 08/15**		

Department Approval ~~Date(s)~~:	**~~07/15~~09/22**
Administration Approval:	**03/23**
Professional Affairs Committee Approval ~~Date(s)~~:	**~~08/15~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**08/15**

A. **POLICY:**
1. Registry Contracts:
   a. All r~~R~~egistry **companies**~~ies~~ **for temporary staff** will sign a Tri-City Healthcare District (TCHD) Standardized Contract & Rate Addendum Sheet.
   b. All registry companies will sign a TCHD HIPAA Business Agreement.
   c. The contract, rate addendum, and business agreement will be updated previous to expiration date.
   d. These forms will be maintained on record in the Staffing Resource Center.
   e. All registry **companies**~~ies~~ will maintain a current TCHD Orientation Manual.
   f. All r~~R~~egistry **companies**~~ies~~ will have their employees complete the required training, documentation, and receive the generalized Hospital Orientation Packet for Non-TCMC e~~E~~mployees **prior to the start of their first shift.** ~~s.~~
2. Shiftwise Contracts
   a. All registry **companies** ~~ies~~ will obtain and maintain a current contract with Shiftwise our current vendor management system **or temporary staffing.**~~.~~
   b. All Registries will upload and maintain required documents specified in the contract in Shiftwise.
3. Registry Audits:
   a. Annually the **Director of** Patient Throughput and the Resource Network, ~~Staffing ,Staffing~~**Education,** and the Telemetry Administrative Secretary ~~Project Co~~will complete an Audit of each Registry.
   b. This is to ensure compliance with Joint Commission, California Department of Public Health and Occupational Safety and Health Administration.
   c. Any deficiency will be noted and forwarded to the Registry for correction.
      i. A letter acknowledging corrections and if possible, copies of these corrections are to be sent to Staffing within a specified time frame.
   d. All audit information will be maintained on file in the Staffing Resource Center for one year.
   e. Previous years audit information will be ~~backfiled~~ **saved** or 6 years.

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

February 23, 2023 – 2:00 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 2:00 p.m. on February 23, 2023.

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 M. Younger

Also present were:

Steve Dietlin, CEO
Ray Rivas, CFO
Candice Parras, CNE
Dr. Gene Ma, CMO
Jeremy Raimo, Senior Director, Business Development
Susan Bond, General Counsel
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant
Rick Crooks, Security Protection Agent

1. The Board Chairperson, Director Chavez, called the meeting to order at 2:00 p.m. with attendance as listed above.

2. Approval of Agenda

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

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

   Chairperson Chavez made an oral announcement of the items listed on the February 23, 2023 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Reports Involving Trade Secrets, one matter of Potential Litigation and Public Employee Appointment: CEO.

4. Motion to go into Closed Session

   It was moved by Director Coulter and seconded by Director Younger to go into Closed Session at 2:05 p.m. The motion passed unanimously (7-0).

5. At 3:25 p.m. the Board returned to Open Session with attendance as listed above.

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

The Board in Closed Session discussed a possible new program and took no action.

The Board discussed a potential litigation matter pursuant to Government Code 54956.9 (d) (4) and directed the Chairman to take appropriate action.

The Board voted unanimously to direct the Chair to take appropriate action to hire Gene Ma, M.D. as interim CEO.

7a) Consideration to approve agreements with Sunil Jeswani, M.D., a professional corporation for Emergency Department call and Medical Directorship for Neurosurgery coverage for a term of 36 months, beginning March 13, 2023 and ending March 12, 2026.

It was moved by Director Gleason to approve agreements with Sunil Jeswani, M.D., a professional corporation for Emergency Department call and Medical Directorship for Neurosurgery coverage for a term of 36 months, beginning March 13, 2023 and ending March 12, 2026. Director Younger seconded the motion

The vote on the motion was as follows:

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

7. Adjournment

Chairperson Chavez adjourned the meeting at 3:25 p.m.

Rocky J. Chavez
Chairperson

ATTEST:

Gigi Gleason
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
February 23, 2023 – 3:30 o'clock p.m.

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held via teleconference at 3:30 p.m. on February 23, 2023.

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 M. Younger

Also present were:

Steven Dietlin, Chief Executive Officer
Candice Parras, Chief, Patient Care Services
Ray Rivas, Chief Financial Officer
Dr. Gene Ma, Chief Medical Officer
Aaron Byzak, Chief External Affairs officer
Roger Cortez, Chief Compliance Officer
Jeffrey Scott, Board Counsel
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant

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

2. Approval of Agenda

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

3. Pledge of Allegiance

   Director Chavez led the Pledge of Allegiance.

4. Public Comments – Announcement

   Chairperson Chavez read the Public Comments section listed on the February 23, 2023 Regular Board of Directors Meeting Agenda. He asked that members of the public wishing to speak submit a speaker card at this time.

5. Reports – Information Only

   a) Foundation Report – Jennifer Paroly, Foundation President

      The Foundation Report was tabled to the March meeting.

6. December, 2022 Financial Statements – Ray Rivas, Chief Financial Officer

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

   - Net Operating Revenue – $192,824
   - Operating Expense – $209,734
   - EBITDA – (2,822)
   - EROE – ($11,165)

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

   - Average Daily Census – 117
   - Adjusted Patient Days – 50,385
   - Surgery Cases – 3,157
   - ED Visits – 32,574

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

   - Net Operating Revenue – $29,115
   - Operating Expense – $30,395
   - EBITDA – $605
   - EROE – ($532)

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

   - Average Daily Census – 121
   - Adjusted Patient Days – 7,132
   - Surgery Cases - 448
   - ED Visits – 4,077

   Mr. Rivas presented two graphs which reflected trending of the Average Length of Stay (ALOS) and Average Daily Census (ADC).

7. New Business - None

8. Old Business - None

9. Chief of Staff –

   a) Consideration of February 2023 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Practitioners as recommended by the Medical Executive Committee on February 21, 2023.

      In Dr. Showah's absence, Dr. Gene Ma, Chief Medical Officer presented the February 2023 Credentialing Actions and Reappointments Involving the Medical

Staff and Allied Health Practitioners. No concerns or “red flags” were raised by the Credentials Committee.

It was moved by Director Coulter to approve the February 2023 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Practitioners as recommended by the Medical Executive Committee on February 21. 2023, 2023. Director Younger seconded the motion.

The vote on the motion was as follows:

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

10. Consideration of Consent Calendar

It was moved by Director Gleason to approve the Consent Calendar. Director Coulter seconded the motion.

The vote on the motion was as follows:

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

11. Discussion of items pulled from Consent Calendar - None

12. Comments by Members of the Public – None

13. Comments by Executive Leadership and Chief Executive Officer

Candace Parras, CNE reported on February 23, 2023 we onboarded 23 new grads and they are doing amazing. She stated it is the one way we will solve the staffing crisis by “growing our own”. A luncheon will be held for the new grads on March 8th and board members are welcome to attend.

Dr. Ma, Chief Medical Officer stated he would like to use his time to reflect on the last 10 years. Today is Mr. Dietlin’s last board meeting, and since Mr. Dietlin’s arrival, the organization has been led by a man with great integrity and honor. He has given everything and sacrificed for the organization, always putting the organization first. Dr. Ma commented on Mr. Dietlin’s many accomplishments both as the CFO and CEO and relationships he has helped build. Dr. Ma stated It has been the distinct honor and privilege to serve under Mr. Dietlin as his Chief Medical Officer.

Mr. Ray Rivas, Chief Financial Officer Ray also reflected on the last 10 years with Mr. Dietlin as CEO. Mr. Rivas stated in record time Mr. Dietlin was able to get the district a substantial line of credit and we were able to secure an $85 million-dollar loan with

HUD. Mr. Rivas stated Mr. Dietlin will be greatly missed and wished him the best of luck.

15. Board Communications

Director Mizell stated as a new Board member, Mr. Dietlin has been very welcoming. It has been a good experience getting to know him.

Director Coulter stated he has been here at Tri-City since 1983 and has not seen a better CEO than Mr. Dietlin. He will be greatly missed. Director Coulter wished Mr. Dietlin the best of luck in the future.

Director Chaya commented on Mr. Dietlin's integrity and the fact that he has always done the right thing for the organization. She extended her best wishes for Mr. Dietlin.

Director Sanchez expressed her appreciation for Mr. Dietlin's hard work to turn this hospital around and move us forward. She commented on the many important decisions for this hospital in the coming months and hopes to move forward in the same direction that Mr. Dietlin has guided us.

Director Gleason echoed comments made by others. She stated she is so grateful for Mr. Dietlin's leadership and expressed her appreciation for all he has done.

Director Younger stated for eight years she worked at Tri-City and reported to Mr. Dietlin who was a great mentor and a great boss. She has witnessed so much that Mr. Dietlin has done for the hospital over his 10 years and there will be big shoes to fill!

Mr. Dietlin stated it has been an honor and privilege to serve this community and district along with this incredible team. He stated the hospital is a complex organization and there are so many committed people here to bring our mission to fruition. Mr. Dietlin also extended a gracious thank you to the public board. It has always been a collaboration with the Board and the Medical Staff working together. In closing, he stated he is proud of what the Tri-City team has done in unison for this community. He expressed his appreciation to everyone for working together.

16. Report from Chairperson

Chairperson Chavez stated Mr. Dietlin is a competent, strong and silent leader and it has been a pleasure working with him.

17. Adjournment

There being no further business, Chairperson Chavez adjourned the meeting at 3:57 p.m.

____
Rocky J. Chavez, Chairperson

ATTEST:

____
Gigi Gleason, Secretary

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

March 13, 2023 – 3:00 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 3:00 p.m. on March 13, 2023.

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

Absent was Director Tracy M. Younger

Also present were:

Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant
Rick Crooks, Security Protection Agent

1. The Board Chairperson, Director Chavez, called the meeting to order at 3:00 p.m. with attendance as listed above.

2. Approval of Agenda

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

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

   Chairperson Chavez made an oral announcement of the items listed on the March 13, 2023 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Public Employee Appointment: CEO and one matter of Potential Litigation.

4. Motion to go into Closed Session

   It was moved by Director Gleason and seconded by Director Coulter to go into Closed Session at 3:05 p.m. The motion passed (6-0-0-1) with Director Younger absent.

5. At 5:00 p.m. the Board returned to Open Session with attendance as listed above.

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

   The Board discussed a potential litigation matter pursuant to Government Code 54956.9 (d) (4) and directed the Chairman and counsel to take appropriate action.

7. Adjournment

   Chairperson Chavez adjourned the meeting at 5:00 p.m.

____
Rocky J. Chavez
Chairperson

ATTEST:

____
Gigi Gleason
Secretary

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending February 28, 2023

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	LeaseTerm Beginning	Ending	Services & Location	Cost Center
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	$3.59	(a)	51,751.31	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)	36,054.14	07/01/17	07/31/24	**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
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)	15,597.31	09/01/21	10/31/31	**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)	12,872.86	07/01/21	06/30/26	**Outpatient Behavioral Health** 510 West Vista Way Vista, Ca 92083	7320
Nextmed III Owner LLC 6125 Paseo Del Norte, Suite 210 Carlsbad, CA 92011 V#83774	Approx 4,553	$4.00	(a)	23,297.92	09/01/21	08/31/33	**PCP Clinic Calrsbad** 6185 Paseo Del Norte, Suite 100 Carlsbad, CA 92011	7090
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 #V81250	Approx 7,000	$4.12	(a)	30,907.00	10/01/12	02/28/23	**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)	14,447.11	06/01/21	05/31/26	**OSNC Encinitas Medical Center** 351 Santa Fe Drive, Suite 351 Encinitas, CA 92023	7095
SoCAL Heart Property LLC 1958 Via Centre Drive Vista, Ca 92081 **V#84195**	Approx 4,995	$2.50	(a)	17,473.44	07/01/17	06/30/27	**OSNC - Vista** 1958 Via Centre Drive Vista, Ca 92081	7095
TCMC, A Joint Venture 3231 Waring Court, Suit D Oceanside, CA 92056 V#83685	Approx 1,444	$2.59	(a)	3,754.00	02/01/20	02/28/23	**Pulmonary Specialists of NC** 3231 Waring Court Suit D Oceanside, CA 92056	7088
Total				**233,522.26**				

(a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending February 2023

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6171 LIFE SUPP		13123EDU	291.00	84228	MURPHY EMILY
8740 ACLS		20223 EDU	185.00	84213	PEREZ CANDELARIA
8740 CRCST		20923EDU	125.00	84226	RAMON JESUS A
8740 CRCST		20923EDU	125.00	84227	WILLETT TIERRA
8740 ACLS		12623 EDU	195.00	71802	WARD, CARMEN
8740 RN-BSN		20923 EDU	2,500.00	82702	ORENCIA, RIZALINA

**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.