REVISED

TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
September 28, 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 – a) Foundation Report – Jennifer Paroly, Foundation President	10 min.	Foundation President
6	August 2023 Financial Statement Results	10 min.	CFO
7	New Business – a) Consideration to accept the Fiscal Year 2023 Financial Statement Audit – CFO/Moss Adams	15 min.	CFO/Moss Adams
8	Old Business – None	--	--
9	Chief of Staff - a) Consideration of September 2023 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on September 25, 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
10.	Consent Calendar **(1) Board Committee** **(A) Finance, Operations & Planning Committee** **Director Younger, Committee Chair** (1) Approval of the renewal of the agreement with Richard Liu, M.D., as part of the existing ED On-Call Coverage Panel for ENT/Otolaryngology services for a term of 12 months, beginning August 1, 2023 and ending July 31, 2024, resulting in no increase in cost for the shared total term amount. (2) Approval of the renewal of the agreement with Cary Mells, M.D., as the Chair of the Physician Well-Being Committee, at a cost of $3,000 a month for the term of 24 months, beginning August 1, 2023, and ending July 31, 2025, at an annual cost of $36,000 and a total term cost of $72,000. (3) Approval of an agreement to establish the Medical Directorship for Structural Heart Disease in Cardiology with services provided by Aaron Yung, M.D., for a term of 24 months, beginning October 1, 2023 and ending September 30, 2025, with an annual cost not to exceed $16,200 and a total term cost not to exceed $32,400. (4) Approval of the renewal of the comprehensive neurology services agreement with the Neurology Center for a term of 24 months beginning October 1, 2023 and ending September 30, 2025, at a total 24-month term cost, not to exceed $1,204,374. (5) Approval of an agreement with Emad G. Tadros, M.D. for the provision of Inpatient and Emergency Department psychiatric evaluations for patients without a payer source for a term of 12 months, beginning October 1, 2023, and ending September 30, 2024, at an annual and total term cost not to exceed $59,727. (6) Approval of an agreement with Nicholas Kusnezov, M.D. as part of the existing ED On-Call Coverage Panel for Orthopedic Services for a term of 15 months, beginning August 1, 2023 and ending, October 31, 2024, resulting in no increase in cost for the shared total term amount of $874,100. (7) Approval of an agreement with Megan E. Nova, M.D. as part of the existing ED On-Call Coverage Panel for Gastroenterology – General & ERCP services, for a term of 12 months, beginning September 1, 2023 and ending August 31 2024, resulting in no increase in cost for the shared total term amount. **(2) Administrative Committees – Policy & Procedures** **a. Engineering** 1) Emergency Eyewash, Shower and Flushing Stations 5025 2) Engineering Disaster Response Plan **b. Environment of Care Manual** 1) Hazardous Material and Waste Management and Communication Plan 6000 2) Medical Equipment Management Plan 3) Security Management Plan **c. Outpatient Behavioral Health**	10 min.	

	Agenda Item	Time Allotted	Requestor
	1) Fire Safety **d. Security** 1) Lost and Found Procedures for Security Department 230 2) Patient Valuables Collection and Return 237 3) Security Incident Notification 208 4) Use of Force 209 **e. Wound Hyperbaric Oxygen Therapy** 1) Bomb Threat 2) Earthquake **(3)** Minutes a) August 31, 2023 – Special Meeting b) August 31, 2023 – Regular Meeting **(4)** Meetings and Conferences – None **(5)** Dues and Memberships – None **(6)** Reports – (Discussion by exception only) a) Dashboard b) Lease Report – (August, 2023) c) Reimbursement Disclosure Report – (August, 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	1.5 hours	
17	Adjournment		

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
September 13, 2023

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 9/29/2023 – 7/31/2025)

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 9/29/2023 through 7/31/2025:

- **BOYDSTUN, Natasha DO/Emergency Medicine (TeamHealth)**
- **JOHNSON, William MD/Radiology (Blue Ocean Imaging)**
- **OANA, Julia MD/Internal Medicine - Telemedicine (Sound Physicians)**
- **PARKS, Monica MD/Cardiology (Blue coast Cardiology)**
- **SAVANI, Aman MD/Neurology (The Neurology Center)**
- **WARD, Daniel MD/Pathology (North Coast Pathology)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 1 of 1
September 13, 2023

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 10/01/2023 –09/30/2025)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 10/01/2023 through 09/30/2025, 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:

- **AMORY, David, MD/Orthopedic Surgery/Active**
- **BESSUDO, Alberto, MD/Oncology/Active**
- **CALHOUN, Chanelle, MD/Pediatrics/Active**
- **FARNSWORTH, William, MD/Neurology/Provisional**
- **GUERIN, Chris, MD/Endocrinology/Active Affiliate**
- **KABRA, Ashish, MD/Cardiology/Active**
- **KADAKIA, Hemal, MD/Telemedicine/Provisional**
- **KERN, Hannah, MD/Infectious Diseases/Provisional**
- **KIRBY, Hannah, MD/Orthopedic Surgery/Provisional**
- **RIZVI, Nadia, MD/Internal Medicine/Provisional**
- **SADOFF, Mark, MD/Neurology/Active**
- **SIDDIQUI, Fareeha, MD/Oncology/Active**
- **VADAKARA, Tom, MD/Telepsychiatry/Provisional**
- **YUNG, Siyi, MD/Pediatrics/Provisional**

RESIGNATIONS: (Effective date 09/30/2023 unless otherwise noted)

Automatic:

Voluntary: Physicians

- **ALUNNI, Marisa, MD/Obstetrics & Gynecology**
- **BARRON, Jr., Robert, MD/Family Medicine**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 1 of 1
September 13, 2023

Attachment B

- COLL, Jonathan, MD/Teleradiology
- DEES, Richard, DO/Orthopedic Surgery
- GAO, Sean, DO/Orthopedic Surgery
- GILBERT, Stewart, MD/Teleradiology
- LAUFIK, Martin, MD/Diagnostic Radiology
- LUO, Ran, MD/General Surgery
- MALHIS, Safouh, MD/Pulmonary Medicine
- MERCER, Lynn, MD/Pediatrics
- MYATT, Toby, MD/Emergency Medicine
- PALMA, Joseph, DO/Anesthesiology
- RUIZ, Lizette, MD/Emergency Medicine
- SWEET, Thomas, MD/Oncology
- TINGLE, Matthew, MD/Orthopedic Surgery

Voluntary: Allied Health Professionals

- BIERMAN, Andrew, NP/Allied Health Professional
- LEE, Jisoo, PA/Allied Health Professional
- ROSS, Jessica, NP/Allied Health Professional

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
September 13, 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 **September 29, 2023**

- **SERRY, Rod, MD** — **Cardiology**

REQUEST RELINQUISHMENT OF PRIVILEGES

This Provider is voluntarily relinquishing the following privileges: effective as of **September 29, 2023**

- **MAZAREI, Rahele, DO** — **OB/GYN**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
September 13, 2023

PROCTORING RECOMMENDATIONS

- **AMORY, David, MD** — **Orthopedics**
- **LAUW, Marietya, MD** — **Pathology**
- **OVERMAN, Allison, MD** — **Anesthesiology**
- **RAJA, Wasim, MD** — **Tele-Medicine**
- **RIZVI, Nadia, MD** — **Internal Medicine**
- **TOUMA, Elie, DPM** — **Podiatry**

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
September 20, 2023

Members Present	Director Tracy Younger, Dr. Mohammad Jamshidi-Nezhad, Director Marvin Mizell
Non-Voting Members Present:	Dr. Gene Ma, CEO; Ray Rivas, CFO; Donald Dawkins, CNE; Roger Cortez, CCO; Jeremy Raimo, COO, Mark Albright, CIO
Others:	Eva England, Jane Dunmeyer, Miava Sullivan, Barbara Hainsworth
Members Absent:	Director Dr. Nina Chaya, Director Adela Sanchez, Dr. Henry Showah, Susan Bond

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to Order	Director Younger called the meeting to order at p.m.		Chair
2. Approval of Agenda		**MOTION** **It was moved by Director Mizell, and Dr. Jamshidi-Nezhad seconded, and it was unanimously approved to accept the agenda of September 20, 2023.** **Members:** **AYES: Younger, Mizell, Jamshidi-Nezhad** **NOES: None** **ABSTAIN: None** **ABSENT: Director Adela Sanchez, Director Dr. Nina Chaya, Dr. Henry Showah**	Chair
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Younger read the paragraph regarding comments from members of the public.	No comments	Chair
4. Ratification of minutes of August 23, 2023		Minutes were ratified. **MOTION** **It was moved by Director Mizell, and Dr. Jamshidi-Nezhad seconded, and the minutes of**	

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		August 23, 2023 were unanimously approved, with Director Younger abstaining from the vote.	
5. Old Business	None		
6. New Business			
a. Discuss Addition of Physician(s) to Approved Panel & ED On-Call Agreements, Which Would Be Co-Terminus for Such Agreements	Discussion ensued regarding possible language change prior to approval.	**MOTION** **It was moved by Director Mizell, and Dr. Jamshidi-Nezhad seconded, and it was unanimously approved to accept.** **Members:** **AYES: Younger, Mizell, Jamshidi-Nezhad** **NOES: None** **ABSTAIN: None** **ABSENT: Director Adela Sanchez, Director Dr. Nina Chaya, Dr. Henry Showah**	Dr. Gene Ma
7. Consideration of Consent Calendar:		**MOTION** **It was moved by Director Mizell, and Dr. Jamshidi-Nezhad seconded, and it was unanimously approved to accept the Consent Calendar for September 20, 2023.** **Members:** **AYES: Younger, Mizell, Jamshidi-Nezhad** **NOES: None** **ABSTAIN: None** **ABSENT: Director Adela Sanchez, Director Dr. Nina Chaya, Dr. Henry Showah**	Chair
a. Physician Agreement for ED On-Call Coverage - ENT/Otolaryngology • Richard Liu, M.D.		**Approved via Consent Calendar**	Bert Lawson

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
b. Physician Agreement for Physician Well-Being Committee Chair • Cary Mells, M.D.		**Approved via Consent Calendar**	Jeremy Raimo
c. Physician Agreement for Cardiology Structural Heart Disease Medical Director • Aaron Yung, M.D.		**Approved via Consent Calendar**	Eva England
d. Physician Agreement for Comprehensive Neurology Services • The Neurology Center		**Approved via Consent Calendar**	Dr. Gene Ma
e. Psychiatric Consultative Service Agreement • Emad G. Tadros, M.D.		**Approved via Consent Calendar**	Dr. Gene Ma
f. Physician Agreement for ED On-Call Coverage – Orthopedics • Nicholas Kusnezov, M.D.		**Approved via Consent Calendar**	Bert Lawson
g. Physician Agreement for ED On-Call Coverage – Gastroenterology • Megan E. Novo, M.D.		**Approved via Consent Calendar**	Bert Lawson
8. Financials:	Ray Rivas presented the financials ending August 31, 2023 (dollars in thousands) **TCHD – Financial Summary** **Fiscal Year to Date** Operating Revenue $ 50,743 Operating Expense $ 59,630 EBITDA $ (5,150) EROE $ (7,431) **TCMC – Key Indicators** **Fiscal Year to Date** Avg. Daily Census 118 Adjusted Patient Days 14,064		Ray Rivas

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	Surgery Cases 844 ED Visits 7,983 **Graphs:** • TCMC-Average Daily Census, Total Hospital - Excluding Newborns • TCMC-Emergency Department Visits		
a. Dashboard	No discussion		Ray Rivas
10. Comments by committee Members	None		Chair
11. Date of next meeting	Wednesday, October 18, 2023		Chair
13. Adjournment	Meeting adjourned 3:23 p.m.		Chair

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 20, 2023
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – ENT / Otolaryngology

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

Physician's Name: Richard Liu, M.D.

Area of Service: Emergency Department On-Call: ENT / Otolaryngology

Term of Agreement: 12 months, Beginning, August 1, 2023 - Ending, July 31, 2024

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Add physician to current shared call panel; no increase in expense

Rate/Day	Term	Annual Cost
$650	FY2024	$237,900
	Total Term Cost	**$237,900**

Description of Services/Supplies:

- Provide 24/7 patient coverage for all ENT - Otolaryngology 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: Bert Lawson-Director, Emergency Services / Donald Dawkins, Chief Nurse Executive

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the renewal of the agreement with Dr. Richard Liu as part of the existing ED On-Call Coverage Panel for ENT/Otolaryngology services for a term of 12 months, beginning August 1, 2023 and ending, July 31, 2024, resulting in no increase in cost for the shared total term amount of $237,900.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 20, 2023
PHYSICIAN AGREEMENT FOR PHYSICIAN WELL-BEING COMMITTEE CHAIR

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

Physician's Name: Cary Mells, M.D.

Area of Service: Medical Staff Leadership: Physician Well-Being Committee Chair

Term of Agreement: 24 months, Beginning August 1, 2023 – Ending July 31, 2025

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

Rate/Month	Annual Term Cost	24 Month (Term) Cost
$3,000	$36,000	**$72,000**

Position Responsibilities:

- Perform the duties of Chair of the Physician Well-Being Committee as set forth in the Tri-City Healthcare District Medical Staff Bylaws
- Be available as a resource to the Medical Staff and Hospital with respect to well-being issues
- Liaise with hospital Administration and Medical Staff on issues relating to physician well-being 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: Dr. Gene Ma, Chief Executive Officer

Motion:
I move that Finance Operations and Planning Committee recommend that the TCHD Board of Directors authorize the renewal of the agreement with Dr. Cary Mells as the Chair of the Physician Well-Being Committee at a cost of $3,000 a month for a term of 24 months, beginning August 1, 2023 and ending July 31, 2025, at an annual cost of $36,000 and a total term cost of $72,000.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 20, 2023
PHYSICIAN AGREEMENT for CARDIOLOGY STRUCTURAL HEART DISEASE MEDICAL DIRECTOR

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

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

Area of Service: Medical Director- Structural Heart in Cardiology

Term of Agreement: 24 months, Beginning, October 1, 2023 - Ending, September 30, 2025

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

Hourly Rate	Maximum Hrs. / Month	Maximum Cost / Month	Annual Cost (NTE)	Total Term Cost (NTE)
$225/hr.	6 hours	$1,350	$16,200	**$32,400**

Description of Services/Supplies:

- Medical Directorship agreement with responsibilities to establish a structural heart program, provide program oversight and stewardship aligned with the strategic initiatives adopted by the District Board of Directors for this key service line
- In collaboration with TCHD, the Medical Director of Cardiology Structural Heart will provide educational opportunities for both district employees and local medical groups
- The medical director will have shared responsibility for the quality of the program and service line growth

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

Person responsible for oversight of agreement: Eva England-Cardiovascular Service Line Administrator / Gene Ma, Chief Executive Officer

Motion:

I move that Finance Operations and Planning Committee recommend that the TCHD Board of Directors authorize the renewal of agreement to establish the Medical Directorship for Structural Heart Disease in Cardiology with services provided by Aaron Yung, M.D. for a term of 24 months, beginning October 1, 2023 and ending, September 30, 2025, with an annual cost not to exceed $16,200 and a total term cost not to exceed $32,400.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 20, 2023
PHYSICIAN AGREEMENT for COMPREHENSIVE NEUROLOGY SERVICES

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

Physician's Name: The Neurology Center

Area of Service: Emergency Department On-Call for Neurology, Medical Directorship and Clinical Coverage for ARU, Stroke care, Epilepsy monitoring, and General neurology.

Term of Agreement: 24 months, Beginning October 1, 2023– Ending September 30, 2025

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
3% COLA per year, service has not seen increase since start in 2019

Service	Rate Year	Hours per Month (NTE)	Hours per Year (NTE)	Monthly Cost (NTE)	Annual Cost (NTE)	24 Month Term Cost (NTE)
ED Neurology Call Coverage	Yr. 1: $803/24 hr. Yr. 2: $828/24 hr.	N/A	N/A	Yr. 1: $24,893 Yr. 2: $25,668	Yr. 1: $293,898 Yr. 2: $302,220	$596,118
Stroke Medical Director	Yr. 1: $206/hr. Yr. 2: $212/hr.	12	144	Yr. 1: $2,472 Yr. 2: $2,544	Yr. 1: $29,664 Yr. 2: $30,528	$60,192
Neurology Medical Director	Yr. 1: $206/hr. Yr. 2: $212/hr.	8	96	Yr. 1: $1,648 Yr. 2: $1,696	Yr. 1: $19,776 Yr. 2: $20,352	$40,128
Epilepsy Monitoring/Director	Yr. 1: $206/hr. Yr. 2: $212/hr.	4	48	Yr. 1: $824 Yr. 2: $848	Yr. 1: $9,888 Yr. 2: $10,176	$20,064
ARU Medical Director	Yr. 1: $170/hr. Yr. 2: $175/hr.	80	960	Yr. 1: $13,600 Yr. 2: $14,000	Yr. 1: $163,200 Yr. 2: $168,000	$331,200
APC Coverage	Yr. 1: $63/hr. Yr. 2: $65/hr.	102	1224	Yr. 1: $6,426 Yr. 2: $6,630	Yr. 1: $77,112 Yr. 2: $79,560	$156,672
			Cost Not to Exceed		**Yr. 1: $593,538 Yr. 2: $610,836**	**$1,204,374**

Position Responsibilities:

- The Neurology Center to provide comprehensive coverage and directorship services for all areas of service requiring clinical neurological care and oversight.

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

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

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

Motion:
I move that Finance Operations and Planning Committee recommend that the TCHD Board of Directors authorize the renewal of the comprehensive neurology services agreement with The Neurology Center for a term of 24 months beginning October 1, 2023 and ending September 20, 2025, at a total 24-month term cost not to exceed $1,204,374.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: September 20, 2023
PSYCHIATRIC CONSULTATIVE SERVICE AGREEMENT

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

Physician's Name: Emad G. Tadros, M.D.

Area of Service: Inpatient and ED Psychiatric Consultations

Term of Agreement: 12 months, Beginning October 1, 2023- Ending September 30, 2024

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

Service Code (CPT)	Rate	Annual Volume*	Annual Cost*
99223-New Inpatient Evaluation	$190.92	60	$11,455
99233-Follow Visit	$98.49	150	$14,773
99285-New ED Evaluation	$167.49	200	$33,498
		Total Term Cost*	**$59,727**

**Not to exceed cost estimated based on unfunded behavioral health visits in 2021*

Description of Services/Supplies:

- Provide Emergency Department and Inpatient Psychiatric consultations for patients without a payer source

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

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

Motion:

I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Emad G. Tadros, M.D., for the provision of Inpatient and Emergency Department psychiatric evaluations for patients without a payer source for a term of 12 months, beginning October 1, 2023 and ending September 30, 2024, at an annual and total term cost not to exceed $59,727.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 20, 2023
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Orthopedics

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

Physician's Name: Nicholas Kusnezov, M.D.

Area of Service: Emergency Department On-Call: Orthopedics

Term of Agreement: 15 months, Beginning, August 1, 2023 - Ending, October 31, 2024

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Shared Call Agreement with Entire ED call panel for Orthopedic Surgery

Service	Rate/Day	Panel Days During Term	Annual Cost
General	Mon-Fri: $1,750 Sat/Sun/Holidays: $1,800	293 days 134 days	$512,750 $241,200
Foot & Ankle	Mon-Fri: $250 Sat/Sun/Holidays: $350	293 days 134 days	$73,250 $46,900
		Total Term Cost	**$874,100**

Description of Services/Supplies:

- Provide 24/7 patient coverage for all Orthopedic 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: Bert Lawson-Director, Emergency Services / Donald Dawkins, Chief Nurse Executive

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the approval of the agreement with Nicholas Kusnezov, M.D. as part of the existing ED On-Call Coverage Panel for Orthopedic services for a term of 15 months, beginning August 1, 2023 and ending, October 31, 2024, resulting in no increase in cost for the shared total term amount of $874,100.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 20, 2023
PHYSICIAN AGREEMENT FOR ED ON-CALL COVERAGE – GASTROENTEROLOGY-GENERAL & ERCP

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

Vendor's Name: Megan E. Novo, M.D.

Area of Service: Emergency Department On-Call: Gastroenterology - General and ERCP

Term of Agreement: 12 months, Beginning, September 1, 2023 - Ending, August 31, 2024

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Shared Call Agreement with Entire ED call panel for Gastroenterology - General and ERCP

Rate/Day	Term	Annual Cost
GI- $1,000	FY 2024	$365,000
ERCP- $700	FY2024	$255,500
	Total Term Cost	**$621,500**

Description of Services/Supplies:

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

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

Person responsible for oversight of agreement: Bert Lawson, Director-Emergency Services / Donald Dawkins, Chief Nurse Executive

Motion:

I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the agreement to add Megan E. Novo, M.D., to the Emergency Department call coverage panel for Gastroenterology - General & ERCP services for a term of 12 months, beginning September 1, 2023 and ending, August 31, 2024, as part of the existing coverage panel, resulting in no increase in cost for the shared total term amount.

Tri-City Medical Center

ADMINISTRATION CONSENT AGENDA
September 18th, 2023

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
Engineering		
1. Emergency Eyewash, Shower and Flushing Stations 5025	Practice change	Forward to BOD for Approval
2. Engineering Disaster Response Plan	3 year review	Forward to BOD for Approval
Environment of Care Manual		
1. Hazardous Material and Waste Management and Communication Plan 6000	1 year review, practice change	Forward to BOD for Approval
2. Medical Equipment Management Plan	1 year review	Forward to BOD for Approval
3. Security Management Plan	1 year review, practice change	Forward to BOD for Approval
Outpatient Behavioral Health		
1. Fire Safety	3 year review, practice change	Forward to BOD for Approval
Security		
1. Lost and Found Procedures for Security Department 230	3 year review, practice change	Forward to BOD for Approval
2. Patient Valuables Collection and Return 237	3 year review	Forward to BOD for Approval
3. Security Incident Notification 208	3 year review, practice change	Forward to BOD for Approval
4. Use of Force 209	3 year review, practice change	Forward to BOD for Approval
Wound Hyperbaric Oxygen Therapy		
1. Bomb Threat	3 year review	Forward to BOD for Approval
2. Earthquake	3 year review	Forward to BOD for Approval

Tri-City Medical Center
Oceanside, California

ENGINEERING
EQUIPMENT

ISSUE DATE: 08/21

SUBJECT: Emergency Eyewash Shower and Flushing ~~Stations~~

REVISION DATE(~~S~~):

POLICY NUMBER: 5025

Engineering Content Expert Approval: ~~09/18~~03/23
Environmental Health & Safety Committee Approval: ~~03/20~~05/23
Administration Approval: ~~08/21~~09/23
Professional Affairs Committee Approval: n/a
Board of Directors Approval: 08/21

A. **PURPOSE:**
1. This Standard practice provides minimum requirements for performance, use and testing of equipment that is used for emergency drenching and/or flushing of the eyes and body

B. **POLICY:**
1. It is the policy of Tri-City Healthcare District (TCHD) that suitable emergency eyewash, shower and flushing equipment be provided in areas where there is reasonable potential for exposure to injurious corrosive **or caustic** materials **and or required**. All personnel who may need to use the emergency eyewash, shower or flushing equipment are to be trained on its location and use.

C. **GUIDELINES:**
1. Immediate and proper use of emergency drenching and flushing is essential to minimizing injury upon injurious corrosive **or caustic** chemical contact. The following guidelines should aid in minimizing injury due to contact with corrosive materials.
2. Use of Emergency Eyewash / Shower:
   - **a. Used approved plumbed eyewash station**
   - ~~a.~~**b.** Flush eyes and/or skin for at least 15 minutes.
   - ~~b. If using a portable eyewash station, follow manufacturer guidelines on bottle.~~
   - ~~a.~~**c.** Hold eyelids open with fingers so flushing fluid can fully irrigate the eyes. Nearby staff should be prepared to assist with holding the eyelids open and other staff may be needed to assist with keeping the person under the flushing fluid for 15 minutes.
   - ~~b.~~**d.** Immediately remove contaminated clothing. Do this while under a shower when gross contamination has occurred. Have someone assist with clothing removal when possible and use a blanket or other article as a shield to provide privacy to the person under the emergency shower.
3. The ~~Engineering Department is~~**Building engineers are** responsible for making sure that flushing, inspection, and repair of the emergency drenching and flushing equipment occurs. The minimum flushing and inspection requirements are as follows:
   - a. Plumbed eyewash and eye/face wash stations must be activated and flushed once per week. Flush for a duration of at least five minutes.
   - b. Inspect eyewash stations while flushing to make sure that water raises approximately equal heights and that fluid flow is sufficient to flush both eyes simultaneously while at a velocity low enough to be non-injurious to the user.

c. Each eyewash station must be reviewed weekly to make sure components are in place, inspect for leaks or pipe damage, proper placement of protective covers and the station is readily accessible with no obstacles.

d. Plumbed emergency showers and drench hose stations must be activated and flushed once per month.

e. **Building Engineers will complete weekly PM's to document inspection completion.** ~~Testers must sign their initials and date inspected on tags to inform users of the most recent inspection and the unit is safe and ready for use.~~

f. Failed inspections/testing will be corrected immediately when deficiencies are noted. **Submit a corrective work order.** If deficiencies cannot be immediately corrected, tag the unit "DO NOT USE" & notify department staff.

D. **REFERENCE(S):**

1. ANSI Standard Z358.1-1998
2. Barclay's California Code of Regulations. Title 8 p. 5152
3. OSHA Standard 29 CFR 1910.151

Tri-City Medical Center
Oceanside, California

ENGINEERING
EQUIPMENT

ISSUE DATE: 11/88 **SUBJECT:** Engineering Disaster Response Plan

REVIEW DATE~~(S)~~:
REVISION DATE~~(S)~~: 10/93, 03/97, 06/00, 05/09, 06/12, 12/19

Department Approval:	~~07/19~~03/23
Environmental Health & Safety Committee Approval):	~~09/19~~05/23
Administration Approval:	~~11/19~~09/23
Professional Affairs Committee Approval Date(s):	n/a
Board of Directors Approval Date(s):	12/19

A. **DISASTER ACTIVATION:**

1. The private branch exchange (PBX) Operator will announce "Code Orange" three times over the intercom system.
2. ON-DUTY HOURS 0730-1600 MONDAY THROUGH FRIDAY
   a. Staff will report to the Engineering Department and Director of Facilities or designee will determine what Engineering assistance if any is needed. The Director of Facilities or designee will communicate with Incident Command Center.
   b. If call-back protocol is activated, all personnel are subject to reporting for duty at the discretion of the Director of Facilities or designee in charge.
   c. The Director of Facilities or designee will be responsible for completion of departmental status reports and inventory to be delivered to the Incident Command Center via runner.
3. OFF-DUTY HOURS
   a. Call-back protocol will be activated and staff will be notified to report to duty. Personnel will work as needed to manage disaster. Personnel called to come in will report to the Engineering Department for instructions.

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE MANUAL
HAZARDOUS MATERIAL MANAGEMENT

ISSUE DATE:	**11/87**	**SUBJECT:**	**Hazardous Material and Waste Management and Communication Plan**
REVISION DATE:	**09/94, 07/97, 09/00, 04/03, 12/10, 05/15, 01/17, 03/19, 12/21**	**POLICY NUMBER: 6000**	

Department Approval:	**~~10/21~~03/23**
Environmental Health & Safety Committee Approval:	**~~11/21~~05/23**
Administration Approval:	**~~11/21~~09/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/21**

A. **PURPOSE**

1. The purpose of the management plan is to define how hazardous materials and waste are identified, labeled, handled, whose responsibility they are, how training and communication is managed, and how monitoring occurs.

B. **DEFINITIONS :**

1. Hazardous materials: materials by their nature are a potential threat to the health and safety of persons coming into contact with them. Examples of hazardous materials include but are not limited to the following:
   a. Corrosives - having a pH less than or equal to 2 or greater than or equal to 12.5 and liquids that corrode steel at a rate of greater than .25 inch per year.
   b. Toxics (EP Toxicity) - a waste whose constitutes have a tendency to leach or migrate when disposed of in an improperly designed landfill; able to cause illness, death or restrict awareness enough to present a danger.
   c. Flammable liquids (ignitable) - flammable gases, oxidizers, liquids with a flash point of less than 140F, and solids that ignite spontaneously through absorption of moisture or friction.
   d. Reactive (Explosives) - substances that are unstable and readily undergo violent change, react violently with water, form potentially explosive mixtures with water, capable of detonation when exposed to a strong initiating source, generate significant quantities of toxic gas when exposed to water or in the case of cyanide or sulfide bearing waste, pH conditions between 2 and 12.5.
   e. Pharmaceutical Waste and Expired Medications – Expired or unusable parenteral or oral liquids; dextrose/saline intravenous (IV) solutions containing; antibiotics, multivitamins, dopamine, dobutamine, electrolytes epinephrine, epi-cal, heparin, insulin, lidocaine, lorazepam, magnesium sulfate, meperidine, midazolam, morphine, nitroglycerin, norepinephrine, oxytocin, theophylline,; Maalox, Mylanta, alcohol containing liquids with less than 24% alcohol.
   f. Expired Unusable Pharmaceuticals: Intact expired or unused medications.

C. **POLICY**

1. Tri-City Healthcare District (TCHD) is committed to providing a safe and healthy environment for all employees, medical staff, patients and visitors by establishing ongoing mechanisms for controlling and monitoring the use of hazardous materials and waste in

compliance with State and Federal regulations.

2. Right to Know Law

   a. Instructional signs informing employees of their rights under the law are posted. Contractors are to be provided with information about the known and suspected health hazards that may result from working with Hazardous and Infectious Materialswhile performing duties at TCHD..
   b. General Orientation: New employees will be informed of "Right to Know Law" Employee Orientation.
      i. Employees have the right to refuse to work with a hazardous substance if they have not been provided with Safety Data Sheet information.
      ii. Employees, former employees, or applicants may not be terminated or discriminated against in any way for exercising any rights they are given under the law.
   c. . Department Specific Initial Orientation: Employees will receive training on any chemical which is known to be present in the workplace in such a manner that employees may be exposed under normal conditions of use or in a foreseeable emergency. If an employee is not ordinarily in a position to be exposed to hazardous chemicals, they need not be trained.
   d. Contracting for Outside Services:
      i. Departments that obtain outside services through contracts or service agreements will ensurecontractors are informed of all hazardous materials to which their employees may be exposed. The department will insure that the contracted employee has completed the Non-Tri-Healthcare District Employee Orientation Program.

D. **GUIDELINES**:

1. Method of Identification of Hazardous Material:
   a. Material is identified as hazardous by evaluation produced by manufacturer, information disseminated from a reliable source, or by professional knowledge and experience.
   b. Directors or hospital designated leader of Engineering, Surgery, Nutrition, Laboratory, Pharmacy, and Environmental Services, will submit a list of substances determined to be hazardous by this policy to the Safety Leader or designee
      i. The list will be updated as new products determined to be hazardous are introduced to the department.
   c. Labels are required on all hazardous substances to identify the hazardous material(s) contained therein and to provide warning about the type of hazard and the type of precautions required. This includes all containers with toxic substances in a concentration greater than or equal to 1% of the total composition, or 0.1% if carcinogens; unless specifically exempted.
2. Safety Data Sheets (SDS:
   a. Request an SDS using the internet or TCMC's intranet link when assistance is needed with medical emergencies, chemical spills, and employee.
      i. Emergency Request – Immediate to 15 minutes: Poisoning, chemical exposure, chemical spill, human or environmental contamination, fire.
      ii. Immediate to 30 minutes: Regulatory Agency Request e.g., Occupational Safety and Health Administration (OSHA), Environmental Protection Agency (EPA), The Joint Commission (TJC).
      iii. Immediate to 3 hours: Employee request (non-emergency)
      iv. Standard Request – Immediate to 24 hours: Customer Request, Contractor Request.
      v. Mail Request – Rush: mailed within 24 hours – Standard: mailed within 3

business days: Request of 10 or more Safety Data Sheets.

b. To request a SDS contact the Environmental Services Supervisor or Facilities Director.

c.

3. Employee Training:
   a. Department leaders are responsible for providing training to employees on hazardous materials in their work area at the time of their initial orientation and when a new hazard is introduced into their work area.
   b. All employees must complete the Annual Computer Based Learning (CBLs) modules which include a section on Hazardous Materials/Global Harmonization/Right-to-know training. The CBL course content includes but is not limited to ethe following:
      i. Employee rights under the law.
      ii. Explanation of the (SDS)
      iii. Explanation of the labeling system and pictograms
      iv. Explanation of methods used to identify hazards and how to detect the presence of toxic substances in the work place, and routes of entry into the body.
      v. Safety and control devices to include personal protection.
      vi. Location of hazardous substance list.
      vii. Emergency procedures for spill control.
      viii. Review of blood-borne diseases and potential for transmission.
      ix. Types of protective equipment and proper use.
      x. Situations requiring use of protective equipment.
      xi. Review of concept of standard precautions as it applies to the workforce members specific work practices.
      xii. Review of methods to determine and designate infectious waste and linen along with instructions for proper disposal.
      xiii. Training in proper handling of needles and sharps along with proper disposal
      xiv. Training in completion of Employee Health Injury Report to indicate exposure to potential infectious agents.
      xv. Department directors will ensure that all employees annually complete the CBLmodule on Hazardous Materials. .
4. Hazardous Chemical Waste & Infectious Medical Waste Disposal
   a. General Disposal Guidelines:
      i. Disposal methods must comply with all federal, state and local regulations. Flammable materials are not to be disposed of into the drainage system.
      ii. Wear appropriate protective equipment (i.e., gloves, safety glasses, lab coat and respirator where applicable).
      iii. Date must be filled in on the substance's hazardous material storage label upon final use or disposal. All Chemical Waste will be placed into the Chemical Waste Storage Shed for final disposal.
      iv. All empty discarded containers will be disposed of according to the manufacturer instructions and/or in accordance with Federal, State and local regulations.
      v. TCHD is contracted with an outside company for the disposal of hazardous materials and waste in accordance with local, State and Federal regulations.
      vi. Medical Infectious Waste will be placed into the RED Bio-Hazardous Container or Sharp Container and collected by the EVS Department and placed into the Bio-Hazardous Waste Storage shed until collected by the Waste Disposal Vendor final disposal (See Infection Control Manual).
      vii. Waste Pharmaceuticals – Refer to AP&P # 276 Handling of Pharmaceutical Waste, Expired Medications & Expired IV Solutions.
   b. Monitoring:
      i. Waste Gas Levels (Surgical Suites):
      ii. Waste gas levels in surgical areas are to be tested at least annually.

iii. Testing is to be conducted by an independent testing company contracted by TCHD-.
iv. Results of such testing are to be kept on file by the respective departments.
v. Results of the annual testing should be posted along with the maximum permitted levels of the gases tested for employee review.
vi. In the event levels exceed permitted levels, the Engineering Department and the Environment of Care/Safety Officer shall be notified in order that corrective measures can be taken.

c. Airflow Testing:
i. Airflow and air changing systems will be monitored and tested by the Engineering Department on an as needed basis. All new equipment is to be certified at the time of installation.
ii. Areas using or storing hazardous materials must have adequate ventilation in order to comply with room air change and flow standards as governed by the California Building Codes.
iii. Fume hoods should be utilized when using volatile or gaseous-forming hazardous materials to ensure gas levels remain at safe levels and do not affect air quality, fume hoods should remain running at all times.

d. Radiation
i. All monitoring of radiation levels will be conducted according to departmental policies per State regulations by the Radiation Safety Officer.

e. Formaldehyde Testing
i. Air monitoring for formaldehyde will be conducted annually. Methods will be in accordance with OSHA regulations and will be of two (2) types: 1) Personal and 2) Area.
ii. Engineering controls will be utilized to reduce airborne concentrations whenever feasible.
iii. Employees working with solutions of 1% or more formaldehyde will utilize protective equipment as follows:
1) Safety Glasses.
2) Gloves.
3) Disposable chemical resistant Lab coats.

f. Work Test Area:
i. Work areas suspected of containing airborne hazardous materials will be evaluated and tested immediately by Engineering Department and or the Safety Leaderdesignee
ii. Levels exceeding permitted safe limits will be reported to the Safety Officer/hospital appointed personnel.
iii. A consultation with Administration, Safety Officer/hospital appointed personneland the Director of the department involved will be made to determine whether or not work can continue in the affected area or to determine steps to be taken to ensure employee safety.

g. Employee Monitoring and Medical Testing:
i. Appropriate medical testing will be conducted to determine the effects of the exposure and in order that an effective diagnosis and proper treatment can be conducted.
ii. Testing will be done under the supervision of a licensed qualified physician.

h. Storage and Transportation:
i. A Flammable Storage Cabinet will be provided for flammable materials in order to prevent the spreading of fire.
ii. Flammable liquids will be stored away from flammable gases.
1) In the event of fire the possibility of explosion is reduced and containment is readily achieved.

iii. All openings will be controlled with approved self-closing fire doors.
iv. Every inside storeroom will have a mechanical exhaust system that provides at least six complete air changes per hour.
1) The Hazardous Material Storage Building has a switch that controls the ventilation system as well as the lights.
v. Cylinders will be stored at least 20 feet from flammable and combustible liquids and other ignitable.
vi. Cylinders will be stored separately (rooms) from flammable material
vii. Hazardous wastes/materials will not be stored with nonhazardous waste in order to prevent accidental contamination.
1) Incompatible materials will be stored away from each other.
2) No hazardous material will be transported to and stored in areas other than work or storage areas
viii. Materials will be transported in approved safety containers or in their original shipping packages.
ix. .
x. Materials will be transported in amounts comparable to regulated daily or weekly limits.
xi. Materials will not be transported and then stored in unapproved areas or in an unsafe manner.
xii. All materials packaged and shipped for outside disposal must comply with Department of Transportation (DOT) regulations.
xiii. Daily limits will be stored in approved safety cabinets.

i. Emergency Response Procedures:
i. Various hazardous chemicals are used throughout the hospital which could pose a threat of danger if a moderate or major spill should occur.
ii. The following procedure is outlined in the event that such a chemical spill occurs within the hospital environment. All personnel will be familiar with the proper procedure for handling these events to minimize the risk towards patients, visitors and staff members.
1) Areas of concern:
a) Laboratory - Large variety of chemicals.
b) Pharmacy - Large variety of chemicals.
c) Materials Management - Cleaning supplies and hospital chemical supplies.
d) Environmental Services - Cleaning supplies and solvents.
e) Radiology Radioactive material.
f) Food and Nutrition - Degreasers and cleaning supplies.
g) Respiratory –Disinfectants.
h) Facilities Management - Large variety of chemicals.
i) Sterile Processing Department – Disinfectants.
j) Surgical Services – Tissue Fixative.

j. Chemical Spills:
i. Immediately alert personnel in area.
ii. Dial "66" and inform Public Broadcast Exchange (PBX) Operator that there is a chemical spill and the location.
iii. The PBX Operator will alert: The Safety Leader/designeel Manager of Environmental Services (EVS) or Lead EVS, Security, and Engineering.
iv. Evacuate and seal off areas from a safe distance; if flammable are involved, eliminate ignition source if possible. Allow no one to enter area until Environmental Services, Security, and the Safety Leader/designee has been notified and arrives on scene.
v. Review the Safety Data Sheet (SDS) information on how to handle the spill and what type of Personal Protective Equipment is needed. 3 E Company will

fax the information within minutes to the closest fax machine number provided. Employees will need to know the name of the chemical to tell the 3 E Company operator.

vi. If at this time an evacuation is necessary the Hospital Evacuation Procedure will be implemented. The Safety Officer/hospital appointed personnel will consult with Management and area personnel as to proper containment, identification, and disposal procedure as prescribed by the EPA or other written instructions that provide measures that are approved by law or ordinance.

vii. Notification of the fire department will depend on the type of the spill and the potential danger involved.

viii. If a minor spill of flammable, corrosives, toxics or reactive occurs and there is no immediate danger to employee(s) then:

1) Properly trained employees may clean-up the spill using approved spill kits/supplies/equipment that meet or exceed the PPE requirements listed on the SDS notice.
2) Contact EVS who will contain the spill, and clean the chemical per SDS guidelines.
3) All collected chemicals must be handled per hazardous waste requirements and placed in an appropriate container, then labeled with the chemical name and other hazardous waste properties.
4) Contact the Safety Leader/designee with any questions.

k. Treatment of Contaminated Area:

i. Wash area immediately.

ii. Clothing contamination: Take item of clothing off immediately to prevent soaking through and contaminating skin. This includes all clothing affected.

iii. First Aid:

1) If skin/eye/mouth area(s) have been contaminated, flush affected area with large amounts of water for at least 15 minutes.
2) Do not try to neutralize.
   a) Go to the Emergency Department immediately after flushing affected area.

E. **GOALS/OBJECTIVE ~~FOR FY2021~~**

1. **Monitor sharps containers for proper disposal. This will be done by EOC rounds and random audits.**
2. **Monitor Eyewash Stations and Emergency Showers weekly logs. This will ensure each station is being properly checked on a weekly basis to stay complaint with Ansi/ISEAZ358.1. The monitoring of weekly logs will be done by EOC rounds and random audits.**

~~1. Provide training to all applicable Pharmacy, Engineering and Lab employees on how to properly respond to a chemical spill. Measurement will be number of applicable employees/number of employees receiving the spill management training. Goal is 100% of applicable employees.~~

~~2. Update and complete department specific hazardous material lists for all TCHD areas.~~

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

1. TCMC Waste Disposal Guidelines.

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE MANUAL
EQUIPMENT MANAGEMENT

ISSUE DATE:	**10/94**	**SUBJECT:**	**Medical Equipment Management Plan**
REVIEW DATE:	**03/97, 07/00, 05/03, 05/08**		
REVISION DATE:	**03/97, 07/00, 05/03, 05/08, 06/15, 01/17, 03/19, 12/21**		

Department Approval:	**~~10/21~~03/23**
Environmental Health & Safety Committee Approval:	**~~11/21~~05/23**
Administration Approval:	**~~11/21~~09/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/21**

A. **SCOPE:**

1. The Medical Equipment Management Program is designed to assure proper selection, of the appropriate medical equipment to support a safe patient care and treatment environment.
2. The Program:
   a. Ensures effective preparation of staff responsible for the use, maintenance, and repair of the equipment, and manage risks associated with the use of medical equipment technology.
   b. Is designed to assure continual availability of safe, effective equipment through a program of planned maintenance, timely repair, ongoing education and training, and evaluation of all events that may have an adverse impact on the safety of patients or staff as applied to the building and services provided at Tri-City Healthcare District (TCHD).
   c. Is applied to TCHD and offsite care locations.
3. The Medical Equipment Management Plan describes the processes implemented to manage the effective, safe, and reliable operation of medical equipment as well as provide a safe environment for patients, staff members, visitors, and other individuals in the hospital. Directly or indirectly, the plan involves every person in the hospital who uses, maintains, or is associated with medical equipment.

B. **FUNDAMENTALS (RISKS):**

1. The sophistication and complexity of medical equipment continues to expand. Selecting new medical equipment technology requires research and a team approach.
2. Patient care providers need information to develop an understanding of medical equipment limitations, safe operating conditions, safe work practices, and emergency clinical interventions during failures.
3. Medical equipment may injure patients or adversely affect care decisions if not properly maintained.

C. **OBJECTIVES:**

1. The objectives for the Medical Equipment Program are developed from information gathered during risk assessment activities, annual evaluation of the previous year's program, performance measures, and environmental tours.
2. e plan's objectives include the following::
   a. To increase training, both formal and informal, for all resident technicians.
   b. Develop departmental rounds to ensure medical equipment safety within the facility.

c. Keep the medical equipment inventory current and accurate.
d. Minimize risks to patients, users, and the environment.
e. Maintain the highest level of availability of medical equipment to clinical users.
f. Reduce the need for premature replacement of equipment.
g. Comply with applicable laws, regulations, standards, and codes.
h. Continually seek opportunities for quality improvement and cost reduction.
i. Reduce unnecessary workload that does not produce positive impact of care delivery.

D. **ORGANIZATION AND RESPONSIBILITY:**

1. The Hospital Governing Board receives regular reports of the activities of the Medical Equipment Management Program from the Environmental Health and Safety Committee (EHSC). Reports are reviewed to communicate concerns about identified issues and regulatory compliance. They provide support to facilitate the ongoing activities of the Medical Equipment Management Program.
2. The Chief Operating Officer (COO) / designee receives regular reports of the current status of the Medical Equipment program through the EHSC. The COO / designee reviews the reports and, as necessary, communicates concerns about key issues and regulatory compliance to the medical staff, nursing, Engineering, and other appropriate staff.
3. The Clinical Engineering leaders with COO support assures that the Medical Equipment Program is implemented in all key clinical areas. The program manages a variety of activities, including tracking of rental or leased equipment, warranty repairs, and contract services. The Program also assists in the management of the activities of specialty service contractors providing services to other departments, such as radiology, laboratory, respiratory care, and surgery and anesthesia.
4. The Manager of Clinical Engineering implements the in-house medical equipment maintenance program and tracks maintenance provided by original equipment manufacturers, and other contractors who provide maintenance and repair services for specific items of equipment.
5. Department leaders ensure new staff are oriented to their department and, as appropriate, specific uses of medical equipment. When requested, the Engineering Technicians provides assistance.
6. Individual staff members are responsible for learning and following job and task specific procedures for safe medical equipment operation.

E. **PERFORMANCE ACTIVITIES:**

1. The performance measurement process is one part of the evaluation of the effectiveness of the Medical Equipment Program. Performance measures have been established to measure important aspect of the Medical Equipment Program.
2. The following fundamental performance indicators will be monitored:
   a. Scheduled Maintenance (SM) completion rate benchmark is 95% or greater.
   b. Repair completion rate within 30-days benchmark is 85% or greater.
   c. Critical/High Risk Equip SM Mthly Completion rate is 100%.
   d. Use Error Percentages
   e. Could not Duplicate Percentages per year
   f. Equipment found without PM Safety Sticker <1%
3. As they occur:
   a. Safe Medical Device Act of 1990 (SMDA)
   b. Incident investigations
   c. Device recalls and alerts

F. **PROCESSES FOR MANAGING MEDICAL EQUIPMENT:**

1. The hospital plans activities to minimize risks in the environment of care
   a. The hospital has a written plan for managing medical equipment. The organization develops and maintains the Medical Equipment Management Plan to effectively manage the medical equipment risks of the staff, visitors, and patients at TCHD.

2. The hospital manages safety and security risks
   a. The hospital responds to product notices and recalls. Engineering responds and acts on medical equipment notices and recalls. Any notices or recalls (OEM voluntary or FDA) which are affected on any devices or equipment in the facility will be acted on immediately and reported to the EHSC meeting. The Department leadership(owner of the equipment) and Risk Manager will be notified of the notice or recall and action taken. The notice or recall will be annotated on the EHSC medical equipment report until the issue is resolved. This will also be discussed at the EHSC meeting to all members.
3. The hospital manages medical equipment risks
   a. The hospital solicits input from individuals who operate and service equipment when it selects and acquires medical equipment. TCHDTCHD utilizes a committee to select and assure the proper equipment is selected. Examples of committee participation include but is not limited to the following: Engineering, Nursing, Facility Management, Finance and Materials Management.
4. The hospital manages medical equipment risks
   a. The hospital maintains a written inventory of all medical equipment. TCHD maintains an electronic and written inventory of all medical equipment. This includes all Critical/High Risk equipment. Engineering evaluates new types of equipment before initial use to determine whether to include this equipment in the inventory.
   b. Written criteria are used to identify risks associated with medical equipment. The risks include, equipment function, physical risks associated with use, and equipment incident history as it relates to patient safety. The risks identified are used to assist in determining the strategies for maintenance, testing, and inspection of medical equipment. In addition, the identified risks are used to guide the development of training and education programs for staff that use or maintain equipment.
   c. Equipment requiring a program of planned maintenance is listed as part of a maintenance inventory. The list includes equipment maintained by in-house staff as well as equipment maintained by vendors.
5. The hospital manages medical equipment risks
   a. The hospital identifies high-risk medical equipment on the inventory for which there is a risk of serious injury or death to a patient or staff member should the equipment fail.
      i. Note: High-risk medical equipment includes life-support equipment. Engineering leadership identifies the activities used for maintaining, inspecting, and testing all of the medical equipment in the inventory used for the diagnosis, care, treatment, and monitoring of patients thus assuring safety and maximum useful life. The determination of the appropriate activity is made as part of the initial evaluation of equipment. Critical/High Risk equipment is identified and scheduled according to manufacturer recommendations. They are electronically tracked.
   b. Potential activities selected to ensure reliable performance include:
      i. Predictive maintenance based on manufacturer's recommendation.
      ii. Reliability-centered maintenance based on equipment history.
      iii. Interval-based inspections based on specified intervals between tests, inspections, or maintenance activity.
   c. TCHD Engineering Department follows manufacturer's recommendations for predictive (scheduled) maintenance including frequency and task (or the activity that requires MORE frequent inspections). Any changes of maintenance strategy and specific tasks shall be based on the experience accumulated locally or elsewhere, upon approval of the Environment of Care/Safety Committee or appropriate hospital authority.
6. The hospital manages medical equipment risks
   a. The hospital identifies the activities and associated frequencies, in writing, for maintaining, inspecting, and testing all medical equipment on the inventory. These activities and associated frequencies are in accordance with manufacturers' recommendations or with strategies of an alternative equipment maintenance (AEM) program. Engineering identifies the frequencies for inspecting, testing, and maintaining

medical equipment on the inventory in accordance with manufacturers' recommendations. The frequency of scheduled (planned) maintenance is determined based on manufacturer recommendations, risk levels, and current hospital experience. The frequency of maintenance is determined at the time of initial evaluation of the medical equipment.

b. A work order is used to manage the work for each scheduled maintenance event. Work orders are issued for maintenance performed by in-house staff and by contractors. Engineering manages the work order generation and completion process via electronic system. The Engineering Technicians perform assigned work orders and review prior to filing. Work done by outside contractors is tracked to assure the work is completed in accordance with the terms of a contract.

c. In addition, other departments manage performance testing and daily user maintenance of sterilizers.

7. The hospital manages medical equipment risks

a. The hospital's activities and frequencies for inspecting, testing, and maintaining the following items must be in accordance with manufacturers' recommendations:

i. Equipment subject to federal or state law or Medicare Conditions of Participation in which inspecting, testing, and maintaining must be in accordance with the manufacturer recommendations, or otherwise establishes more stringent maintenance requirements.

ii. Medical laser devices.

iii. Imaging and radiologic equipment (whether used for diagnostic or therapeutic purposes).

iv. New medical equipment with insufficient maintenance history to support the use of alternative maintenance strategies Note: Maintenance history includes any of the following documented evidence:

1) Records provided by the hospital's contractors.

2) Information made public by nationally recognized sources.

3) Records of the hospital's experience over time.

b. The Manager of Engineering identifies the frequencies for inspecting, testing, and maintaining medical equipment on the inventory in accordance with Manufacturers' recommendations. The frequency of scheduled (planned) maintenance is determined based on manufacturer recommendations, and can be more often based on risk levels, and current hospital experience. The frequency of maintenance is determined at the time of initial evaluation of the medical equipment.

c. A work order is used to manage the work for each scheduled maintenance event. Work orders are issued for maintenance performed by in-house staff and by contractors. Engineering manages the work order generation and completion process via an electronic system.

8. The hospital manages medical equipment risks -

a. A qualified individual(s) uses written criteria to support the determination whether it is safe to permit medical equipment to be maintained in an alternate manner that includes the following:

i. How the equipment is used, including the seriousness and prevalence of harm during normal use.

ii. Likely consequences of equipment failure or malfunction, including seriousness of and prevalence of harm.

iii. Availability of alternative or back-up equipment in the event the equipment fails or malfunctions.

iv. Incident history of identical or similar equipment.

v. Maintenance requirements of the equipment.

b. Engineering assists in the development of written procedures that are followed when medical equipment fails. These procedures include emergency clinical interventions and the location and use of backup medical equipment. The leader of each

department that uses Critical/High Risk medical equipment develops and trains staff about the specific emergency procedures to be used in the event of failure or malfunction of equipment whose failure could cause death or irreversible harm to the patient dependent on such equipment.

c. These emergency response procedures provide clear, specific instructions for staff responding to an emergency and provide information about notifying appropriate administrative staff of the emergency, actions required to protect patients from harm, contacts for spare equipment or repair services, and contacts to obtain additional staff to manage the emergency.

d. Each department leader maintains copies of applicable emergency procedures in accessible locations in their departments. Departmental staff receives orientation and ongoing education and training about the emergency procedures.

e. Each department Director/Manager reviews the department specific medical equipment emergency procedures annually.

9. The hospital manages medical equipment risks

a. The hospital identifies medical equipment on its inventory that is included in an alternative equipment maintenance program. The Manager of Engineering will bring any alternative equipment maintenance programs to the Environmental Health & Safety Committee for approval before using the alternative measures. There are no alternative maintenance programs currently being used.

10. The hospital manages medical equipment risks

a. The hospital monitors and reports all incidents in which medical equipment is suspected in or attributed to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Devices Act of 1990.

b. The Risk Manager is:

i. Responsible for monitoring and reporting all incidents in which medical equipment is suspected in or attributed to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Devices Act of 1990.

ii. Collecting information about potentially reportable events through the incident reporting and investigation process.

iii. Conducting investigations of medical equipment incidents to determine if the incident is reportable under criteria established by the Food and Drug Administration. Engineering will help in the investigation only when instructed by Risk Management.

iv. Using the Sentinel Event Process to investigate and document reportable incidents.

v. Reporting to the EHSC on those incidents determined to be reportable.

vi. Responsible for completing all reports and handling other communications with medical equipment manufacturers and the Food and Drug Administration (FDA) required by the Safe Medical Devices Act.

c. Appropriate changes in processes and training are made through the performance improvement process. The changes are communicated to all appropriate staff.

11. The hospital manages medical equipment risks

a. The hospital has written procedures to follow when medical equipment fails, including using emergency clinical interventions and backup equipment. The Manager of Engineering assists in the development of written procedures that are followed when medical equipment fails. These procedures include emergency clinical interventions and the location and use of backup medical equipment. The leader of each department that uses Critical/High Risk medical equipment develops and trains staff about the specific emergency procedures to be used in the event of failure or malfunction of equipment whose failure could cause death or irreversible harm to the patient dependent on such equipment.

b. These emergency response procedures provide clear, specific instructions for staff responding to an emergency and provide information about notifying appropriate

administrative staff of the emergency, actions required to protect patients from harm, contacts for spare equipment or repair services, and contacts to obtain additional staff to manage the emergency.

c. Each department head maintains copies of applicable emergency procedures in accessible locations in their departments. Departmental staff receives orientation and ongoing education and training about the emergency procedures.

d. Each department Director/Manager reviews the department specific medical equipment emergency procedures annually.

12. The hospital inspects, tests, and maintains medical equipment

a. Before initial use and after major repairs or upgrades of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. The Engineering staff will test all medical equipment on the inventory before initial usage and perform safety, operational, and functional checks. The inventory includes, equipment owned by TCHD, leased, and rented from vendors. These inspection, testing and maintenance documents are maintained in the Engineering Department for review. The Manager of Engineering manages the program of scheduled inspection and maintenance.

13. The hospital inspects, tests, and maintains medical equipment

a. The hospital inspects, tests, and maintains all high-risk equipment. These activities are documented. The Manager of Engineering assures that scheduled testing (inspects, tests and maintains) of all Critical/High Risk equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Environmental Health & Safety Committee. If the monthly rate of completion falls below 100%, the Manager of Engineering will present an analysis to determine the cause of the problem and make recommendations for addressing it. These inspection, testing, and maintenance documents are maintained in the Engineering Department for review.

14. The hospital inspects, tests, and maintains medical equipment

a. The hospital inspects, tests, and maintains non–high-risk equipment identified on the medical equipment inventory. These activities are documented. The Manager of Engineering assures that scheduled testing (inspects, tests and maintains) of all Non Critical/Non High Risk equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Environmental Health & Safety Committee. If the monthly rate of completion falls below 95%, the Manager of Engineering will present an analysis to determine the cause of the problem and make recommendations for addressing it. These inspection, testing and maintenance documents are maintained in the Engineering Department for review.

15. The hospital inspects, tests, and maintains medical equipment

a. The hospital conducts performance testing of and maintains all sterilizers. These activities are documented. The Manager of Engineering is responsible for the maintenance and documentation of maintenance of all types of sterilizers used at TCHD. Maintenance documentation to include SMs are maintained in electronic system (the Engineering Medical Equipment Database) and filed into the equipment file for review.

b. Records of load testing (performance) and regular user maintenance are maintained by Sterile Processing Department (SPD) and Perioperative Services Department, respectively.

16. The hospital inspects, tests, and maintains medical equipment

a. The hospital performs equipment maintenance and chemical and biological testing of water used in hemodialysis. These activities are documented. The Manager of Engineering is responsible for managing the service and maintenance of the dialysis units performed by Fresenius. The service maintenance records are also entered into the electronic system the Engineering shop medical equipment database and filed into the equipment file for review.

b. Engineering is responsible for managing the chemical and biological testing of water used in hemodialysis at TCHD by Fresenius. The program of maintenance includes, regular cleaning and disinfection of all dialysis equipment, and testing for compliance with biological and chemical standards for the dialysis water supply. Documentation of the testing and maintenance activities is maintained in the Dialysis storage room for review.

17. The hospital inspects, tests, and maintains medical equipment
    a. Qualified hospital staff inspect, test, and calibrate nuclear medicine equipment annually. The dates of these activities are documented. The Manager of Engineering assures that scheduled inspecting, testing, and calibrating (for the service and Scheduled Maintenance) of the Nuclear Medicine Camera and related equipment is performed in a timely manner at least annually. The service maintenance records are also entered into I-Desk the Engineering shop medical equipment database and filed into the equipment file for review.
18. The hospital collects information to monitor conditions in the environment.
    a. The hospital establishes a process for continually monitoring, internally reporting, and investigating the following:
        i. Medical or laboratory equipment management problems, failures, and use errors
            1) Note 1: All the incidents and issues listed above may be reported to staff in quality assessment, improvement, or other functions. A summary of such incidents may also be shared with the person designated to coordinate safety management activities.
            2) Note 2: Review of incident reports often requires that legal processes be followed to preserve confidentiality. Opportunities to improve care, treatment, or services, or to prevent similar incidents, are not lost as a result of following the legal process. Medical/Laboratory equipment management problems, failures, and use errors will be reported to the EHSC by Engineering on the EHSC report. All use errors will have in-service education and follow-up.
19. The hospital collects information to monitor conditions in the environment
    a. Based on its process the hospital reports and investigates the following: Medical/laboratory equipment management problems, failures, and use errors. (See also Medical/Laboratory equipment management problems, failures, and use errors will be reported to the EHSC by Engineering on the EHSC report.
20. The hospital collects information to monitor conditions in the environment.
    a. The hospital conducts environmental tours every six months in patient care areas to evaluate the effectiveness of previously implemented activities intended to minimize or eliminate environment of care risks. Engineering participates on the multi-disciplinary team which conducts environmental safety tours every 6-months in patient care areas and annually in non-patient care areas at TCHD .
21. The hospital collects information to monitor conditions in the environment
    a. Every 12 months, the hospital evaluates each environment of care management plan, including a review of the plan's objectives, scope, performance, and effectiveness. On an annual basis, Manager of Engineering evaluates the objectives, scope, performance, and effectiveness of the Plan to manage the medical equipment risks to the staff, visitors, and patients at TCHD. The basis for the evaluation will include but not be limited to the medical equipment performance standards and the EHSC Committee reports on medical equipment issues (supported from IDesk). The goal of the annual evaluation is to continually improve processes and outcomes to improve the patient experience.
22. The hospital addresses National Patient Safety Goal - Improve the safety of clinical alarm systems
    a. Leaders establish alarm safety as a hospital priority.
    b. Prepare an annual inventory of alarms used in the hospital and identify the default alarm

settings.

c. Based on the annual inventory, identify the most important alarms to manage.
d. Establish policies and procedures for managing the alarms identified above that at a minimum address the following:
    i. Whether specific alarms are needed or unnecessarily contribute to safety concerns.
    ii. When alarms can be disabled.
    iii. When alarm parameters can be changed.
    iv. Who in the organization has the authority to make decisions about disabling alarms and changing alarm parameters.
    v. Monitoring and responding to alarms.
    vi. Checking individual alarms for accurate settings, proper operation, and detectability.
e. Educate staff about alarm policies and procedures.

G. **INFECTION CONTROL**

1. Engineering staff will observe the hospitals infection-control policies and procedures, including current CDC hand hygiene guidelines, in order to minimize the risk of cross-contamination to patients and clinicians. In addition, Engineering employees are required to follow the blood borne pathogens exposure control plan (including training, universal precautions, engineering and safe work practices, personal protective equipment usage, and post-exposure evaluation and follow-up) developed by TRIMEDX Healthcare Technologies as required by Occupation Safety Health Administration (OSHA) per 29 CFR 1910.1030.

H. **PATIENT INFORMATION PRIVACY (HIPAA):**

1. As a service provider, Engineering staff do not use or disclose protected health information (PHI), as defined by the Health Insurance Portability and Accountability Act of 1996 – HIPAA, specifically the Standards for Privacy of Individually Identifiable Health Information. Any disclosure of protected health information to Engineering staff that occurs in the performance of their duties (such as what may occur while repairing a piece of medical equipment) is limited in nature, occurs as a by-product of the maintenance duties, and cannot be reasonably prevented. Such disclosures are incidental and permitted by the HIPAA Privacy Rule (45 CFR 164.502(a)(1)).
2. On the other hand, Engineering staff shall follow policies and procedures established by client to protect PHI, including attending required training and assisting clients in identifying privacy risks and practicing risk reduction measures. Specifically, the Technology Managers and Engineering staff is instructed to:
    a. Assist in identifying and recommending preventive measures for PHI theft risks for medical devices that are exposed to non-authorized employees, patients and visitors.
    b. Work with the Information Technology department to remove all PHI from equipment that is sent out for repair or disposal.
    c. Not use or disclose any information (oral, transmitted, or recorded in any form or medium) that relates to the health (past, present, or future) of or provision of healthcare to an individual.

I. **EMERGENCY PREPAREDNESS AND MANAGEMENT:**

1. Engineering staff will observe the client's emergency preparedness and management policies and procedures in order to provide care to the population served by the client in the case of local, regional, and national emergencies.

J. **GOALS AND OJECTIVES ~~FOR FY21~~:**

1. Identify and respond to equipment hazard and recall notices in a timely manner.
2. Review and Update as required the Medical Equipment Management Plan annually.

3. Complete annual equipment preventative maintenance according to manufacture guidelines, goal 100% compliance.

K. **RELATED DOCUMENTS(S)**:

1. Engineering Policy: Equipment Management Plan

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE MANUAL
SECURITY MANAGEMENT

ISSUE DATE: 01/97 **SUBJECT: Security Management Plan**

REVISION DATE: 01/99, 07/00, 04/03, 12/05, 12/11, 06/15, 12/17, 03/19, 12/21

Department Approval:	~~10/21~~03/23
Environmental Health & Safety Committee Approval:	~~11/21~~05/23
Administration Approval:	~~11/21~~09/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/21

A. **EXECUTIVE SUMMARY:**

1. Each environment of care poses unique security risks to the patients served, the workforce and medical staff who use and manage it, and to others who enter the environment.
2. The Security Management Program is designed to identify and manage the security risks of the environments of care operated and owned by Tri-City Healthcare District (TCHD) by conducting and maintaining a proactive risk assessment. The security management program manages identified risks using applicable laws, regulations, and accreditation standards.
3. The Management Plan for a Secure Environment describes the security risk and daily management activities that TCHD has put in place to achieve the lowest potential for adverse impact on the security of patients, workforce, and other individuals, coming to the organization's facilities. The management plan and the Security Management Program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.
4. The scope of the program is applied to the Medical Center and affiliated clinics owned and operated by TCHD.
5. The Security Management Plan and associated policies extend to inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care and business occupancies of TCHD.
6. The plan also affects all workforce, volunteers, medical staff and associates including contracted services of TCHD.

B. **PRINCIPLES:**

1. Security is a system made up of human assets and technology.
2. Timely identification of changes in the types of TCHD security threats facing are performed through initial and ongoing assessments. Visible and clandestine components of the system are used to reduce the potential for criminal activity, the threat of workplace violence, and to increase feelings of security among patients, the workforce, and visitors.
3. Collection and analysis of information about adverse security events provides information to help predict and prevent personal violence, crime, and other incidents.
4. Workforce members awareness of security is an essential part of an effective program. TCHD orients and trains all staff to basic components of the security program, including workplace violence prevention and active threat, along with techniques for managing security risks related to work areas or daily activities.

C. **OBJECTIVES:**

~~1. Perform an initial proactive risk assessment of the buildings, grounds, equipment, workforce members' activities, and the care and work environment for patients and workforce to evaluate the potential adverse impact on all persons coming to the facilities of TCHD.~~

~~2. Perform additional risk assessments when changes in the campus design or patterns of security events indicate a change in the security threat level.~~

1. **Ensure that all applicable security personnel have received adequate training to effectively participate in the security management plan.**
2. **Develop a security awareness program. The program will consist of training staff, monthly meeting and adding power minutes.**

~~3. Analyze security incidents and occurrences to identify root cause elements.~~

~~4. Conduct ongoing random security patrols (rounds) in all areas of the medical center, affiliated business offices and outpatient facilities to evaluate the physical environment, equipment, and work practices.~~

~~a. Rounds are conducted in all support areas and all patient care areas at least once per day.~~

~~5. Present reports of Environment of Care management activities to the Environmental Health and Safety Committee quarterly. The reports identify key issues of performance and regulatory compliance, present recommendations for improvement, and provide information about ongoing activities to resolve previously identified security issues. The Security Leadership coordinates the documentation and presentation of this information.~~

~~6. Assure that departments have current organization-wide and as needed department specific procedures and controls designed to manage identified security risks.~~

~~7. Review the risks and related procedures and controls at least once every three years to assure that the security program is current.~~

~~8. Assign qualified individuals to manage the program and to respond to immediate security threats.~~

~~9. Perform an annual evaluation of the management plan.~~

~~10. Ensures security education and training is provided to new and current workforce members, volunteers, medical staff, contract staff and others as appropriate.~~

~~11. Provide timely response to emergencies and requests for assistance.~~

~~12. Communicate with law enforcement and other civil authorities as needed.~~

~~13. Manage access to the grounds, buildings, and sensitive areas of TCHD.~~

D. **PROGRAM MANAGEMENT STRUCTURE:**

1. The Board of Directors of TCHD receives regular reports of the activities of the Security program from the Environmental Health and Safety Committee. The Board reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety Officer.
2. The Board collaborates with the Chief Executive Officer (CEO) and other senior leaders to ensure budget and staffing resources are available to support the Security Program.
3. The CEO or designee of TCHD receives regular reports of the activities of the Security program. The CEO or designee collaborates with the Security Leader and other appropriate workforce members to address security issues and concerns.
4. Security Leadership works under the general direction of the CEO or designee. The Manager of Security is responsible for managing the Security Program. The Security reports program findings to the Environmental Health and Safety Committee. The reports summarize organizational experience, performance management and improvement activities, and other security issues.
5. Department Leaders are responsible for orienting new workforce members according to TCHD, Human Resource and unit/department policies and procedures
6. Department Leaders are responsible for participating in the reporting and investigation of incidents occurring in their departments.

E. **ELEMENTS OF THE SECURITY PLAN:**

1. Appointment of Security Leadership
   a. A Safety Officer or Security Leader is appointed to oversee the development, implementation and monitoring of the security program. The Safety Officer/Security Leader's responsibilities are defined by job description. The competency of the Safety Officer/Security Leader competency is evaluated annually by the CEO or designee.
   b. The Security Leader:
      i. Coordinates the development and implementation of the security program and assures it is integrated with the patient safety, information management, and other programs as appropriate
      ii. Maintains a current knowledge of laws, regulations, and standards of security
      iii. Continually assesses the need to make changes to procedures, controls, training, and other activities to assure that the security management program reflects the current risks present in the environment of TCHD.
2. Designation of Persons to Intervene When Immediate Threats to Life, Health, or Property are identified
   a. The Emergency Management Program includes specific response plans for TCHD to implement as appropriate whenever conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings. The response plans follow the Hospital Incident Command System (HICS) all hazards response protocol. An appropriate Incident Commander is appointed at the time any emergency response is implemented.
   b. The Immediate Threat Procedure is included in the Emergency Operations Procedure manual. The procedure lists the communications and specific actions to be initiated when situations posing an immediate threat to patients, workforce, physicians, or visitors or the threat of major damage to buildings or property.
      i. The objective of the procedure is to identify and respond to high risk situations before significant injuries, death or loss of property occurs.
      ii. The CEO has appointed the Safety Leader, the Nursing Administrative Supervisor on duty, and the Administrator on Call to exercise to assume the role of incident command and to coordinate the mobilization of resources required to take appropriate action to quickly minimize the effects of such situations.
3. Management Plan for a Secure Environment
   a. The Security Management Program is described in this management plan. The security management plan describes the policies, procedures and controls in place to minimize the potential that any patients, workforce members, and other people coming to the facilities of TCHD experience an adverse security event.
4. Proactive Risk Assessment
   a. The Security Leader coordinates proactive risk assessments to identify risks that create the potential for personal injury of staff or others or adverse outcomes of patient care. The purpose of the risk assessments is to gather information that can be used to develop procedures and controls to minimize the potential of adverse events affecting workforce members, patients, and others.
   b. The Security Leader works with department directors, managers, the Patient Safety Officer, Risk Manager and others as appropriate.
   c. The Security Department is responsible for enacting proactive security measures as follows:
      i. Scheduling patrolling of the Medical Center and parking lots to help prevent work place violence/incidents.
      ii. Locking/unlocking of exterior doors, departments, and associated rooms; and on-going inspections of all sensitive areas throughout the Medical Center.
      iii. Ensuring all workforce members and physicians properly display their photographic identification badges at all times.

iv. Submitting reports to the Director of Engineering or designee pertaining to security and safety violations, including but not limited to: defective lighting, damaged equipment, unsafe situations or conditions that may present a danger to others.
v. Maintaining unrestricted locations for the timely loading and unloading of persons seeking medical treatment in the Emergency Department (ED) and Women's Center.
vi. Security will also ensure a location for long-term vehicle parking.
vii. Monitoring the Security Department Closed Circuit Television (CCTV)
viii. Providing campus escort services 24 hours per day as needed for employees and visitors.

5. The hospital takes action to minimize or eliminate identified security risks in the physical environment
   a. The results of the risk assessment process are used to create new or revise existing procedures and controls. They are also used to guide the modification of the environment or the procurement of equipment that can eliminate or significantly reduce identified risks. The procedures, controls, environmental design changes, and equipment are designed to effectively manage the level of security in a planned and systematic manner.
   b. In response to Cal/OSHA, Workplace Violence Prevention in Healthcare, Title 8, Chapter 4, § 3342 regulations, TCHD has created new environmental risk assessment tools and general employee education programs.
   c. TCHD has implemented the Non-Violent Crisis Intervention Program (NVCI) for the mandated training of workforce members working in high-risk areas per h the California Health and Safety Code Section 1247.7 and 1257.8. The training includes, but is not limited to the following:
      i. General safety measures.
      ii. Personal safety measures.
      iii. The assault cycle.
      iv. Aggression and violence predicting factors.
      v. Characteristics of aggressive and violent patients and victims.
      vi. Verbal and physical maneuvers to diffuse and avoid violent behavior.
      vii. Strategies to avoid physical harm.
      viii. Restraining techniques.
      ix. Resources available to employees coping with violence (stress debriefing, employee assistance programs, etc.).
   d. The NVCI program will be offered to ancillary staff routinely assigned to the Emergency Department. Ancillary department managers will be responsible for determining staff appropriate for this training.
6. Development and Management of Policies and Procedures
   a. The Security Leader follows the administrative policy for the development of organization-wide and department specific policies, procedures, and controls designed to eliminate or minimize the identified risks. Security assists department leaders with the development of department or job specific environmental safety procedures and controls.
   b. The organization-wide policies, procedures and controls are available to all departments and services on the organizational intranet. Departmental policies, procedures and controls are maintained by department directors who are responsible for ensuring their workforce are familiar with organizational, departmental, and appropriate job related policies, and procedures.. Department directors are also responsible for monitoring appropriate implementation of the policies, procedures and controls in their area(s) of responsibility. Each workforce member is responsible for implementing the policies, procedures and controls related to her/his work processes.

c. The policies, procedures and controls are reviewed when significant changes in services occur, when new technology or space is acquired, and at least every three years. The Security Leader coordinates the reviews of procedures with department leaders and other appropriate workforce members.

7. Identification of Patients, Staff, and Others Entering the Facility
   a. The identification (ID) of workforce members are an interdisciplinary function. Several Directors share responsibility for designing identification systems and establishing procedures and controls to maintain the effectiveness of the systems.
   b. The current systems in place include photographic ID badges for all workforce, volunteers, students, contracted staff and members of the medical staff; password systems to limit access to authorized users of information system applications, physical security systems to limit access to departments and areas of the hospital, and distinctive clothing/badges to facilitate rapid visual recognition of critical groups of the workforce.
   c. The ID of patients is also an interdisciplinary function. The current system includes personal identification of patients in medical records and by use of various arm band systems.
   d. The identification of others entering TCHD is managed by the Security and Materials Management Departments. The Security Leader in collaboration with the CEO or designee and other appropriate workforce members provides a secure environment that requires identification of all contractors/vendors and the badging of visitors to the various areas of the facility. The Director of Materials Management manages the procedures for identification of vendors. The Security Leader takes appropriate action to remove unauthorized persons form areas and to prevent unwanted individuals from gaining access to TCHD.

8. Identification and Management of Security Sensitive Areas
   a. The following areas have been designated as sensitive areas:
      i. Emergency Department
      ii. Maternal Child Health
      iii. Neonatal Intensive Care Unit
      iv. Pharmacy Department.
      v. Human Resources Department
      vi. Adult Critical Care Unit
      vii. Information Technology
      viii. Administration
      ix. Progressive Care Unit
      x. Medical Records Office and Storage areas
      xi. Nuclear Medicine Hot Lab
   b. Workforce members -in each sensitive area participates in training addressing the unique risks of the area and the procedures and controls in place to manage them. Key personnel and security staff receive specialized training related to processes in high risk security areas.
   c. The Security Plan has a program for the inspection, preventative maintenance and testing of the following security equipment:
      i. Emergency Department:
         1) Electronic access control.
         2) Panic buttons.
         3) Closed Circuit Television (CCTV) cameras.
         4) Security Officer Station – Posted 24 hours per day.
      ii. Women and Newborn Services Units:
         1) Electronic access control.
         2) Access Control System CCTV.
         3) Department policy in place for identifying visitors.
         4) Department procedure for uniquely identifying mother-infants.

5) Teaching program to educate parents or guardians to explain the security processes.
6) Unique identification for staff members.
7) Unique visitor badge identification for visitors.

iii. Neonatal Intensive Care Unit:
1) Electronic access control.
2) Panic buttons.
3) The Maternal Child Health units are protected with both active video surveillance systems on entrances and exits of the units. The unit has electronic access control systems for entrances and exits that alarm if unauthorized entry or exit occurs.

iv. Pharmacy Department:
1) Electronic access control
2) Infrared Security System
3) Panic buttons

v. Business Office:
1) Electronic access control
2) Panic buttons
3) Local area surveillance system

vi. Human Resources department:
1) Panic buttons
2) Access Control System CCTV

vii. Adult Critical Care Unit:
1) Electronic access control

viii. Case Management:
1) Panic buttons

9. Management of Security Incidents Including an Infant or Pediatric Abduction
a. The Security Leader has developed procedures for rapid response to breaches of security. On-duty Security Officers and local police have the manpower and technological resources to respond to a wide variety of incidents. The Security Leader or a designee is responsible for assessing breaches of security and determining what resources are required to respond effectively.
b. The Security Leader, Safety Leader and -Director of Women's and Children's Services are responsible for the design and management of systems to reduce the threat of abduction of infants or children and to respond to any threats of or actual abductions.
c. A Code Adam is announced over the paging system, as well as selected radios when a potential or actual abduction has occurred.
i. All available workforce respond per the Patient Care Services Code Adam.
ii. The Code Adam plan is tested at least annually and the responses are documented, evaluated, critiqued and as appropriate corrective activity, additional training, or program improvements are made.
d. The Security Leader and Director of Women and Newborn Services are required to conduct at least one abduction drill annually.
i. Activations of the abduction alert system and all attempted or actual abductions of infants or children are treated as security incidents and reported and analyzed appropriately.

10. The hospital monitors conditions in the environment
a. Risk Management coordinates the design and implementation of the incident reporting and analysis process.
b. The Security Leaders works with Risk Management to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.
c. Incident reports are completed by the staff member or witness to whom a patient or

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

d. Risk Management and the Security Leader collaborate to conduct an aggregate analysis of incident reports generated to determine if there are patterns of deficiencies in the environment or workforce members behaviors that require action. The findings of such analysis are reported to the Environmental Health and Safety Committee (EHSC) and the Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Committee Chairpersons provide summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.

e. The Security Leader works with the EHSC to collect information about security deficiencies and opportunities for improvement from all areas of TCHD. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the six environments of care functions use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

f. The EHSC and the Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the Environment of Care Management Programs.

g. The Safety Leader and the Patient Safety Committee prepare a quarterly report to the leadership of TCHD. The quarterly report summarizes key issues reported to the Committees and the recommendations of them. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to ensure leaders of management responsibilities have been carried out.

11. Annually the hospital evaluates each environment of care management plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.

a. The Safety Leader coordinates the annual evaluation of the management plans associated with each of the Environment of Care functions.

b. The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care (EC) program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources.

   i. The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews, benchmarking programs or assessments by regulators, accrediting bodies, insurers, consultants, minutes from appropriate committees, and analytical summaries of other activities.

   ii. The findings of the annual review are presented to the EHSC by the end of the first quarter of the fiscal year.

   iii. Each report presents a balanced summary of the EHSC program for the preceding fiscal year.

   iv. Each report includes an action plan to address identified risks.

c. The annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review.

d. Identified risk or deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Safety Leader.

e. The results of the annual evaluation are presented to the EHSC. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the CEO, the Board of Directors, organizational leaders, the Patient Safety Committee, and others as

appropriate. The manager of each Environment of Care Program is responsible for implementing the recommendations in the report as part of the performance improvement process.

12. Analysis and actions regarding identified environmental issues
    a. The EHSC receives reports of activities related to the environmental "EOC Rounding" program at least quarterly.
    b. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital and the Patient Safety Committee as indicated.
13. Improving the Environment
    a. When the leadership of the hospital, quality improvement, or patient safety concurs with the EHSC recommendations for improvements to the environment of care management programs, a team of appropriate workforce is appointed to manage the improvement project. The EHSC works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.
    b. The EHSC establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital, quality improvement, and patient safety leadership.
14. Orientation and Ongoing Education and Training
    a. Orientation and training addressing the environment of care and workplace safety is provided to each workforce member, contract staff and volunteer. All Licensed Independent Practitioners (LIP) receive orientation to the Environment of Care and workplace safety in accordance with the Medical Staff policies and bylaws.
    b. Annual EOC and workplace safety training is provided and documented via **learning management system**~~NetLearning~~.
    c. The Human Resources Department with assistance from the Education Department coordinates the general New Employee Orientation (NEO) program per HR and the Education Department policies and procedures
    d. The Safety Leader collaborates with the EOC leaders, the manager of Quality Improvement, Infection Control, Patient Safety Officer and others as appropriate to develop content materials for general and job-related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each EOC program and revised as necessary.
    e. The Safety Leader gathers data during environment of care rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job-related physical risks are to be managed or eliminated as part of daily work. The environment of care rounds (tours) evaluates the degree to which workforce members and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.
    f. Information about the workforce and LIPs knowledge and technical skills related to managing or eliminating environment of care risks is reported to the EHSC. When deficiencies are identified action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

F. **RELATED DOCUMENT(S):**
1. Patient Care Services: Code Adam Policy

G. **REFERENCE(S):**
1. The Joint Commission Environmental of Care Standards

2. Cal/OSHA Workplace Violence Prevention in Healthcare, Title 8, Chapter 4, § 3342 regulations

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

ISSUE DATE: 08/96 **SUBJECT:** Fire Safety

REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 07/17, 10/21

Department Approval:	~~08/20~~05/23
Environmental Health & Safety Committee Approval:	05/23
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~10/24~~09/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	10/21

A. **PURPOSE:**

1. To identify specific guidelines for fire safety in Outpatient Behavioral Health Services (OPBHS).
2. **To identify the actions the OPBHS workforce members shall implement to ensure protection of patients, visitors and property from fire, smoke and other products of combustion.**
3. **To provide instructions on performing the following:**
   a. **Identifying fire hazards**
   b. **Identifying when to report a fire**
   c. **Identifying when to initiate a fire alarm**
   d. **Smoke and fire containment**
   e. **Using a fire extinguisher**
   f. **Assisting with relocating and evacuating patients and workforce members**

B. **DEFINITION(S):**

1. **Workforce Members (WFM) – Employees, medical staff, and Allied Health Professionals (AHP), volunteers, trainees, and other persons whose conduct, in the performance of work for TCHD, is under the direct control of TCHD whether or not they are paid by TCHD**
2. **RACE – an standardize acronym for the actions to implement when a fire is identified**
   a. **R: Rescue - remove anyone from immediate danger, closing fire and room doors and calling out for assistance**
   b. **A: Alarm - activate the nearest fire alarm (pull station) and call PBX operators by dialing "66" and notify them of the "Code Red" fire. All off campus locations dial "911".**
   c. **C: Contain - close all remaining doors.**
   d. **Extinguish - extinguish the fire if it can be done without endangering yourself or others.**
3. **PASS – an acronym used to provide instructions for using a fire extinguisher**
   a. **P: PULL the pin**
   b. **A: AIM the nozzle at the base of the fire**
   c. **S: SQUEEZE the handle**
   d. **S: SWEEP back and forth across the base of the fire**

~~1.~~**4. Evacuation Plans –Plans that identify evacuation routes and the location of alarms and firefighting equipment. The plans are throughout the facility.**

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

1. Patient and staff safety is the most important consideration. Everyone must **evacuate**~~be removed~~ quickly and safely from the facility. The fire drill plan will be implemented ~~at least~~ **once a year**~~annually~~.
2. **In the event of an actually to detention of smoke, dial 911.**
3. ~~1.~~ Documentation of the fire drills will be completed on the "Fire Drill Record". Any problems identified, corrective action taken, and staff participation will also be documented. Fire drill records are also shared with the **EOC/**Safety Officer.

~~C.~~**D. PROCEDURE**

1. Who may perform/responsible: OPBHS Staff
2. In Case of Fire:
   a. Utilize ~~"R.A.C.E."~~
      ~~i. The Procedure for Code Red is "R.A.C.E."~~
      1) "R" Rescue/**remove any one from**~~people in~~ immediate danger.
      2) "A" Activate the fire notification process and report the fire and the exact location.
      3) "C" Contain the fire by closing all doors.
      4) "E" Extinguish the fire with the fire extinguisher, using the P.A.S.S. method ~~(Pull pin, Aim hose, Squeeze handle, Sweep from side to side at base of fire)~~. Evacuate if necessary.
   b. The **OPBHS Leaders**~~Operations Manager~~ or designee will designate an area to which everyone in the facility will evacuate.
   c. The **OPBHS Leaders**~~Operations Manager~~ or designee will assign staff the following tasks:
      i. Announce Code Red
      ii. Evacuate patients
      iii. Call 911
      iv. Call **TCMC** ~~66 to~~**security to** notify main hospital
      v. Attempt to extinguish
      vi. Close Doors to contain fire
      vii. Notify hospital safety officer **or designee**
      viii. Secure medical records
      ix. Sweep the building
      x. Take head count once everyone is evacuated
   d. The designated staff will conduct a count of patients, visitors and staff by means of verifying patient sign-in sheets, visitor sign-in sheets.
   e. Remain at the designated evacuation area until an "All Clear" is announced, which indicates that it is safe to return to the building.

E. RELATED DOCUMENT(S):

1. **Outpatient Behavioral Health Services – Emergency Evacuation Policy**
2. **Environment of Care – Fire Plan (Code Red)**
3. **HICS 260 Patient Evacuation Form**
4. **Hospital Incident Command System Forms 2014 | EMSA (ca.gov)**

~~e.~~**5. HICS 260 Patient Evacuation / Transfer Tracking Form Ins**

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

ISSUE DATE: 05/03 **SUBJECT:** Lost and Found Procedures for Security Department

REVIEW DATE: 11/06, 03/09, 07/15 **POLICY NUMBER: 230**
REVISION DATE: 04/08, 06/11, 09/15, 11/20

Department Approval: ~~07/15~~04/23
Environmental Health and Safety Committee Approval: ~~08/20~~05/23
Administration Approval: ~~10/20~~09/23
Professional Affairs Committee Approval: n/a
Board of Directors Approval: 11/20

A. **PURPOSE:**
1. To establish guidelines for Security Department personnel to utilize when receiving Lost and Found items.

B. **POLICY:**
1. It is the policy of the Security Department to utilize the following procedure when receiving, returning, and disposing of Lost and Found articles.

C. **PROCEDURE:**
1. Receiving Lost and Found Items
   a. When Security is requested to receive a Lost and Found item, the responding Security Officer will inquire as to the owner's name, phone number, and call them as to ensure that every attempt has been made to identify and return the item to the owner. If this information is collected late at night, the shift will still collect the contact information~~,~~ and ask the following shift to place the call. If after every reasonable attempt has been made, it is the responding Officer's responsibility to properly log in the item(s) to the Lost and Found **system.** ~~Logbook #2.~~
   b. A Lost and Found Property Slip will be completed with a detailed description of the item(s) contents. The responding Officer's information must be **legibly written** ~~included~~ in the "Received by" area as well as the item number documented on the Property Slip, owner's name, and owner's phone number.
   c. All applicable information will be logged into the Lost and Found Logbook. ~~#2.~~ The Property Slip needs to be placed inside the belongings bag, and the item number labeled with label facing toward the front on the outside of the bag with the bag tied in a knot so the belongings do not fall out when moved. **The Lost and Found item(s) will be correctly placed in their designated storage area [e.g. rack/shelf/cabinet] as determined by the system's organization.**
   d. ~~All Lost and Found items will be logged into the Lost and Found Logbook before being sent to their area for storage (i.e. Pharmacy, Safe, Customer Relations).~~ Valuables **found during Lost and Found procedures** such as jewelry, money, checks, **and** credit cards, ~~etc.~~ **even if the owner is unknown,** will be **logged into the safe/valuables' system using a gray Univault Bag.** ~~collected when a second officer is available as a witness. Valuables will be locked in the small (Drop) safe located inside the Lost and Found office and Logged in the **Lost and Found Valuables Property Logbook #5.** The item(s) will be placed in a white Valuables envelope with~~

~~article description, date inserted, and officer's signature printed on a valuables inventory sheet and placed on the outside of the envelope. Driver's License, ID cards, health cards, and paperwork will be placed in the locked metal cabinet as well as bulk items of value (i.e. laptops, cell phones, and other electronic devices). Prescription eyeglasses and Patient Care items (i.e. hearing aides, medic alert devices, dentures etc.) are to go to the Customer Relations office located next to the Main Admitting Department waiting room.~~

2. Lost and Found Inquiries
   a. The Responding Security Officer will complete a detailed search for the lost item(s). If the item is not located, the individual's name, phone number, date of inquiry and description of the lost item(s) need to be taken **in case the lost item(s) is eventually found and so that the item(s) may be returned to their owner.**~~and logged into the Lost and Found Inquiry Logbook #3.~~
3. Returning Lost and Found items.
   a. When requested to return an item, every attempt will be made to ensure that the item is being returned to the proper owner **by verifying personal information, verifying descriptions of the lost and found item(s), or through a legal a durable power of attorney document**.
   b. The Officer will have the owner ~~or person receiving~~ **of** the property complete the Lost and Found Property slip by signing for the item; **if owner is not present, then the security officer attempting to return the lost and found item must seek approval from the Administrative Supervisor (AS) in addition to making a copy of a valid form of identification. A durable power of attorney document must be provided to TCMC and verified by the AS before returning the item to someone other than the owner.**
   c. The Officer will then complete the Lost and Found disposition section of the Lost and Found Log**book** and file the Property slip ~~in the Property Slip Bin~~.
   ~~d. When returning lost and found valuables, the Officer must verify that the person claiming the item is the owner, and positive ID made through photo identification. If the person claiming the item is someone other than the owner, they must show proof of Durable Power of Attorney for the owner or a letter from the owner approved by the Customer Service Representative.~~
4. Destruction of Lost and Found Property
   a. If any Lost and Found items are not returned within 90 days, the items will be disposed of in a manner specified by the Director of the Risk, Legal, and Regulatory Department**s**.
   b. Any soiled articles, flammable items (~~i.e.~~ **e.g.** lighters, matches, flammable liquids or items containing flammable liquids), or perishable items such as food will be logged into the Lost and Found Log ~~B~~**b**ook then disposed of and notated in the disposition area **of the logbook as soiled/perishable items are contact precautions and flammable items are safety hazards.**~~with the reason for disposal.~~

D. **RELATED DOCUMENTS:**
1. Administrative Policy:: Lost and Found Articles #202

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

ISSUE DATE:	**05/11**	**SUBJECT:**	**Patient Valuables Collection and Return**
REVIEW DATE:	**06/11**	**POLICY NUMBER:**	**237**
REVISION DATE:	**09/15, 11/20**		

Department Approval:	**~~05/20~~04/23**
Environmental Health and Safety Committee Approval:	**~~08/20~~05/23**
Administration Approval:	**~~10/20~~09/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**11/20**

A. **PURPOSE:**

1. To establish guidelines for Security Department personnel to utilize when receiving Patient Valuables.

B. **POLICY:**

1. It is the policy of the Security Department to utilize the following procedure when receiving, returning, and disposing Patient Valuables.

C. **PROCEDURE:**

1. Receiving Patient Valuables
   a. When Security is requested to collect patient valuables, the responding Security Officer will first encourage the patient to send the item(s) home with a family member for safe-keeping.
   b. If the patient is unable or unwilling to send the item(s) home for safe keeping, the Officer will bring a grey UniVault bag to the location of the patient. The Officer will collect the item(s) with the patient's nurse as a witness to the collection process. Once the item is collected, the Officer will inventory the item(s) and write a complete and accurate description of the item(s) on the outside of the UniVault bag using a sharpie or other permanent type marker, then place the item(s) in the bag securing it. Only valuables will be collected and placed in the bag (i.e. if the patient is securing a wallet, the valuables are removed from it in the patient's presence, and placed in the UniVault bag, then the wallet is returned to the patient.) All information on the bag must be filled out completely, and signed by the patient. If the patient is unable to sign, the patient's nurse will sign as a witness. The top flap portion of the bag is to be removed and filled out, then given to the patient as receipt of collection. Two (2) copies of the completed inventoried bag must be made by placing the bag directly on a copy machine, one copy is to be given to the Patient's Nurse to be included in the Patient's chart, and the second copy is to be placed in the "For Copies Only" tray located on the counter above the Small (Drop) Safe in the Lost and Found office. The Officer must verify the patient's phone number with the patient (not collected from the chart) to ensure current and accurate contact information.
   c. All applicable information will be logged into the **Patient Valuables Property Logbook #4** including the patient's name, phone number, and bag serial number. The bag will be placed in the slot and dropped with the Officer verifying the bag fully dropped in.

2. Returning Patient Valuables.
   a. When requested to return a patient's valuables, every attempt will be made to ensure that the item(s) is/are being returned to the proper owner.
   b. The Officer will collect the UniVault receipt from the owner, or if it has been lost or misplaced, will receive the copy of the bag from the patient's chart.
   c. The Officer will take the UniVault receipt or chart copy and contact the Cashiering Department or Administrative Coordinator (After Hours) to meet and open the Small (Drop) Safe to collect the patient's valuables. The Officer will return to the floor and in the presence of the patient and nurse, will cut the bag open on the dotted line of the bag. The Officer will inventory the contents of the UniVault Bag and compare them to the inventory listed on the outside of the bag while checking off the inventory items. When the patient is satisfied that all their valuables are accounted for, the Officer will have the patient sign the UniVault Bag and the copy. The Officer will make two copies of the signed inventory sheet and give to the patient's nurse to be included in the patient's chart as a permanent record of receipt.
   d. The Officer will return the signed UniVault Bag and the signed inventory sheet and place both in the "For Copies Only" tray located on the counter above small (Drop) safe.
   e. The Lost and Found Administrator will collect the signed receipts and attach them to the copy filed in Lost and Found, and file them together in the Disposition section of Patient Valuables filing cabinet.
3. Destruction of Patient Valuables Property
   a. If any patient valuables items are not claimed within 180 days, the items will be disposed of in a manner specified by the Director of the Risk, Legal, and Regulatory Department.

D. **RELATED DOCUMENTS:**

1. Patient Care Services Policy: Patient Valuables Liability and Control

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

ISSUE DATE:	**05/94**	**SUBJECT: Security Incident Notification**
REVIEW DATE:	**01/97, 05/03, 11/06, 03/09, 06/11**	**POLICY NUMBER: 208**
REVISION DATE:	**07/03, 09/15, 11/20**	

Department Approval:	**~~05/20~~04/23**
Environmental Health and Safety Committee Approval:	**~~08/20~~05/23**
Administration Approval:	**~~10/20~~09/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**11/20**

A. **PURPOSE:**

1. To establish guidelines for **all on-duty** Security Department personnel for the proper Incident Notification whenever a **Serious** Security Incident occurs.

B. **POLICY:**

1. It is the responsibility of all **on-duty** Security Officers to properly notify the appropriate individuals whenever a **Serious** Security Incident occurs. Reference Administrative Policy #234 Security Department Incident Notification.

C. **PROCEDURE:**

1. Security Department personnel are required to notify the **local Law Enforcement agency and the on-duty Administrative Supervisor in addition to the** Security **Director,** Manager, Supervisor, ~~, or~~ **and** Shift Lead Officer anytime a **Serious** Security Incident occurs on the Medical Center campus **or is reported**~~.~~
2. The following is a list of Serious Security Incidents that would require the immediate Security Department Incident Notification to be executed including but not limited to:
   a. Armed and Strong Armed Robbery~~,~~
   b. Homicide or Suspected Homicide~~,~~
   c. Kidnap or Suspected Kidnap~~,~~
   d. Rape~~,~~
   e. Serious Assault or Battery~~,~~ **or Workplace Violence**
   f. Theft of Narcotics~~,~~
   g. Any Arrest made by or to a Security Officer~~,~~
   h. Natural Disaster~~,~~
   i. Fire~~,~~
   j. Flood~~,~~
   k. Any Incident involving a Medical Center employee and requiring an immediate follow up investigation by the Security Manager, Supervisor, or Shift Lead Officer.
   l. Death or Serious Injury to any Visitor or Staff Member.
   m. Removing a Parked Vehicle from the Medical Center.
   n. Credible Threat of Mass Casualty
   o. Trips and Falls that result in the victim seeking medical attention
   p. Any Injury as a result of these serious security incidents
   q. Psychiatric Patient or 5150 hold patient elopement attempt or successful elopement

r. Activation of any TCMC emergency response code [Code Orange, Silver/Gray, etc.]

s. Significant theft of property or significant property damage

~~m.~~t. Any loss of TCMC utilities that would require the Security Dept. to provide traffic control and evacuations.

3. All notifications will be properly documented, in detail, on the Security Officer's DSR, including the time and type of contact.

~~4. Once the Security Manager, Supervisor, or Shift Lead Officer has been notified they will make the proper notifications to any appropriate Administrative or Medical Center personnel.~~

D. **RELATED DOCUMENTS:**

1. Administrative Policy #234: Security Department Incident Notification

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

ISSUE DATE: 03/91 **SUBJECT: Use of Force**

REVIEW DATE: 01/94, 11/96, 12/01, 05/03, 11/06, 03/09, 06/11, 05/13 **POLICY NUMBER: 209**

REVISION DATE: 01/94, 12/01, 07/03, 07/09, 11/20

Department Approval:	**~~05/20~~04/23**
Environmental Health and Safety Committee Approval:	**~~08/20~~05/23**
Administration Approval:	**~~10/20~~09/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**11/20**

A. **PURPOSE:**

1. To establish guidelines as to when and how much physical force is to be utilized by Tri-City Healthcare District Security Officers in the performance of specific duties.

B. **POLICY:**

1. It is the policy of the Tri-City Medical Center Security Department that all Security Officers will utilize a standard and systematic policy for the use of force and have been trained in Non-Violent Crisis Intervention [N~~.~~V~~.~~C~~.~~I~~.~~]. All use of physical force will consist of reasonable force or that force necessary to protect themselves and others from harm while accomplishing a lawful purpose and within the parameters of Non-Violent Crisis Intervention training.

C. **PROCEDURE:**

1. While the following guidelines generally apply, a Security Officer may use only physical force which is reasonable and necessary as well as physical force which would temporarily neutralize an imminent physical threat in order to protect themselves, staff, visitors, and patients from harm while accompanying a lawful purpose
2. Use of force shall be used **by** ~~at~~ the officer~~'s discretion~~ **in the 3 scenarios that follow:**~~.~~
   a. To defend ~~him/herself~~ **themselves** or others **from imminent physical harm**
   b. To effect an arrest for a violation of a serious felony/crime~~.~~
   c. To assist in the patient's care plan as per the specific instruction provided by authorized medical **staff member and workforce-**staff members
3. The use of physical force shall be restricted:~~.~~
   a. To circumstances authorized by law~~.~~
   b. To the level necessary to accomplish a lawful security task~~.~~**[instructional order from medical staff member or workforce-staff member]**
   c. To the training of N.V.C.I. practices
4. Examples of force options consist of the following but are not limited to:
   a. Verbal contact and intervention [first], situational proximity i.e. standing in the way / using your body as a deterrent [second], and then physical strength / N.V.C.I. application techniques [last].
5. The Security Officer shall only choose the available force option that is reasonable and necessary to effectively control the situation.
6. Improper use of force includes but is not limited to bodily-slams, limb manipulation or pressure-point applications, restriction of airway / asphyxiation, and the choke-hold maneuver.

a. The use of improper force occurs when the type or degree of force employed was excessive, unnecessary, or unreasonable regardless of a sustained or reported injury.
b. The use of improper force by any member of the Security Department will not be tolerated and will be subject to disciplinary action up to termination.

7. The reporting procedure for Use of Force will be as follows and shall be properly followed.
   a. When a Security Officer has utilized any force option(s), all Officers present shall report such use in ~~-~~their daily security report.
   b. In an arrest situation, the arresting Security Officer shall within the ~~crime~~ report articulate those facts which let ~~him/her~~ **them** to believe that a particular force option was reasonable and necessary.
   c. In all other situations when a particular level of force has been utilized against an individual, the involved Security Officer(s) shall report it on the approved report detailing the specific circumstances of the incident [i.e. why physical force was used, what specific physical force technique was used, who provided an instructional order for the patient's care plan, physical description of the individual force was used against, and any reported injury or discrepancy with the use of force by a security officer].
   d. All Security Officer(s) witnessing the use of force by anyone on the Tri-City Medical Center campus shall document the use of force in ~~-~~their daily security report.
8. For reporting purposes, the following are considered ~~s~~use of force.
   a. Any force where physical contact is made with another person and / or physical force resulting in injury to the security officer or subject.
9. While physical force is approved for security officers, physically assisting with a patient needs an instructional order asked by the security officer and directly provided from the authorized medical **staff member or workforce-**staff member involved with the patient's care plan [e.g. Doctor, Nurse, Psychiatric Liaison, or Administrator].
   a. An instructional order is asked for when a security officer identifies a safety risk [i.e. patient elopement attempt, combative / violent behavior, self-harm, or a reasonable assumption that harm might occur when high-risk behavior is observed].
   b. An instructional order is provided by the appropriate medical staff member; the order / directions are for the patient's care plan. Security officers are not medical trained or certified and cannot make patient care plan decisions.
   c. Once the safety issue is determined or presumed, the security officer will intervene and act on the medical staff's behalf for safety reasons but will act within the parameters of this use of force policy as well as ~~N-V-C-I-~~ techniques. The security officer's actions are their own, and liability is still theirs even with an instructional order.
   d. Examples of instructional orders are but not limited to: seeking authorization to physical intervene / stop the patient or stand in their way if a patient attempts to elope whether on a psychiatric or medical hold or if a patient attempts harm to self or others.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE ~~CENTER~~
& HYPERBARIC MEDICINE~~CLINIC~~

ISSUE DATE: **06/07** **SUBJECT: Bomb Threat**

REVISION DATE~~(S)~~: 12/10, 04/20

Department Approval:	**~~02/20~~04/23**
Environmental Health and Safety Committee Approval:	**05/23**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administrative Approval	**~~04/20~~09/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**04/20**

A. **PURPOSE:**
1. To establish procedure guidelines in the event of a bomb threat emergency.

B. **POLICY:**
1. In the event the Center has been placed on alert for a threat of a bomb, the personnel will follow hospital emergency shutdown procedures.

C. **PROCEDURE:**
1. Guidelines for patient evacuation to the determined safe location will be followed.
2. If a hyperbaric treatment is underway, prompt and safe termination of the dive will be conducted. The chamber personnel will:
   a. Decompress the patient at a normal travel rate. If danger is imminent, the decompression rate may be increased to the maximum travel rate of 60 fpm (1 foot per second).
   b. Calm and reassure all patients
   c. Remove the patient from the chamber and prepare for transport
   d. Shut down system as applicable and assist with patient transport and support as required
   e. Turn off and unplug all electrical equipment. Shut down system as necessary for safe departure
   f. Evacuate the patients following the emergency evacuation route specified for the department
   g. When appropriate, make contact with the hospital command post to give all names of patients and personnel assigned for a "head count"

D. **RELATED DOCUMENT(S):**
~~g.~~1. **Emergency Operation Procedures: Bomb Threat**

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE ~~CENTER~~
& HYPERBARIC MEDICINE~~CLINIC~~

ISSUE DATE: 06/07 **SUBJECT: Earthquake**

REVISION DATE~~(S)~~: 12/10, 04/20

Department Approval:	**~~02/20~~04/23**
Environmental Health and Safety Committee Approval:	**05/23**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administrative Approval	**~~04/20~~09/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**04/20**

A. **PURPOSE**

1. To establish procedure guidelines in the event of an earthquake.

B. **PROCEDURE**

1. Decompress the patients at a normal travel rate. If danger is imminent, the decompression rate may be increased to the maximum travel rate of 60 fpm (1 foot per second).
2. Calm and reassure all patients.
3. Remove the patient from the chamber and prepare for transport.
4. Shut down system as applicable and assist with patient transport and support as required.
5. Turn off and unplug all electrical equipment.
6. Shut down system as necessary for safe departure.
7. Evacuate the patients following the emergency evacuation route specified for the department.
8. When appropriate, contact the hospital command post to give all names of patients and personnel assigned for a "head count".

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

August 31, 2023 – 2:30 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 2:30 p.m. on August 31, 2023.

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

Director Rocky J. Chavez
Director Nina Chaya, M.D.
Director George W. Coulter
Director Gigi Gleason
Director Marvin Mizell
Director Adela Sanchez
Director Tracy M. Younger

Also present were:

Dr. Gene Ma, CEO
Susan Bond, General Counsel
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant

1. The Board Chairperson, Director Younger, called the meeting to order at 2:30 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 Younger made an oral announcement of the items listed on the August 31, 2023 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one matter of Existing Litigation, Conference with Labor Negotiators and Reports Involving Trade Secrets with a disclosure date TBD.

4. Motion to go into Closed Session

   It was moved by Director Gleason and seconded by Director Coulter to go into Closed Session at 2:35 p.m. The motion passed unanimously (7-0).

5. At 3:20 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 conferred with legal counsel regarding the Pruitt litigation and directed counsel to take appropriate action.

   The Board also conferred with the District's Labor Negotiator and took no action.

The Board also discussed a Report Involving Trade Secrets and took no action.

7. Adjournment

Chairperson Younger adjourned the meeting at 3:25 p.m.

_____
Tracy M. Younger
Chairperson

ATTEST:

_____
Gigi Gleason
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
August 31, 2023 – 3:30 o'clock p.m.

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held at 3:30 p.m. on August 31, 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 Gigi Gleason
Director George W. Coulter
Director Marvin Mizell
Director Adela Sanchez
Director Tracy M. Younger

Also present were:

Gene Ma, M.D., Chief Executive Officer
Ray Rivas, Chief Financial Officer
Roger Cortez, Chief Compliance Officer
Dr. Henry Showah, Chief of Staff
Jeffrey Scott, Board Counsel
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant

1. The Board Chairperson, Tracy Younger called the meeting to order at 3:30 p.m. with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Gleason to approve the agenda as presented. Director Coulter seconded the motion. The motion passed unanimously (7-0).

3. Pledge of Allegiance

   Director Chaya led the Pledge of Allegiance.

4. Public Comments – Announcement

   Chairperson Younger read the Public Comments section listed on the August 31, 2023 Regular Board of Directors Meeting Agenda. She asked that members of the public wishing to speak submit a speaker card at this time.

5. Reports – Opioid Stewardship

   Ellen Langenfeld, Director of Pharmacy introduced Clinical Physician Champion, Dr. Ole Snyder for the Opioid Stewardship Program and Substance Use Navigator Cecilia Velazquez. Dr. Snyder gave a passionate presentation on the opioid crisis and what Tri-City is doing to help those who present to the Emergency Department

due to an overdose. He provided information on a new drug, Tranq Dope which is an animal sedative mixed with fentanyl that brings fresh horror to U.S. drug zones. Dr. Snyder explained the Opioid Stewardship is a multidisciplinary committee who are passionate about safe prescribing, as well as working with law enforcement. He stated the first pillar in the implementation of a good stewardship program is to start treatment. Treatment works and saves lives. Through the Opioid Stewardship program, we have the opportunity in the Emergency Department to save lives when a person comes in with a nonfatal overdose, in crisis or withdrawal.

Ellen Langenfeld, Director of Pharmacy stated the CA Bridge was launched in 2018 to expand access to medication for addiction treatment through Emergency Departments as critical access points for medical intervention. Tri-City, along with many other hospitals in CA was awarded a $145,000 grant. Supplemental Funding of an additional $25,000 was also submitted on August 30, 2023. The program was designed to have access to a Substance Use Navigator in our Emergency Department. Ms. Langenfeld introduced Cecilia Velazquez, Substance Use Navigator for Tri-City.

Ms. Velazquez explained her role and how it makes a difference in patient's lives. She stated treatment in our community is crucial. She explained the implementation of Buprenorphine in the Emergency Department and in the hospital and presented a graph with an estimate of how many prescriptions have been administered for the drug at Tri-City from May through August. The information is also being given to our providers and hospitalists so education is continuing to spread, which helps save lives. Cecilia also explained how the Medical Assisted Training Clinic works in our community that includes a 10-day detox program. In closing, Ms. Velazquez stated today is Overdose Awareness Day and the team wore purple to commemorate those who we have lost and those who continue fighting.

Chairperson Younger thanked Dr. Snyder, Cecilia Velazquez and Ellen Langenfeld for their great work.

6. July, 2023 Financial Statements – Ray Rivas, Chief Financial Officer

Mr. Rivas, Chief Financial Officer reported on the current month/fiscal year to date financials as follows (Dollars in Thousands):

- Net Operating Revenue – $25,410
- Operating Expense – $29,701
- EBITDA – ($2,442)
- EROE – ($3,585)

Mr. Rivas also reported on the current month/ fiscal year to date Key Indicators as follows:

- Average Daily Census – 122
- Adjusted Patient Days – 7,512
- Surgery Cases – 418
- ED Visits – 4,387

7. New Business –

Consideration to approve the Risk Management Plan 2023

Susan Bond, General Counsel introduced Heidi Benson, Clinical Quality Manager. Ms. Bond explained that Heidi currently oversees Risk Management, however going forward Risk has been transferred to the legal department.

Ms. Benson stated she is requesting board approval of the Risk Management Plan for 2023 that was included in today's agenda packet and explained in detail.

It was moved by Director Gleason to approve the Risk Management Plan for 2023. 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**

8. Old Business –

Consideration to approve Resolution No. 824, A Resolution of Tri-City Healthcare District Authorizing Execution and Delivery of a Promissory Note, Loan and Security Agreement, and Certain Actions in Connection Therewith for a Loan Under the Distressed Hospital Loan Program

As was discussed at last month's meeting, Dr. Ma stated the district submitted an application under the Distressed Hospital Loan Program. As a result, Tri-City was awarded the largest sum of all hospitals, short of Madera being able to reopen. In order to accept the award, a Resolution is needed on behalf of the Board authorizing execution of the note.

Director Chavez asked questions regarding the terms of the loan and payment which were addressed by Dr. Ma and Board Counsel, Jeff Scott.

It was moved by Director Chavez to approve Resolution No. 824, A Resolution of Tri-City Healthcare District Authorizing Execution and Delivery of a Promissory Note, Loan and Security Agreement, and Certain Actions in Connection Therewith for a Loan Under the Distressed Hospital Loan Program. Director Gleason 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**

9. Chief of Staff –

a) Consideration of August 2023 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on August 21, 2023.

Dr. Henry Showah, Chief of Staff presented the August 2023 Credentialing Actions and Reappointments Involving the Medical Staff. No concerns or "red flags" were raised by the Credentials Committee.

It was moved by Director Chaya to approve the August 2023 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on August 28, 2023. Director Gleason 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

Director Chavez pulled item (8) Approval of a consulting agreement with Robert E. Hertzka, M.D. for Governmental Affairs for a term of 12 months, beginning September 1, 2023 and ending August 31, 2024, for an annual and term cost of $120,000. Director Mizell seconded the motion.

It was moved by Director Chaya to approve the Consent Calendar minus the item pulled. 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

Director Chavez who pulled the consulting agreement with Robert Hertzka, M.D. had a series of questions which Dr. Ma responded to. Director Chaya also provided clarification. In essence, the agreement with Dr. Hertzka will provide a more aggressive approach in advocacy for the district and put Tri-City front and center. Dr. Ma stated the right messaging is crucial to many of our initiatives in order for the district to move forward.

Director Sanchez commented that the agreement also went through the Finance, Operations & Planning Committee and committee members were supportive.

Hearing no further discussion:

It was moved by Director Mizell to approve the consulting agreement with Robert E. Hertzka, M.D. for Governmental Affairs for a term of 12 months, beginning September 1, 2023 and ending August 31, 2024, for an annual and term cost of $120,000. Director Chaya seconded the motion.

The vote on the motion was as follows:

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

12. Comments by Members of the Public

Chairperson Younger recognized Linda Slater, an 18-year resident of the City of Oceanside and past President of DEMCCO. Linda commented on transparency and encouraged administration to be out in the public as much as possible and help the public understand what is going on at the hospital. She expressed her appreciation to Director Sanchez who agreed to speak at an upcoming DEMCCO meeting. Lastly, Ms. Slater stated she would like information on the status of the retrofit that is required by 2030.

13. Comments by Chief Executive Officer

Dr. Ma stated in the spirit of trying to be as transparent and as communicative as possible, we have ramped up many of our communications. In addition to the Heart of Tri-City (HOTC) weekly communication to staff we have created a new Heart of Tri-City (HOTC) for our Medical Staff. Dr. Ma stated he would be happy to come and speak to organizations, clubs and groups at any time. He stated our financial numbers are moving in the right direction and our focus is about delivering good care and our future. Dr. Ma stated good things are happening and he appreciates everyone's hard work.

14. Board Communications

Director Younger wished everyone a safe Labor Day weekend filled with gratitude for our workers, especially our healthcare workers.

15. Adjournment

There being no further business, Chairperson Younger adjourned the meeting at 3:55. p.m.

_____
Tracy M. Younger, Chairperson

ATTEST:

_____
Gigi Gleason, Secretary

Tri-City Medical Center

ADVANCED HEALTH

Financial Information

TCMC Days in Accounts Receivable (A/R)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY24	69.7	72.7											71.2	48 52
FY23	74.3	72.0	67.7	69.8	71.5	71.0	71.3	72.7	70.6	74.6	71.6		73.2	

TCMC Days in Accounts Payable (A/P)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY24	140 9	153 4											147.1	7% :00
FY23	105.3	105.6	106.4	115.2	119.0	128.8	142.0	153.6	168.0	158.4	144 5		105.5	

TCHD EROE $ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY24	($3,585)	($3,847)											($7,431)	($7,097)
FY23	($1,651)	($1,599)	($2,185)	($1,358)	($1,812)	($2,028)	($532)	($1,051)	($2,982)	($6,274)	($3,739)		($3,250)	

TCHD EROE % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY24	-14.11%	-15.18%											-14.64%	-13.44%
FY23	-5.96%	-5.83%	-8.19%	-4.89%	-6 83%	-7 33%	1.83%	-3 94%	-10.69%	-25 56%	-13.62%		-5.90%	

Tri-City Medical Center

ADVANCED HEALTHCARE FOR YOU

Financial Information

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

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY24	($2,442)	($2,708)											($5,150)	($4,705)
FY23	($686)	($205)	($987)	($175)	($594)	($781)	$605	$75	($1,648)	($5,086)	($2,549)		($891)	

TCHD EBITDA % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY24	-9.61%	-10.69%											-10.15%	-8.91%
FY23	-2.48%	-0.75%	-3.70%	-0.63%	-2.24%	-2.82%	2.08%	0.28%	-5.90%	-20.72%	-9.28%		-1.62%	

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

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY24	6.12	6.88											6.50	7.18
FY23	6.53	5.91	5.93	6.48	7.13	7.14	6.35	5.96	6.12	6.30	7.10		6.21	

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

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY24	$18.3	$11.6										
FY23	$43.9	$38.1	$29.6	$25.3	$20.7	$22.5	$25.4	$11.4	$6.9	$27.7	$23.8	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending August 31, 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)	53,103.84	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)	40,518.61	07/01/17	08/31/24	**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)	20,594.69	07/01/20	06/30/25	**PCP Clinic Vista** 1926 Via Centre Drive, Ste A Vista, CA 92081	7090
SoCAL Heart Property LLC 1958 Via Centre Drive Vista, Ca 92081 **V#84195**	Approx 4,995	$2.50	(a)	14,910.73	10/01/22	06/30/27	**OSNC - Vista** 1958 Via Centre Drive Vista, Ca 92081	7095
BELLA TIERRA INVESTMENTS, LLC 841 Prudential Dr, Suite 200 Jacksonville, FL 32207 V#84264	Approx 2,460	$2.21	(a)	7,158.60	04/01/23	03/31/25	**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)	16,351.60	05/14/21	10/31/31	**Seaside Medical Group** 115 N EL Camino Real, Suite A Oceanside, CA 92058	7094
Nextmed III Owner LLC 6125 Paseo Del Norte, Suite 210 Carlsbad, CA 92011 V#83774	Approx 4,553	$4.00	(a)	23,811.92	09/01/21	08/31/33	**PCP Clinic Calrsbad** 6185 Paseo Del Norte, Suite 100 Carlsbad, CA 92011	7090
500 W Vista Way, LLC & HFT Melrose P O Box 2522 La Jolla, CA 92038 V#81028	Approx 7,374	$1.67	(a)	12,812.09	07/01/21	06/30/26	**Outpatient Behavioral Health** 510 West Vista Way Vista, Ca 92083	7320
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 #V81250	Approx 7,000	$4.12	(a)	31,770.00	10/01/22	09/30/25	**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)	14,880.52	06/01/21	05/31/26	**OSNC Encinitas Medical Center** 351 Santa Fe Drive, Suite 351 Encinitas, CA 92023	7095
BELLA TIERRA INVESTMENTS, LLC 841 Prudential Dr, Suite 200 Jacksonville, FL 32207 V#84264	Approx 3,262	$2.21	(a)	9,492.42	05/01/23	06/30/25	**Pulmonary Specialists of NC** 3907 Waring Road, Suite 2 Oceanside, CA 92056	7088
Total				**245,405.02**				

(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 August 2023

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
8740	BRAIN HEALTH	81123 EDU	110.00	83331	GAVIN, PATRICIA R

**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.