TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
February 29, 2024 – 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	Foundation Report, Jennifer Paroly, Foundation President	10 min.	CEO
6	January 2024 Financial Statement Results	10 min.	CFO
7	New Business – None		
8	Old Business – a) Affiliation Update – Information Only	5 min.	CEO
9	Chief of Staff - a) Consideration of February 2024 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on February 26, 2024.	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 Tri-City Healthcare District regarding any item on this Agenda is available for public inspection in the Administration Departme 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 an agreement with Werfen USA, LLC for Blood Gas Testing Instrumentation, Consumables, Instrument Service Software, and Software Service for a term of 60 months, beginning February 1, 2024 and ending January 31, 2029, for an annual cost of $151,387.20 and a total cost for the term of $756.936. 2. Approval of an agreement with Sysmex for Hematology Equipment, Service and Consumables for a term of 60 months, beginning March 1, 2024 and ending February 28, 2029 for an annual cost of $155,520 and a total cost for the term of $777,600. 3. Approval of an agreement with the San Diego Blood Bank for blood products for a term of 12 months, beginning March 1, 2024, and ending February 28, 2025 for a total term cost of $1,468,740. (2) **Administrative Policies & Procedures** **A. Patient Care Services** 1. Admission Criteria Policy 2. Assault Victims/Domestic Violence, Reporting Requirements 3. Critical Results and Critical Tests – Diagnostic 4. Perinatal Death (Miscarriage, Stillbirth and Neonatal Death Care and Disposition **B. Administrative** 1. Email Access 604 2. EMTALA Emergency Medical Screening (QAPI) 3. Parking Program 261 4. Quality Assessment Performance Improvement Plan (QAPI) **C. Allied Health Professional** 1. Oncology Standardized Procedure **D. Cardiac Rehab** 1. Patient Discharge Criteria 2. Scope of Practice **E. Engineering** 1. Utility Management Plan 4003 **F. Environment of Care** 1. Emergency Management Plan 2. Safety Management Plan **G. Medical Staff** 1. Medical Staff Funds & Medical Staff Representation by Legal Counsel 8710-572 2. Professional Behavior Policy & Committee 8710-570	10 min.	

	Agenda Item	Time Allotted	Requestor
	H. Supply Chain 1. Value Link Audit Procedures **I. Manuals to be Retires (Services Suspended)** 1. Home Care Table of Contents 2. NICU Table of Contents 3. Women & Newborn Services Table of Contents (3) Minutes a) Special Meeting – January 25, 2024 b) Regular Meeting – January 25, 2024 (4) Reports – (Discussion by exception only) a) Building Lease Report – (January, 2024) b) Reimbursement Disclosure Report – (January, 2024)		
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	18 min.	Standard
15	Total Time Budgeted for Open Session	1.25 hour	
16	Adjournment		

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
February 14, 2024

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 03/01/2024 – 02/28/2026)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 03/01/2024 through 02/28/2026, 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:

- **ANAND, Neil, MD/Teleradiology/Active Affiliate**
- **BAROUDI, Sam, MD/Internal Medicine/Active**
- **BLOOM, Irving, MD/Internal Medicine/Active**
- **DEVEREAUX, Christopher, MD/Gastroenterology/Active**
- **GOMEZ, Denise, MD/Internal Medicine/Refer and Follow**
- **GOODING, Justin, MD/Interventional Radiology/Active**
- **HANNA, Karen, MD/General Surgery/Active**
- **PINNELL, Sean, MD/Diagnostic Radiology/Active**
- **PONEC, Donald, MD/Interventional Radiology/Active**
- **TRAN, Quoc, MD/Family Medicine/Refer and Follow**
- **YUH, Theresa, MD/Teleradiology/Active Affiliate**

UPDATE TO NOVEMBER REAPPOINTMENT:

- **PEREIRA, Isabel, MD/Internal Medicine**

UPDATE TO JANUARY REAPPOINTMENT:

- **MOUSSAVIAN, Mehran, DO/Cardiology**

RESIGNATIONS: (Effective date 02/29/2024 unless otherwise noted)

Automatic:

- **IIBRIL, Deanah, DO/Obstetrics & Gynecology**

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- LEONARD, Lisa, MD/Obstetrics & Gynecology
- QUAN, Maria, MD/Obstetrics & Gynecology

Voluntary:

- BISHAY, Emad, MD/Internal Medicine
- CADMAN, Karen, MD/Internal Medicine
- CAMBRIDGE, Christine, MD/Obstetrics & Gynecology
- FERNANDEZ, Janice, MD/Anesthesiology
- FLINN, Anna, DO/Obstetrics & Gynecology
- HARIPOTEPORNKUL, Nora, MD/Obstetrics & Gynecology
- KARANIKKIS, Christos, DO/Obstetrics & Gynecology
- KLARISTENFELD, Daniel, MD/General Surgery
- LINGENFELTER, David, MD/Obstetrics & Gynecology
- MACHALA, Sasa, MD/Pulmonary
- MORNEAU, Leonard, MD/Obstetrics & Gynecology
- MEGALI, Nicole, PA/Allied Health Professional
- MOON, Nah, MD/Obstetrics & Gynecology
- NGUYEN, Tan, MD/Diagnostic Radiology
- PAAS, John, MD/Obstetrics & Gynecology
- PENDLETON, Robert, MD/Ophthalmology
- SIMPSON, Jessica, MD/Obstetrics & Gynecology
- TAO, Amy, MD/Obstetrics & Gynecology
- TARIQ, Musaddiq, MD/Telepsychiatry
- TOLEN, Jennifer, MD/Obstetrics & Gynecology

Attachment B

- **VORA, Maulin, MD/Anesthesiology**
- **WENGER, Scott, DO/General Surgery**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
February 14, 2024

PROCTORING RECOMMENDATIONS

- **BATASIN, Ma Lovely, DO**
  Release from Proctoring: **Emergency**
  General Patient Care

- **CAVIN, Lillian, MD**
  Release from Proctoring: **Tele-Radiology**
  Teleradiology (Ultrasound, Magnetic Resonance Imaging, General nuclear medicine & Computed tomography).

- **FAIQ, Nadia, MD**
  Release from Proctoring: **Emergency**
  Moderate and Deep Sedation

- **FRIEDMAN, Sydney, MD**
  Release from Proctoring: **Tele-Radiology**
  Teleradiology (Ultrasound, Magnetic Resonance Imaging, General nuclear medicine & Computed tomography).

- **HAYS, Jonathon, MD**
  Release from Proctoring: **Tele-Radiology**
  Teleradiology (Ultrasound, Magnetic Resonance Imaging, General nuclear medicine & Computed tomography).

- **HIRASUNA, Richard, MD**
  Release from Proctoring: **Anesthesiology**
  Consultation including via telemedicine (F), Evaluate and treat patients with anesthesia related problems, perform history and physical examination, including via telemedicine (F), General Anesthesia, Regional Anesthesia and Invasive Monitoring includes: Arterial line, Central line, Midline and Pulmonary Artery catheters.

- **KUSNEZOV, Nicholas, MD**
  Release from Proctoring: **Orthopedic**
  Admit patients, Consultation, including via telemedicine (F), Perform History and Physical, including via telemedicine (F). Basic Orthopedic Privileges, Extremity-Fractures and Extremity Dislocation.

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
February 14, 2024

- **NISSIM, Lahav, MD**
  Release from Proctoring:
  Tele-Radiology
  Teleradiology (Ultrasound, Magnetic Resonance Imaging, General nuclear medicine & Computed tomography)

- **PINEDA, Melissa, MD**
  Release from Proctoring:
  Anesthesia
  Consultation including via telemedicine (F), Evaluate and treat patients with anesthesia related problems, perform history and physical examination, including via telemedicine (F), General Anesthesia, Regional Anesthesia (Epidural, Spinal and Nerve Block) Invasive Monitoring (Includes: Arterial line, Central line, Midline, and Pulmonary Artery catheters).

- **RUFFOLO, Aldo, MD**
  Release from Proctoring:
  Tele-Radiology
  Teleradiology (Ultrasound, Magnetic Resonance Imaging, General nuclear medicine & Computed tomography).

- **WRIGHT, Brenton, MD**
  Release from Proctoring:
  Neurology
  Admit patients, Consultation, including via telemedicine (F), History and Physical, including via telemedicine (F) and lumbar puncture.

- **ZAWADA, Nicole, MD**
  Release from Proctoring:
  Emergency
  Moderate and Deep Sedation.

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
February 21, 2024

Members Present	Director Tracy Younger, Director Nina Chaya, Director Adela Sanchez (*joined the meeting at 3:35 p.m.*), Dr. Mohammad Jamshidi-Nezhad, Dr. Henry Showah
Non-Voting Members Present:	Dr. Gene Ma, CEO; Janice Gurley, Interim CFO; Donald Dawkins, CNE; Roger Cortez, CCO; Jeremy Raimo, COO; Susan Bond, General Counsel
Others Present	Eva England, Gary Johnson, Tara Eagle, Miava Sullivan, Jane Dunmeyer, Miava Sullivan
Members Absent:	None

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Younger called the meeting to order at 3:02 pm.		Chair
2. Approval of Agenda		**MOTION** **It was moved by Director Chaya, and seconded by Dr. Showah to approve the agenda of February 21, 2024.** **Members:** **AYES: Younger, Chaya, Dr. Jamshidi-Nezhad, Dr. Showah** **NOES: None** **ABSTAIN: None** **ABSENT: Director Sanchez**	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

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
4. Ratification of minutes of January 16, 2024	Minutes were ratified.	**MOTION** **MOTION** **It was moved by Dr. Showah and seconded by Dr. Jamshidi-Nezhad to approve the minutes of January 16, 2024.** **Members:** **AYES: Younger, Chaya, Dr. Jamshidi-Nezhad, Dr. Showah** **NOES: None** **ABSTAIN: None** **ABSENT: Director Sanchez**	Chair
5. Old Business	None		
6. New Business	None		Chair
7. Consideration of Consent Calendar:	It had been requested by Director Younger that the following items be pulled for discussion: 7.a. Blood Gas Testing, Consumables & Service Proposal • Werfen USA, LLC. 7.b. Primary Blood Supply • San Diego Blood Bank 7.c. Hematology Equipment, Service & Consumables Sysmex America, Inc		Chair

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
a) Blood Gas Testing, Consumables & Service Proposal • Werfen USA, LLC	Discussion was held and questions answered regarding the Blood Gas Testing, Consumables & Service Proposal with Werfen USA, LLC.	**MOTION** **It was moved by Director Chaya, and seconded by Dr. Jamshidi-Nezhad to approve the agreement with the San Diego Blood Bank for Primary Blood Supply as amended to one year.** **Members:** **AYES: Younger, Chaya, Sanchez, Dr. Showah and Dr. Jamshidi-Nezhad** **NOES: None** **ABSTAIN: None** **ABSENT: None**	Eva England/Tara Eagle
b) Primary Blood Supply Proposal • San Diego Blood Bank	Discussion was held and questions answered regarding the Primary Blood Supply Proposal for the San Diego Blood Bank. The term of the agreement was changed to one year	**MOTION** **It was moved by Director Chaya, and seconded by Dr. Jamshidi-Nezhad to approve the agreement with the San Diego Blood Bank for Primary Blood Supply as amended to one year.** **Members:** **AYES: Younger, Chaya, Sanchez, Dr. Showah and Dr. Jamshidi-Nezhad** **NOES: None** **ABSTAIN: None** **ABSENT: None**	Eva England/Tara Eagle
c) Hematology Equipment, Service, & Consumables Proposal • Sysmex America, Inc.	Discussion was held and questions answered regarding the Hematology Equipment, Service & Consumables Proposal with Sysmex America, Inc.	**MOTION** **It was moved by Director Chaya, and seconded by Dr. Jamshidi-Nezhad to approve the agreement with Sysmex America, Inc. for Hematology Equipment, Service & Consumables.**	Eva England/Tara Eagle

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		Members: **AYES: Younger, Chaya,Sanchez, Dr. Showah and Dr. Jamshidi-Nezhad** **NOES: None** **ABSTAIN: None** **ABSENT: None**	
8. Financials	Janice Gurley presented the financials ending January 31, 2024 (dollars in thousands) **TCHD – Financial Summary** **Fiscal Year to Date** Operating Revenue $ 165,090 Operating Expense $ 195,540 EBITDA $ (13,769) EROE $ (25,272) **TCMC – Key Indicators** **Fiscal Year to Date** Avg. Daily Census 111 Adjusted Patient Days 46,107 Surgery Cases 2,761 ED Visits 25,637 **TCHD – Financial Summary** **Current Month** Operating Revenue $ 27,145 Operating Expense $ 27,454 EBITDA $ 2,410 EROE $ 859 **TCMC – Key Indicators** **Current Month** Avg. Daily Census 122 Adjusted Patient Days 6,874 Surgery Cases 470 ED Visits 3,618 **Graphs:** • TCMC-Average Daily Census, Total Hospital - Excluding Newborns		Janice Gurley

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	• TCMC-Emergency Department Visits • TCMC-Acute Average Length of Stay • TCMC-Adjusted Patient Days		
a. Dashboard	No discussion	Information Only	Janice Gurley
9. Comments by Committee Members	None		Chair
10. Date of next meeting	March 20, 2024		Chair
11. Adjournment	Meeting adjourned 4:00 pm		Chair

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: FEBRUARY 21, 2024
BLOOD GAS TESTING, CONSUMABLES & SERVICE PROPOSAL

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

Vendor's Name: Werfen USA, LLC

Area of Service: Laboratory Point of Care (Pulmonary)

Term of Agreement: 60 months, Beginning, February 1, 2024 – Ending, January 31, 2029

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$12,616	$151,387	**$756,936**

Description of Services/Supplies:

- This agreement replaces the current agreement with Siemens for blood gas testing. This agreement includes seven (7) GEM 5000 blood gas instruments, associated consumables, instrument service, GEM Web 500 Plus software, and software maintenance.
- The current Siemens instrumentation, operating on Windows XP, poses a security risk for the organization. As of March 31, 2024, Siemens no longer provides support for devices utilizing Windows XP. To ensure the continuity of blood gas testing services, the acquisition of new equipment is imperative.
- Pricing is Vizient Contract LB0983 Werfen Tier 3 [Annual Spend is between 100,001 to $449,999]. During the agreement term, we may subscribe to another tier through Vizient if we meet the usage criteria.
- Werfen presents several advantages over the Siemens platform. It requires fewer cartridges than Siemens for testing, thereby reducing the consumption of consumables. Werfen cartridges are stored at room temperature before use, eliminating the need for refrigerator space. Additionally, Werfen significantly decreases hands-on processing time by approximately 200 hours per year, equivalent to approximately $10,000 in savings for the respiratory team that can be re-allocated to patient care.

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

Person responsible for oversight of agreement: Tara Eagle, Assistant Director-Laboratory Services / Eva England, Sr. Director Ancillary Services

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Werfen USA, LLC for blood gas testing instrumentation, consumables, instrument service, software, and software service for a term of 60 months, beginning February 1, 2024, and ending January 31, 2029 for an annual cost of $151,387.20 and a total cost for the term of $756,936.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: FEBRUARY 21, 2024
HEMATOLOGY EQUIPMENT, SERVICE, & CONSUMABLES PROPOSAL

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

Vendor's Name: Sysmex America, Inc.

Area of Service: Laboratory (Hematology)

Term of Agreement: 60 months, Beginning, March 1, 2024 – Ending, February 28, 2029

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$12,960	$155,520	**$777,600**

Description of Services/Supplies:

- This agreement replaces the current agreement with Beckman Coulter for Hematology equipment, service, and consumables.
- In order to operationalize the cost, TCMC is taking advantage of a Vizient promotion with Sysmex that uses a "cost per reportable" model where TCMC is charged $1.704 per Complete Blood Count. The promotion includes a $58,179 discount on the total term, a $5,000 reimbursement for deionized water and a $14,500 reimbursement for an interface to Cerner.
- The installation of the instrument will enhance the current hematology workflow by consolidating two separate instruments into an automated line. This workflow introduces a third instrument, effectively streamlining the entire process. Here's the sequential order of specimen processing: the lavender blood tube is initially loaded onto the instrument line, where the first instrument performs the CBC. If the CBC meets the criteria for slide review, the instrument then transfers the lavender tube to the slide maker and stainer. Subsequently, once the slide is stained and dried, the instrument loads it for scanning on the digital microscope, facilitating the scientist's review.

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

Person responsible for oversight of agreement: Tara Eagle, Assistant Director-Laboratory Services / Eva England, Sr. Director Ancillary Services

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Sysmex for Hematology Equipment, Service, and Consumables for a term of 60 months, beginning March 1, 2024 and ending February 28, 2029 for an annual cost of $155,520 and a total cost for the term of $777,600.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: FEBRUARY 21, 2024
PRIMARY BLOOD SUPPLY PROPOSAL

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

Vendor's Name: San Diego Blood Bank (SDBB)

Area of Service: Laboratory

Term of Agreement: 12 months, Beginning, March 1, 2024 – Ending, February 28, 2025

Maximum Totals:

	Monthly Cost	Annual / Total Term Cost
	$122,395	$1,514,165
3% Savings for On Time Payment	($3,786)	($45,425)
	$118,609	**$1,468,740**

Description of Services/Supplies:

- This agreement is to renew our long-standing partnership with San Diego Blood Bank (SDBB) as our primary blood supplier. The agreement is to purchase 95% of blood products from SDBB. This agreement is for 1 year.
- There is a 6% increase from previous spend. This increase is attributed to additional cost in operations and new requirements for product testing prior to transfusion. However, we get 3% rebate if we pay SDBB invoices on-time.
- Benefit Highlight #1: SDBB is closest to us; which means if we need a STAT delivery for a special product or a complicated patient work up, we get quick service.
    - *SDBB* is 40mi away vs. *LifeStream* is in San Bernardino, 96mi away vs. *American Red Cross* is in Pomona, 80mi away
- Benefit Highlight #2: SDBB includes the antigen history of the donor for free. LifeStream and American Red Cross charge for this service. This saves TCMC $30–$50K per year in consumables, demonstrates SDBB's long-standing commitment and partnership to TCMC, and improves patient safety by shortening the process for finding units for patients that are known to produce clinically-significant antibodies.

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

Person responsible for oversight of agreement: Tara Eagle, Assistant Director-Laboratory Services / Eva England, Sr. Director Ancillary Services

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the agreement with San Diego Blood Bank for blood products for a term of 12 months, beginning March 1, 2024 and ending February 28, 2025 for an annual cost of $1,468,740 and a total cost for the term of $1,468,740.

Tri-City Medical Center

ADMINISTRATION CONSENT AGENDA
February 20th, 2024

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services		
1. Admission Criteria Policy	3 year review, practice change	Forward to BOD for Approval
2. Assault Victims/Domestic Violence, Reporting Requirements	3 year review	Forward to BOD for Approval
3. Critical Results and Critical Tests - Diagnostic Procedures	3 year review, practice change	Forward to BOD for Approval
4. Perinatal Death (Miscarriage, Stillbirth and Neonatal Death Care and Disposition)	Practice change	Forward to BOD for Approval
Administrative		
1. Conditions of Admission Form Delivery	NEW	Forward to BOD for Approval
2. Email Access 604	3 year review, practice change	Forward to BOD for Approval
3. EMTALA Emergency Medical Screening 506	3 year review, practice change	Forward to BOD for Approval
4. Parking Program 261	3 year review, practice change	Forward to BOD for Approval
5. Quality Assessment Performance Improvement (QAPI) Plan	1 year review, practice change	Forward to BOD for Approval
Allied Health Professional		
1. Oncology Standardized Procedure	2 year review	Forward to BOD for Approval
Cardiac Rehab		
1. Patient Discharge Criteria	3 year review, practice change	Forward to BOD for Approval
2. Scope of Practice	3 year review, practice change	Forward to BOD for Approval
Engineering		
1. Utility Management Plan 4003	1 year review	Forward to BOD for Approval
Environment of Care		
1. Emergency Management Plan	1 year review	Forward to BOD for Approval
2. Safety Management Plan	1 year review	Forward to BOD for Approval
Medical Staff		
1. Medical Staff Funds & Medical Staff Representation by Legal Counsel 8710-572	3 year review	Forward to BOD for Approval
2. Professional Behavior Policy & Committee 8710-570	3 year review, practice change	Forward to BOD for Approval

Tri-City Medical Center

ADMINISTRATION CONSENT AGENDA
February 20th, 2024
CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
Supply Chain		
1. Value Link Audit Procedures	Practice change	Forward to BOD for Approval
Manuals to be Retired (Services Suspended)		
1. Home Care Table of Contents	RETIRE	Forward to BOD for Approval
2. NICU Table of Contents	RETIRE	Forward to BOD for Approval
3. Women & Newborn Services Table of Contents	RETIRE	Forward to BOD for Approval

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 03/02

SUBJECT: Admission Criteria

REVISION DATE(~~S~~): 10/02; 06/03, 05/05, 12/05, 05/09, 02/12, 08/12, 01/15, 04/17, 08/18, 05/20

Patient Care Services Content Expert Approval:	~~12/19~~02/23
Clinical Policies & Procedures Committee Approval:	~~01/20~~05/23
Nursinge Leadership~~Executive Council~~ Approval:	~~04/20~~06/23
Medical Staff Department/Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~04/20~~09/23
Administration Approval:	~~05/20~~02/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. **PURPOSE:**

1. To provide guidelines for the medical staff, nursing personnel, ancillary disciplines, and admitting personnel to ensure:
   a. A consistent process for admission of patients
   b. An appropriate level of care is based on patient's needs/situation

B. **POLICY:**

1. Admission Requirements:
   a. Hospital admission requires a physician's order.
   b. Patients may be admitted to inpatient or observation status per current InterQual guidelines.
      i. Patients must be 18 years of age or older to be admitted to all units except Labor and Delivery or Neonatal Intensive Care Units.
         1) Refer to Women and Newborn Services Neonatal Intensive Care Unit (NICU) Policy: Admission and Discharge Criteria for the NICU regarding infants up to adjusted 44 week post conceptual age
   c. The attending physician shall be designated by the admitting physician at the time of patient admission.
      ~~c.~~i. **Patients admitted to the Intensive Care Unit (ICU): The on call Intensivist will be assigned to the patient and will collaborate with the admitting physician.**
   d. The Administrative Supervisor (AS)/Nursing Leadership or designee assigns a bed based upon patient diagnosis, acuity, age, bed availability and physician request.
   e. Additional considerations:
      i. The decision to admit a patient continues to be the responsibility of the treating physician.
         1) If cases arise where the circumstances would pose a hazard to the patient's health and/or safety and the appropriate setting is in question, then the case shall be referred for secondary review per chain of command.

ii. Each unit may have limitations of ability to care for certain types of patients in terms of physical layout, environment, equipment, staff expertise, availability, or patient acuity.

iii. Temporary staffing adjustments shall be made for those patients whose acuity level exceeds established guidelines.

~~1)~~ If patient admission requirements exceed hospital bed and/or staffing capacity, the AS collaborates with the Nursing Leadership or designee, **on the appropriate bed placement.** ~~then forwards the request to hold admissions to the Clinical Operations On Call if deemed necessary.~~

iv. Bed placement for those with specific gender identity or sexual orientation needs will be assigned on a case by case basis to ensure the patient's comfort and care needs are met during their admission.

f. Admission of patients to the nursing units may occur by any of the following methods:

i. Direct Admissions:

1) Patients may come directly from a physician's office, their home, a long-term care facility or outpatient department as ordered by a physician.

2) The physician or designee calls the AS for a bed assignment per Patient Care Services (PCS) Policy Transferring and Receiving Patients from Outside Tri-City Medical Center (TCMC).

3) The AS **send the information to admitting to facilitate the registration process.** ~~shall conduct a telephone triage on the patient to assess status~~. Admission orders are required for each patient. The Registered Nurse will call the admitting physician for orders once the patient arrives to the nursing unit. Orders **are** ~~may also be faxed to Registration Department at 760-940-4016, and~~ entered electronically **into the medical record.** ~~or sent with the patient.~~

4) The AS assigns the patient to the appropriate unit and informs the Nursing Leader or designee.

5) Ambulatory patients report to the Registration Department between the hours of 0500-1800 and **after hours, the patient care be directed straight the admitting unit.** ~~to the Emergency Department between the hours of 1800-0500.~~

6) The Registrar notifies the unit that the patient has arrived. Patients admitted via Registration may be escorted to the nursing unit by the office staff or ~~volunteer~~ **other** personnel.

7) Patients unable to complete the registration process in one of the registration areas due to severity of illness or discomfort shall be escorted directly to the nursing unit. ~~These patients shall be registered at the bedside by a registrar or by a family member/conservator/designee in the registration office.~~

~~8) Patients experiencing acute symptoms shall be triaged in the Emergency Department (ED) prior to being escorted by clinical staff to the respective nursing units.~~

9) If an inpatient bed is unavailable, **the physician will determine** if the patient **will:** ~~may be:~~

a) **Be A**~~a~~dmitted to the ED for evaluation and treatment.

b) ~~Requested to r~~**R**emain in physician's office until bed available.

c) ~~Requested to r~~**R**emain home until bed available.

ii. Admissions to Acute Rehabilitation:

1) When a physician orders an inpatient be evaluated for admission to **the** Acute Rehab **Unit (ARU)**, the ~~Rehab~~ **ARU** Coordinator will determine if the patient meets the admission criteria.

2) Once approval is obtained, the patient must be discharged from the inpatient unit and admitted as a direct admit to ~~Rehab~~ **ARU** with a new financial **information**~~account~~ number (FIN#) when a bed is available.
   a) The inpatient unit secretary **or designee** will request a ~~Rehab~~ **ARU** bed in Aionex
   b) The RN will complete the Depart process including all required documentation.
   c) A Cerner communication notice will be sent to Registration upon transfer.
      i) Registration will create the new ~~financial identification number (~~FIN#~~)~~.

iii. Emergency Admission:
   1) ED admission to an inpatient unit:
      a) After a physician determines that an Emergency Department patient will be admitted, the ED unit secretary will enter the bed request into Aionex, AS/Nursing Leader or designee will assign the bed in Aionex, and inputs the bed number into FirstNet.

iv. Transfer Admission:
   1) The AS shall arrange patient transfers from another in-house patient care unit or outside facility.

v. Surgical Admission:
   1) Surgery patients are pre-scheduled through Surgery Scheduling.
   2) Surgery Scheduling schedules the appointment for Pre-Operative Education.
   3) Surgery Scheduling generates a computerized list of pre-scheduled surgical admissions and forwards the list to the AS **and designees**.
   4) The AS **or designee** assigns the bed and notifies the nursing unit.

vi. Outpatient Admissions:
   1) Registration processes all outpatient admissions.

vii. Boarders:
   1) WNS - Boarders are newborn infants admitted after delivery and not discharged with their mother. Boarders may be admitted to the newborn nursery or NICU based on infant status.
   2) ED – Boarders are patients with admission orders greater than four (4) hours after a bed has been requested for **the admission.**~~inpatient admission or observation.~~

viii. The following departments coordinate admissions to their unit(s), see department specific admission criteria:
   1) Neonatal Intensive Care Unit (NICU),
   2) Acute Rehabilitation Unit (ARU or Rehab)
   3) Women and Newborn Services
   4) Progressive Care Unit (PCU)

2. Unit Specific Criteria:
   a. Intensive Care Unit (ICU) (1 East, 1 West):
      i. This level is appropriate to use when the patient has an acute cardiac, medical, surgical, or trauma event, along with any of the following:
         1) Invasive hemodynamic monitoring
         2) Urgent temporary pacemaker insertion
         3) Urgent cardioversion
         4) Intra-aortic Balloon pump (IABP) **or Impella Device**
         5) Continuous cardiac monitoring
         6) Acute intubation and mechanical ventilation management
         7) **Medical emergencies**~~Sepsis~~
         8) Therapeutic Hypothermia- **Targeted Temperature Management**

9) Cardiovascular Surgery
10) Advanced Hemodynamic monitoring
11) Organ Donor
~~11)~~**12) Neurosurgical interventions**

ii. The following patients shall not be managed on this unit due to the lack of available resources:
1) Undergoing organ transplants
2) Requiring specialized burn treatments
3) Under the age of 18 except for post-partum patients

b. Telemetry (2 East, 2 West, 4 East, 4 West, 3 East):
i. This level is appropriate to use when the patient is hemodynamically stable along with any of the following. InterQual criteria will be utilized to meet the level of care required for the available cardiac monitored beds.
1) **Medical conditions requiring c**~~C~~ontinuous cardiac monitoring
2) Continued mechanical ventilation with stable ABG's and extended ventilator weaning
3) Stable temporary pacemaker insertion or transcutaneous pacing
4) See Telemetry Policy: Admission and Discharge Criteria

c. Progressive Care Unit (3 North, 3 South)
i. This is a secured unit that provides various services to patients age 18 and above demonstrating aberrant behavior requiring 24 hour supervision concurrently with their medical condition. Justice involved individuals may be placed on this unit. This level is appropriate to use when the patient is hemodynamically stable along with any of the following. InterQual criteria will be utilized to meet the level of care required for the available bed.
1) **Medical conditions requiring c**~~C~~ontinuous Cardiac Monitoring
2) Chemotherapy Administration
3) Acute rehabilitation
4) **Outpatient services**
5) Medical-Surgical **services**

d. Acute Care Services (1 North, 2 Pavilion, 4 Pavilion and Acute Rehabilitation):
i. This level is appropriate to use when the patient is hemodynamically stable along with any of the following. InterQual criteria will be utilized to meet the level of care required for the available beds.
1) Post critical care or Telemetry monitoring
2) Procedures requiring inpatient hospitalization
3) IV medications requiring hospitalization for initial therapy
4) Designated inpatient ~~post surgical~~**post-surgical** care.

ii. 1 North/Ortho (Ortho and Medical/Surgical Patients)
1) This unit specializes in nursing care for patient's ages 18 years of age and older suffering from diseases, injuries or conditions of the human musculoskeletal system.
2) Orthopedic diagnoses are emphasized including orthopedic surgeries such as total joint replacement and spinal surgeries.

iii. 2 Pavilion (Oncology and Medical/Surgical Patients)
1) This unit provides nursing care for **patient's ages 18 years of age and older** ~~adolescent patients (ages 18 years to 21 years) or adult patients (age 22 years and older).~~
a) Patients receiving chemotherapy must be age 18 or older.
2) Oncological diagnoses are emphasized along with women's surgeries and general medical surgical diagnosis.

iv. 4 Pavilion (~~Dialysis,~~ Rate Monitoring for Medical/Surgical patients, Designated Stroke Unit, and Epilepsy Monitoring Unit [EMU])
1) This unit specializes in nursing care for patients ages 18 years of age and older:

a) Medical/Surgical patients requiring rate monitoring
b) Hemodynamically stable patients status post CVA **or other neurological condition**
c) Visual monitoring of stable epilepsy patients (EMU)

v. Acute Rehabilitation Unit (ARU)
1) The ARU provides restorative and maintenance programs for the adult patient (ages 18years and older) suffering from cerebral vascular disease and other diseases or conditions requiring neurological or functional rehabilitation services.

e. Emergency Services:
i. This unit provides nursing care for patients of all ages that:
1) Require medical care and are in stable, mild, moderate, or acute status.
2) With conditions involving major trauma, major burns, or requiring hyperbaric therapy, and pediatric intensive care services that can be stabilized to the degree medically feasible and subsequently transferred to facilities providing these specialty services in compliance with Emergency Medical Treatment and Active Labor Act (EMTALA) regulations.

f. Women and Newborn Services:
i. This unit specializes in nursing care for:
1) Perinatal patients who have conditions associated with antepartum, intrapartum and/or postpartum management needs to include surgical requirements related to perinatal care.
2) Neonates that may need resuscitation, stabilization and/or ongoing evaluation.

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

1. Patient Care Services Policy: Transferring of Patients and Recovering Patients from Outside TCMC
2. Patient Care Services Policy: Transfer of Patients, Intra Facility
3. Surgery Policy: Scheduling Surgical Procedures
4. Telemetry Policy: Admission and Discharge Criteria
5. Women Newborn and Services NICU Policy: Admission and Discharge Criteria for NICU

Tri-City Health Care District
Oceanside, California

Administrative Policy
Patient Care

ISSUE DATE:	**04/93**	**SUBJECT:**	**Assault Victims/Domestic Violence, Reporting Requirements**
REVISION DATE:	**05/93, 08/94, 04/95, 07/99, 04/02, 06/03, 12/05, 04/09, 06/11, 07/17, 08/20**	**POLICY NUMBER:**	**8610-310**

Patient Care Services Content Expert Approval:	**~~12/19~~11/23**
Clinical Policies and Procedures Approval:	**~~05/20~~12/23**
Nursing Leadership Approval:	**~~06/20~~01/24**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~06/20~~01/24**
Administration Approval:	**~~07/20~~02/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/20**

A. **PURPOSE:**

1. To provide guidelines for compliance with the mandatory reporting requirements for any patient injuries incurred through assault with a deadly weapon, a criminal act or instances of domestic violence presenting at Tri-City Hospital District (TCHD).
   a. ~~(~~For assault and battery occurrences against on-duty Medical Center personnel refer to Administrative **Policy**: **Workforce Violence 463**~~Assault and Battery Reporting Process Policy #241,~~ and for ~~Uniform~~ Reporting ~~and Reporting Requirement~~ Grid, refer to Administrative **Policy**: Mandatory Reporting Requirements ~~Policy #~~236~~)~~.

B. **DEFINITIONS:**

1. Victim – A person who has been subjected to injury through assault, a criminal act, or incident of domestic violence.
2. Injury – Any physical injury which requires any form of professional medical treatment.
   a. Does not include any psychological or physical condition brought about solely through voluntarily administration of a narcotic or restrictive dangerous drug.
3. Abuse – Intentional maltreatment of an individual that may cause injury, either physical or psychological. The following are various types of abuse:
   a. Mental Abuse – includes humiliation, harassment, and threats of punishment or deprivation.
   b. Physical Abuse – includes hitting, slapping, pinching or kicking. Also includes controlling behavior through corporal punishment.
   c. Sexual Abuse – Includes sexual harassment, coercion and assault.
   d. In home care - situations where child abuse is suspected and the person responsible for the child's welfare is a licensee, administrator, or employee of a child care facility, private or public residential home, school, or other institution.
4. Imminent Danger – Foreseen danger that will likely result in irreparable physical or mental harm unless conditions are changed.
5. Exploitation – An unjust or improper advantage or use of another person or their property for one's own profit or advantage (i.e., using a victim's financial means for another's gain).
6. Domestic Violence – The occurrence of any of the following: battery; simple battery; simple assault; assault; stalking; criminal damage to property; unlawful restraint; or criminal trespass by a present or past spouse, parents of the same child, parents and children, stepparents and

stepchildren, foster children and foster parents or others living or formerly living in the same household.

7. Health Practitioner - Physician, psychiatrist, psychologist, social worker, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, emergency medical technician, or any person who is licensed under Business and Professions Code Section 500.
8. Reporting - Refers to mandated verbal and written report to law enforcement agencies pursuant to California Penal Code 11160 et seq. Failure to report an injury caused by an assault with a deadly weapon or an incident of domestic violence is a criminal offense.

C. **POLICY**:

1. California Penal Code Sections 11160 and 11161 require health practitioners and physicians, to immediately report, both by phone and in writing: (A single report may be made when the obligation to report falls to two or more persons)
   a. All injuries resulting from the use of a gun, knife, firearm, or other deadly weapon, whether self-inflicted, or by the actions of another.
   b. Any wounds or physical injuries inflicted upon a person where the injury is the result of assaultive or abusive conduct. (Penal Code Section 11160)
   c. The following criteria may indicate a need for further assessment (including but not limited to):
      i. Injuries inconsistent with what is reported by patient or caregiver to have happened (i.e., burns, welts, bites and scratches).
      ii. Unusual patterns of injury (i.e., hairbrush, rope or belt marks).
      iii. Poor hygiene, malnourishment.
      iv. Exhibiting fear by parent or caregiver; being withdrawn or tearful.
      v. Improper responses to questions such as, "Is anyone misusing your money, food, housing or not allowing you to obtain health care?"
      vi. Inappropriate responses to questions about a safe environment or being threatened at home.
   d. Duty to report is required when the health practitioner provides medical services to a patient for any physical condition, not just the condition or injury from an assault, battery, or firearm incident.
   e. The report shall be prepared even if the patient has expired or declines to report.
2. Pursuant to Penal Code Section 11161.9, a health practitioner who makes a report of injury or abuse as specified under the law shall not incur any civil or criminal liability as a result of making such report.
3. Any evidence procedure or with a victims injured by a deadly weapon or criminal act must be properly handed, retrieved and proper chain of custody maintained. (See Administrative Policy: **Patients Injure by a Deadly Weapon or Criminal Act #** 315)
4. Physician-patient privilege does not relieve any physician from his/her obligation to report acts of domestic violence to law enforcement pursuant to Penal Code Sections 11161 (a).
5. Other Health Practitioners are not relieved of their reporting obligation if a physician or surgeon fails to report an injury by deadly weapon or criminal act. Any health practitioner may make the report. No supervisor or administrator shall impede or inhibit the reporting duties required pursuant to Penal Code 11160.
6. For the purposes of this section, "assaultive or abusive conduct" shall include any of the following offenses:
   a. Murder, (violation of Section 187).
   b. Manslaughter, (violation of section 192 or 192.5).
   c. Mayhem, (violation of Section 203).
   d. Aggravated mayhem, (violation of Section 205).
   e. Torture, (violation of Section 206).
   f. Assault with intent to commit mayhem, rape, sodomy, or oral copulation, (violation of Section 220).
   g. Administering controlled substances or anesthetic to aid in commission of a felony, (violation of Section 222).

h. Battery, (violation of Section 242).
i. Sexual battery, (violation of Section 243.4).
j. Incest, (violation of Section 285).
k. Throwing any vitriol, corrosive acid, or caustic chemical with intent to injure or disfigure, (violation of Section 244).
l. Assault with a stun gun or taser, (violation of Section 244.5).
m. Assault with a deadly weapon, firearm, assault weapon, or machine gun, or by means likely to produce great bodily injury, (violation of Section 245).
n. Rape, (violation of Section 261).
o. Spousal rape, (violation of Section 262).
p. Procuring any female to have sex with another man, (violation of Section 266, 266a, 266b, or 266c).
q. Child abuse or endangerment, (violation of Section 273a or 273d).
r. Abuse of spouse or cohabitant, (violation of Section 273.5).
s. Sodomy, (violation of Section 286).
t. Lewd and lascivious acts with a child, (violation of Section 288).
u. Oral copulation, (violation of Section 288a).
v. Genital or anal penetration by a foreign object, (violation of Section 289 or 289.5).
w. Elder abuse, (violation of Section 368).

7. All assault or domestic violence cases must be reported within mandated time lines by phone and written report to the appropriate law enforcement agency where the alleged incident occurred.
8. Victim of Assault: Upon learning or reasonably suspecting that a patient may be a victim of assault, the Health Practitioner will use the following procedure.
   a. Make a report by phone immediately or as soon as practically possible to the law enforcement agency in whose jurisdiction the alleged offense occurred.
   b. Complete a written report on the form "Health Practitioner and Hospital Report of Injuries by Deadly Weapon or Criminal Act". Distribute as follows:
      i. Keep one copy for patient's chart.
      ii. Mail one copy to appropriate law enforcement agency where alleged assault occurred.
      iii. Mail written report within 2 working days to appropriate law enforcement agency.
   c. Health Practitioner making the reports shall document in the patients chart that both telephone and written reports have been completed and the written report submitted to Social Services Department.
9. If the patient was a victim of abuse, neglect or domestic violence (except child abuse or neglect), the patient must be promptly informed that a report has been or will be made unless:
   a. The health care provider believes, in the exercise of professional judgement, that informing the patient would place him or her at risk of serious harm.
   b. The health care provider would be informing a personal representative, and the provider reasonably believes the personal representative is responsible for the abuse, neglect or other injury and that informing the personal representative would not be in the best interests of the patient.
   c. Verbal notification is sufficient. A report must be made even if the patient objects. The health care provider may suggest that the victim go to a protected environment due to the risk of retaliation after the report is made.
10. In the Emergency Department the social worker may be requested to provide a psychosocial assessment or consultative services to the Emergency Department or attending physician. They may also provide crisis intervention, problem solving advocacy, information and referral to community resources.
11. In the acute care setting, social work services are available to provide assessment, crisis intervention problem solving, advocacy, and information and referral to community resources.
12. According to Government Code Sections 13959 through 13969.1, California residents may apply for restitution for pecuniary losses they suffer as a direct result of criminal acts.
    a. The Emergency Department will display information regarding the "Victims of Crime

Program". (Refer to CHA Consent Manual)

b. A referral may be made to Social Services, to provide information and an application to the patient, for assistance through the "Victims of Crime Program".

c. The nurse can provide the patient with the following information and the patient and/or family can follow-up:
State Board of Control
P.O. Box 3036
Sacramento, CA 95812-3036
(916) 322-4426

13. Victim of Domestic Violence: Upon learning that a patient may be a victim of domestic violence, the Health Practitioner will use the following procedure:
    a. Make a report by phone immediately or as soon as possible to the law enforcement agency in whose jurisdiction the alleged offense occurred.
    b. Request the presence of a police officer at the hospital to interview the victim and conduct an investigation. Every effort should be made to keep the victim at the hospital until an officer arrives.
    c. The Health Practitioner will complete a written report on the form "Domestic Violence and Violent Injury Report" and will forward the written report immediately to TCHD's Social Services Department. One copy will be mailed to the appropriate law enforcement agency (within 2 working days). One copy will be filed in Social Services to protect patient safety and confidentiality.
    d. Health Practitioner making the reports shall document in the patients chart that both telephone and written reports have been completed and the written report submitted to Social Services Department.
14. All suspected, or confirmed, domestic violence cases identified on any inpatient unit, are to be referred to TCHD's Social Services Department. A clinical social worker may assess the patient/family system and will coordinate with the attending physician and nursing staff to ensure the required telephone and written reports are completed within the required time frames.
15. The Social Services Department at TCHD has the primary responsibility for coordinating, tracking the reporting of suspected cases of assault/violence to the appropriate agency, as well as notification of TCHD Compliance Officer. This applies whether seen in the Emergency Department, or admitted to the Medical Center.
16. Social Services Department will be notified of all cases of suspected assault/violence by one of the following methods:
    a. Making a Social Services referral through the computer.
    b. By telephone to the Social Services Department or page to a specific Social Worker.
    c. By completing a "Health Practitioner Report of Injuries by Deadly Weapon or Assaultive/Abusive Conduct" Reporting Form and forwarding it to the hospital Social Services Office.
17. Any problematic cases are reported to the Director/Manager of Social Services and the Director/Manager of Risk Management for additional review.
18. As high-risk patients, all alleged or confirmed victims of child abuse, elder abuse and domestic violence cases presenting in the Emergency Department should involve an assessment by the Emergency Department social worker.
19. In instances where victims include children, seniors or dependent adults, or domestic violence situations, the respective county social service hot lines (for child or elder abuse) are called, and mandated written reports are completed and mailed. Refer to Administrative: Reporting Suspected Child Abuse Policy #308 and Administrative: Reporting Suspected Dependent Adult Elder Abuse Neglect #309.

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

~~1. Administrative: Assault and Battery Reporting Process Policy #241~~

1. Administrative **Policy**: Mandatory Reporting Requirements ~~Policy~~ #236

2. **Administrative Policy: Patients Injure by a Deadly Weapon or Criminal Act 315**

3. Administrative **Policy**: Reporting Suspected Child Abuse ~~Policy #308~~
4. Administrative **Policy**: Reporting Suspected Dependent Adult Elder Abuse Neglect #309
5. Health and Human Services Domestic Violence Intimate Partner Violence Reporting

E. **REFERENCE(S)**:

1. California Hospital Association. (2017). *California Hospital: Consent Manual*. CHA Publications: Sacramento. ;
2. California Penal Code
3. www.jointcommission.org

Tri-City Medical Center	Distribution: Patient Care Services

PROCEDURE: CRITICAL RESULTS OF~~AND CRITICAL~~ TESTS AND - DIAGNOSTIC PROCEDURES

Purpose:

1. **Report critical results of tests and diagnostic procedures on a timely basis.**
2. **The objective is to provide the responsible licensed caregiver these results within an established time frame so that the patient can be promptly treated.**

~~1. A critical result is a test result at such variance with normal as to represent a pathophysiological condition that is potentially LIFE-THREATENING unless action is taken in a short time.~~

~~2. A critical test/diagnostic procedure is defined as one that requires immediate action to be collected, transported, tested and results communicated to meet defined turnaround times. There is a limited menu of tests/diagnostic procedures considered critical tests. All critical tests are performed STAT, but not all STAT orders are critical tests.~~

A. DEFINITION~~(S)~~:

1. **Critical Result is a test result that is significantly outside the normal range and may indicate an actual or potential life threatening situation requiring immediate interventions.**
2. **Critical Test or Diagnostic Procedure is a test or procedure that requires immediate action(s) to be performed in the collection, transportation, testing and communication of the results.**
   a. **There is a limited menu of tests/diagnostic procedures considered critical tests.**
   b. **All critical tests or diagnostic procedures are performed STAT, but not all STAT orders are critical tests or diagnostic procedures.**
3. **Read-Back is a method used to ensure understanding of information being communicated, often used between members of the care, treatment or service team.**
   a. **The process involves the person receiving the test/procedure results via verbal or by telephone writing down the complete test results or order and then reading/repeating the test/procedure results back and receiving confirmation from the person who gave the order or test result.**
4. **Turnaround time:**
   a. **Critical test or diagnostic procedure: the elapsed time between the date and time a critical test or diagnostic procedure is resulted and the date and time the critical test or diagnostic procedure is reported to the ordering physician/Allied Health Professional (AHP).**
   b. **Critical result:**
      i. **The elapsed time between the availability of critical result and receipt of the result by the licensed healthcare member responsible for the patient (registered nurse (RN)).**
      ii. **The elapsed time between communication of the critical result from the RN to the physician/AHP.**

~~A.~~B. POLICY~~CRITICAL RESULTS PROCEDURE~~:

1. **Critical results are the same for inpatients and outpatients.**
2. It is the testing department's responsibility to immediately communicate critical results to the responsible **RN**~~nurse~~ or physician/~~Allied Health Professional~~ (AHP.~~) and to maintain documentation of the communication.~~

Department Review	Clinical Policies & Procedures	Nursing Leadership~~Executive Council~~	Pharmacy and Therapeutics	Department of Pathology	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
08/05, 01/09, 07/09, 06/10, 05/13, 07/14, 07/23	06/10,11/13, 08/14, 07/15, 07/23	08/09, 07/10, 11/13, 10/14, 07/15, 08/23	09/14, 12/15, 09/23	08/17, 01/24	08/09, 07/10, 11/14, 09/17, 01/24	02/24	09/09, 08/10, 01/15, 10/17, n/a	09/09, 08/10, 01/15, 10/17

a. The testing department will document the notification and read-back of critical results in the patient's electronic health record (EHR).

b. The RN receiving the critical result will document the notification, read-back of critical results and if any new orders are received in the patient's EHR.

i. In the instance the patient's RN is unavailable to receive the result, another RN where the patient is located shall be notified of the critical result.

ii. The RN receiving the critical results will the notify the primary RN.

~~1. Critical results are the same for inpatients and outpatients.~~

~~B. **TURNAROUND TIME:**~~

3. The turnaround time for **reporting** a critical result **of a /laboratory test,** ~~is defined as the difference between the time the result is obtained and communicated to the licensed healthcare member responsible for the patient (RN) to the time of receipt of the result by the physician/AHP. Because the reporting process~~**may** involved two steps (lab to RN and RN to physician/AHP in some cases requiring a call back of orders from the physician/AHP), ~~the target turnaround time~~ is less than **sixty (60)**~~90~~ minutes.

a. Goal for the following:

i. Code Blue Panel - 15 minutes

ii. Blood Gas Panel (CVS) - 15 minutes

iii. Frozen Section - 20 minutes

iv. Pro Time/INR and PTT (Stroke Code) - 45 minutes

~~1. Creatinine (Stroke Code) - 20 minutes~~

4. The turnaround time for **reporting** a critical diagnostic procedure ~~is defined as the difference between the time the procedure resulted and the time communicated by the radiologist to the ordering physician/AHP~~ shall be completed in less than **sixty** (60) minutes.

a. Goal for the following:

i. CT (Stroke Code) - 2030 minutes

ii. ECG (Stemi Code) - 10 minutes

5. Diagnostic procedure critical results are reported by the radiologist directly to the ordering physician or on-call physician.

a. Diagnostic procedure documentation shall be completed by the radiologist in the patient's EHR.

~~2.~~6. Cardiology critical test results are communicated by the cardiologist to the ordering physician.

~~C. **COMMUNICATION:**~~

C. PROCEDURE:

1. The laboratory shall call the critical result to the licensed healthcare member responsible for the patient who in turn shall notify the patient's physician/AHP.

a. When the responsible licensed healthcare member is not available to notify the physician/AHP, the notification task shall be delegated to another responsible licensed healthcare member.

~~b.~~**i.** An exception to the above is when a standardized procedure or a physician/AHP order addresses a critical result.

~~c.~~**2.** When a~~n~~ ~~in~~patient is discharged prior to the reporting of a critical lab result, the communication of the critical **result**~~value~~ will be as follows:

~~i.~~**a.** Lab responsibilities:

~~ii.~~**i.** Call the critical **result**~~value~~ to the ~~Call Center extension 5719 Monday – Friday 0900 – 1700 or the~~ Administrative Supervisor (AS) at 760-644-6968 after hours and weekends **and electronically send report**.

~~1) All other critical values will be called by the lab as per the lab procedure for outpatients.~~

~~a)~~**1)** All documentation of lab communication will be according to the Laboratory Procedure for Documenting Phoned or Verbal Communication

~~b)~~**2)** Laboratory documentation shall be as **an Order** Result ~~of Order~~ comment.

~~iii.~~**b.** ~~Call Center/~~AS responsibilities:

~~1)~~**i.** Notify the physician's office of critical **result**~~value~~

~~2)~~**ii.** Document the physician notification in the **patient's** ~~electronic health record~~ (EHR.~~)~~

~~3)~~**iii.** RN documentation shall be completed in the patient's **EHR**~~electronic medical record~~. Refer to Patient Care Services policy Documentation in the Medical Record, IX.I.

~~a)~~**1)** Critical result including physician notification and plan of action (Physician Notification Power Form).

~~2.~~**3.** **Outpatient** ~~C~~critical results ~~from outpatients~~ shall be phoned to the ordering physician's office. After office hours the critical result shall be phoned to the on-call physician/AHP.

a. If, after 60 minutes, the on-call physician/AHP does not return a call or if the on-call physician/AHP refuses to take the critical result, contact the on-call pathologist **and**~~.~~ **h**~~H~~ave the patient's phone number available.

~~3. Diagnostic procedure critical results are reported by the radiologist directly to the ordering physician or on-call physician.~~

~~a. Diagnostic procedure documentation shall be completed by the radiologist in the patient's electronic medical record.~~

~~4. Cardiology critical test results: All results of critical test results are communicated by the cardiologist to the ordering physician.~~

~~D. **DOCUMENTATION:**~~

~~E.~~**D. CRITICAL VALUE LIST:**

1. Diagnostic Procedure Critical Results **for the initial critical result, but not for additional exams that re-demonstrate the same finding**

a. Acute arterial occlusion

~~a.~~**b.** Acute cervical fracture~~/hematoma~~

c. Acute pulmonary embolism

~~b.~~**d.** Acute spinal cord compression

~~c.~~**e.** Aortic dissection, **new or enlarging**

f. Abdominal aortic aneurysm, leaking

~~d.~~**g.** Bowel perforation **or unexplained pneumoperitoneum**

~~e.~~**h.** Cerebral herniation

~~f.~~**i.** Ectopic pregnancy

~~g.~~**j.** Fractures compatible with non-accidental child abuse

~~h.~~**k.** Hemorrhage,~~ Intracerebral~~, Intra**peritoneal**~~bdominal~~/Retroperitoneal, and Intrathoracic

~~i.~~**l.** High probability VQ Scan ~~or pulmonary embolus~~

m. Intracranial hemorrhage, new or enlarging

~~j.~~**n.** Leaking abdominal aortic aneurysm

o. Necrotizing fasciitis

~~k.~~**p.** ~~New p~~**P**neumothorax, **new or enlarging**

~~l.~~**q.** Spinal fractures, **unstable thoracic or lumbar**

r. Tubes/drains, significant misplacement

~~m.~~**s.** Testicular/ovarian torsion

~~n.~~**t.** Volvulus

2. Laboratory critical tests and critical results – see Laboratory Critical Tests and Critical Results Quick Reference Guide

~~2. ABG Lab – Critical Values~~

~~a. Adults:~~

~~i. PaO2 mmHg less than 56~~

~~ii. PaCO2 mmHg more than 55 **and** a pH less than 7.36~~

iii. pH less than 7.32 or more than 7.52
iv. MetHb more than 3.0
v. Carboxy Hgb more than 14.0%

b. Neonatal/Peds:
i. PaO2 mmHg less than 50 or greater than 100, arterial only
ii. PCO2 mmHg less than 25 or greater than 60, arterial or capillary
iii. pH less than 7.28 or greater than 7.50, arterial or capillary

3. Laboratory Quantitative Critical Results:

CHEMISTRY	UNITS	LOW	HIGH	HEMATOLOGY [6]	UNITS	LOW	HIGH
Bilirubin, Total [1]	mg/dL	–	18.0	Fibrinogen	mg/dL	100	–
Calcium [2]	mg/dL	6.0	13.0	Hematocrit [7]	%	20	60
Calcium, Ionized	mg/dL	3.0	6.3	Hemoglobin [7]	g/dL	7.0	20.0
CO2	mmol/L	15	45	Platelet [8]	$x10^3/\mu L$	20	1000
Glucose	mg/dL	40	450	Protime INR	INR	–	4.5
Glucose, CSF	mg/dL	25	450	PTT on Heparin	sec.	–	200
Lactic Acid	mEq/L	–	4.0	PTT no Heparin	sec.	–	80
Magnesium [3]	mg/dL	1.0	4.5	Thrombin Time	sec.	–	90
O2 SAT Venous	%	70	–	WBC	$x10^3/\mu L$	2.0	30.0
Osmolarity, Serum	mOsm/kg	250	323				
Phosphate	mg/dL	1.0	10.0				
Potassium [4]	mEq/L	2.8	6.2				
Sodium	mEq/L	120	165				
Troponin [5]	ng/mL	–	0.06				

1. Bilirubin, Total critical value applies to newborns and infants only.
2. For newborns less than 30 days old the low critical value for calcium is less than 8.0 mg/dL.
3. For OB patients receiving magnesium sulfate therapy call results greater than or equal to 7.0 mg/dL.
4. For patients undergoing dialysis the critical value for potassium is greater than 6.9 mEq/L.
5. For critical value troponins, the critical value applies for the first positive result during the previous 48 hours and must be phoned and documented.
6. Hematology critical results will not be called if reoccurring within the same encounter and pass the delta check.
7. For infants 0-4 days the critical value for Hgb (g/dL) is less than 7.0 or greater than 24.0. For Hct (%) the critical value is less than 20 or greater than 63.
8. Platelet counts less than 10 ($x10^3/\mu L$), i.e. less than 10,000/µL, will always be phoned and documented.

4. Therapeutic Drugs:

DRUG	UNITS	CRITICAL VALUE
Acetaminophen	mcg/mL	greater than 100.0
Amikacin, trough	mcg/mL	greater than 10.0
Amikacin, peak	mcg/mL	greater than 35.0
Amikacin, random	mcg/mL	greater than 35.0
Carbamazepine	mcg/mL	greater than 12.0
Digoxin	mcg/mL	greater than 2.0
Disopyramide	mcg/mL	greater than 7.0
Gentamicin, trough	mcg/mL	greater than 2.0
Gentamicin, peak	mcg/mL	greater than 10.0
Gentamicin, random	mcg/mL	greater than 10.0
Lithium	mcg/mL	greater than 1.2

DRUG	UNITS	CRITICAL VALUE
Lidocaine	mcg/mL	greater than 5.0
Magnesium Sulfate	mcg/mL	greater than 7.0
NAPA	mcg/mL	greater than 30.0
Phenytoin	mcg/mL	greater than 20.0
Phenobarbital	mcgmL	greater than 45.0
Primidone	mcg/mL	greater than 12.0
Procainamide	mcg/mL	greater than 12.0
Procn+NAPA	mcg/mL	greater than 35.0
Quinidine	mcg/mL	greater than 7.0
Salicylate	mcg/dL	greater than 50.0
Theophylline	mcg/mL	greater than 20.0
Tobramycin, trough	mcg/mL	greater than 2.0
Tobramycin, peak	mcg/mL	greater than 10.0
Tobramycin, random	mcg/mL	greater than 10.0
Valproic acid	mcg/mL	greater than 120.0
Vancomycin, trough	mcg/mL	greater than 20.0

5. Qualitative Critical Values:
   a. Blood Bank:
      i. Positive antibody screen
         1) Incompatible cross match
      ii. Newborn positive direct antiglobulin test (DAT) with positive antibody screen from mother
      iii. Transfusion reaction
   b. Hematology:
      i. Presence of blasts on blood smear
      ii. Presence of sickle cells
      iii. Presence of malaria parasites or other blood protozoans.
   c. Microbiology:
      i. Positive gram stain or culture results on CSF, # blood or any sterile body fluid or tissue
      ii. Positive India Ink prep
      iii. Positive bacterial or fungal antigen detection
         1) Serum or CSF Cryptococcal antigen
         2) Serum or CSF bacterial antigen (Haemophilus influenzae, Neisseria meningitides, Strep Group B, Streptococcus pneumoniae)\
      iv. Positive Acid fast stain or culture
      v. Stool positive for Salmonella, Shigella, E. coli 0157:H7 or Campylobacter
      vi. Culture positive for Neisseria Gonorrhoeae, Streptococcus Group A, Streptococcus Group B isolated from women of child bearing age, pregnant women and OB-GYN patients
      vii. Positive Malaria smear
      viii. Positive RSV, Rotavirus, Chlamydia Legionella
      ix. Positive amoebae from CSF direct wet mount
      x. Positive Clostridium difficile PCR.
      xi. Presence of organisms that would require the patient to be in isolation or under certain precautions; i.e. Salmonella spp., Shigella spp., Vancomycin-resistant Enterococcus faecalis or Enterococcus faecium, methicillin-resistant Staphylococcus aureus. For all other organisms, only the nursing unit is notified.
   d. Infectious Diseases:

HIV 1,2 Antibody	Confirmed Positive
Hepatitis B Surface Ag	Confirmed Positive
Hepatitis B Core Ab IgM	Positive

Hepatitis A Ab, IgM	Positive
Hepatitis C Ab	Positive

e. Clinical Microscopy:
   i. Pediatric patient (less than 2 years of age) with Negative Urine Glucose and a Positive Urine Reducing Substance.
      1) Note: This could indicate the patient has galactosuria.
   ii. Presence of pathogenic crystals (cysteine, leucine or tyrosine) in urine

F. **CRITICAL TEST/DIAGNOSTIC TEST – PROCEDURE:**

1. A critical test is one that requires immediate action to be collected, transported, tested and results communicated, regardless of the value, within the defined turnaround time to the responsible licensed caregiver so that further care or treatment can be determined for an unstable patient.
2. Critical Tests And Turnaround Time:
   a. The turnaround time for a critical test is defined as the difference between the time the test is ordered and the time the result is received by the responsible licensed caregiver. In most cases the call will be made to surgery or to the Emergency Department and does not require a call back from a physician.
   b. The following are the critical tests in use and the expected turnaround times:

Critical Tests – Laboratory	Turnaround Time (Order to receipt of result)
Code Blue Panel	15 minutes
Blood Gas Panel (CVS)	15 minutes
Frozen Section	20 minutes
Pro Time/INR and PTT (Stroke Code)	45 minutes
Creatinine (Stroke Code)	20 minutes
Critical Tests – Radiology/Cardiology	
CT (Stroke Code)	30 minutes
ECG (Stemi Code)	10 minutes

G. **COMMUNICATION:**

1. Laboratory results of critical tests shall be communicated by phone to a licensed healthcare member within the turnaround times listed. A read back of results is required for any critical test results that are critical values as per the Procedure for Confirmation and Communication of Critical Results.
2. Diagnostic procedure critical test results are reported directly to the ordering physician within the turnaround times listed.

H. **DOCUMENTATION:**

1. Laboratory critical test result communication shall be documented in Cerner as a result comment by using the template code "RPCT." The required elements are the test(s) called, the name of the licensed healthcare provider to whom the results were given, their credential e.g. RN, LVN, MD, etc., the date and time of the call (F5 key) and the Cerner logon identification of the caller.
2. Diagnostic procedure critical test documentation is defined under Section D.3.

E. **COMPLIANCE MONITORING:**

1. **Periodic monitoring of the critical test communication process shall be conducted on a departmental and organization wide basis.**
   a. **Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures.**

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

1. Lab Gen Lab QA Manual: Procedure for Confirmation and Communication of Critical Results

2. Lab Gen Lab QA Manual: Laboratory Procedure for Documenting Phoned or Verbal Communication
~~2.~~3. **Lab Gen Lab QA Manual: Critical Tests and Critical Results Quick Reference Guide**

~~J.~~G. REFERENCE(S):

1. College of American Pathologists. (2009). Laboratory general checklist. Commission on Laboratory Accreditation.
2. Clevenger, R.R. (1995). A protocol for verifying critical values. Medical Laboratory Observer 17, p. 73-76.
3. Joint Commission.202310. National patient safety goals.
~~3.~~4. **Karon.B.S. MD, PhD, FCAP. Documenting Critical Values at the Point of Care. Clinical Laboratory News. September 2022.**

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**PERINATAL DEATH (MISCARRIAGE, STILLBIRTH AND NEONATAL DEATH CARE AND DISPOSITION)**
Purpose:	To assist the family in coping with a perinatal death via miscarriage, stillbirth or neonatal death, obtain mementos, if applicable and provide postmortem care. Families experiencing a Perinatal death shall be provided support for grieving.
Supportive Data:	Data shows that assisting families in making memories during a perinatal death helps validate the lost life and can help facilitate an effective grieving process. Use of multidisciplinary resource support during this time also has a vital role in helping these grieving families.
Equipment:	1. Personal protective equipment 2. Infant scale 3. Disposable measuring tape 4. ID bracelets, if applicable 5. Disposition preparation items for transfer to the morgue –(Chux, baby blanket, instrument packing drape, tape and 3x 5 card) 6. Authority for Release of Deceased/ Miscarriage Form – triplicate, if applicable 7. Authorization for Autopsy form, if applicable 8. Camera 9. Grief packet, including: • Mementos folder • Mementos box • Discharge Instruction Form

A. **POLICY**:

1. Families who experience a perinatal death during pregnancy or shortly after birth may grieve for their baby and the loss of an entire lifetime with that child. Caring, supportive people can help families move through the initial crisis toward re-establishing their lives without their babies.
2. It is important to meet the needs of bereaved parents and their family during the initial crisis of their perinatal loss by offering comprehensive care that includes compassion and an interdisciplinary perspective.

B. **PROCEDURE**:

1. Miscarriage
   a. Assign patient to a room away from other patients and unit activity to promote a private and queite atmosphere. ~~free from chaos, laboring patients and crying babies if possible.~~
      ~~i. If miscarriage greater than 16 weeks estimated gestational age (EGA) occurs in the ED and the ED provider initiates an Obstetrical consult, arrangements may be made to transfer the patient to the labor and delivery (L&D) unit for admission and care coordination as available per the L&D Charge RN.~~
      ~~ii.~~i. Efforts shall be made to ensure the patient has necessary supports to assist her through this difficult time if not already present.
2. Newborn or stillbirth
   ~~a. Complete the same patient admission requirements to the unit per standards of care for the patient and for the newborn if born alive. See Standards of Care for Intrapartum, Postpartum and Newborn Care.~~
   ~~b.~~a. If the delivery is a stillbirth, there will NOT be a medical record created for baby. ~~All of t~~The delivery information is **documented**~~charted~~ in the mother's **EHR**~~chart~~.

Patient Care Services Content Expert	Clinical Policies & Procedures	Nursing Leadership	Department of OB/GYN	Perinatal Collaborative Practice	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
12/08; 6/11, 09/21, **11/23**	04/11, 10/16, 10/21, **12/23**	04/11, 10/16, 11/21, **01/24**	12/16, 12/21, **n/a**	01/17, 08/22, **n/a**	n/a	05/11, 02/17, 09/22, **01/24**	11/22, **02/24**	06/11, 03/17, n/a	06/11, 03/17, 11/22

i. Identification band information shall be entered on the bands manually and include:
   1) **Mother's** ~~L~~last name and baby's sex, if known
   2) **Mother's**~~Patient's~~ first and last name
   3) **Mother's**~~Patient's~~ medical record number
ii. Attach one band to the **baby's**~~stillbirth's~~ ankle for identification ~~offer~~ remains ~~disposition~~.
iii. The other ~~baby band/parent~~ band~~s~~ can be saved and included as a part of the memory making process.

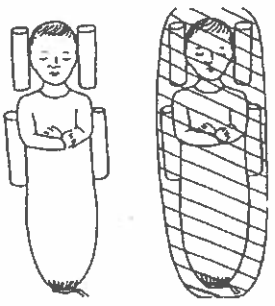
~~c.~~**b.** If the delivery is a LIVE birth, but then later dies, the **newborn will receive an MRN and the identification band will be computer generated per the patient care policy: Assignment of Medical Record Numbers and Standard Naming Guidelines.** ~~banding process for the baby is followed per unit routine and is usually computer generated.~~
i. One band shall remain on the baby's ankle for identification ~~offer~~ remains. ~~disposition.~~
ii. The other ~~baby band/parent~~ band~~s~~ can be saved and included as part of the memory making process.

~~d. The patient shall be included in the decision of where she would like to remain post-delivery and for the remainder of her stay. Transfer off the unit may be coordinated with a providers order, once the patient is stable, and as indicated.~~

3. Staffing considerations should include recognition that this situation may require more intense psychosocial and emotional support and assignments adjusted, as indicated.
4. Post a special bereavement card outside the entrance to the patient to notify staff entering the space that a loss/-death has occurred to ensure sensitivity.
5. Inform Social Services and/or pastoral care of the perinatal death to ensure alternate support measures are offered to the family.
   a. Social Services can evaluate any psychosocial needs, provide bereavement support and discuss disposition options with the family if desired.
      i. For miscarriage see Patient Care Service Procedure: Miscarriage and Stillbirth Identification and Disposition Process.
      ii. A "Comfort Cub" may be given to the family to assist with bereavement support and shall be determined by the social worker.
   b. Pastoral care provides both spiritual comfort and support to families and can provide blessings, naming ceremony, baptism and/or a memorial service as indicated.
6. Discuss the anticipated plan of care with the patient including these options as appropriate:
   a. To see and hold their pregnancy tissue/baby.
      i. The family may wish to hold the newborn/fetus immediately after delivery.
      ii. Care should be taken to treat anything that comes from the mother's body with respect.
      iii. It is helpful to prepare them for what they will see: color, shiny skin, fused eyes, translucency, tiny hands and feet, any defects, skin sluffage, deformities, coloring, etc.
      iv. When handling the remains it is important to use gloves and complete good hand hygiene
      v. Ask the family if they have an outfit they want the baby to wear, a special blanket to wrap him/her, when appropriate
         1) If no outfit, staff can offer donated outfit layettes ~~from the angel room~~.
   b. Weigh and measure the length of the remains.~~, if able.~~
   c. Obtain footprints, if loss is small, can trace around the baby's hands, feet and/or body on paper background to represent size.
      i. The application of acetone to the surface of the foot and then use of a black marker (rather than an ink pad) will make prints clearer in this small gestation
   d. Complete newborn identification certificate/card with parent's name and birth information.

e. Discuss naming the baby
f. Cut locks of the baby's hair if available.
g. Obtain photos upon verbal consent
   i. The parents may take their own photos on personal camera
   ii. A hospital camera may be used for non-medical photography after verbal consent is obtained from the parents.
   iii. When appropriate, attempt to capture candids with the baby and family interactions as well as posed positions to highlight some of the physical attributes of the newborn/stillbirth.
h. Ask family if they want to bathe the baby and facilitate as indicated.

7. Collect all of the mementos and place them in the memory box including any photos, memento booklet, the outfit the baby was wearing, the blanket and hat and any other mementos.
   ~~a. The Labor and Delivery unit has a dedicated room where the memento box and other memory making supplies are stored.~~
   ~~b.~~**a.** If parents refuse mementos, **the box will be given to the Social Service Department for storage up to one year.**~~they remain in a locked file in Women's & Newborn Services Department.~~
8. If the family desires to make arrangements for the miscarriage disposition, ensure the Authority for Miscarriage Remains Release form is completed.
   a. Staff should move the remains to an appropriate and private room to prepare for transport.
   b. It is important that placement of the remains for transport not be done in the parent's presence to ensure dignity is maintained.
   c. Send remains to the Laboratory using the corresponding tissue requisition and per PCS Procedure: Miscarriage and Stillbirth Identification and Disposition Process.
9. When the family is ready for the stillbirth/newborn remains (baby) to be brought to the morgue, it is important that the preparation and positioning of the baby be performed in a way that combats the combined effects of rigor mortis, algormortis (cooling of the body), and permanent discoloration in case the parents wish to view the baby at another time.
   a. The baby should be unclothed except for a diaper in place, if desired and have an identification band located on its ankle.
   b. Place on a chucks pad first, the body supine.
      i. Care should be taken to not place any textured blankets or towels on exposed skin because it may leave permanent impressions.
   c. Support the head in position, by having two rolled towels/chux pads positioned at each side of the head to keep it upright.
      i. If the head is left unsupported, it may fall to one side and blood may collect in the soft facial tissues, leaving permanent discolorations.
   d. Fold the arms with a towel roll inserted under the arms at the side of the body to support the position.
      i. Place the hands crossed or next to each other on the chest.



   e. Wrap the body in the chux and baby blanket mummy-fashion to secure positioning, followed by an instrument packing drape which shall be taped in place.
   f. Complete an index card with the following information and tape it to the outside of the baby's wrap:
      i. Baby's last name and gender (baby girl/baby boy)
      ii. Mother's name and medical record number
         1) May use an admission sticker
         2) Newborn's medical record number if a newborn death
      iii. Date and time of delivery

iv. Weight (g) and length (cm)
v. Attending provider

g. Coordinate transfer to the morgue per PCS: Release of the Deceased Procedure.
i. Ensure the morgue log book is completed when bringing baby to and from the morgue for family viewing.

10. Give the family bereavement support material to review as indicated and discharge instructions for follow-up:
a. Provide information about medical care options available to them by their provider depending on their perinatal loss diagnosis
b. Include in the plan of care regarding post procedure and/or post delivery options, and disposition options.
c. For a miscarriage please review the "Authority for Miscarriage Remains Release form" with the family, per Patient Care Services (PCS) procedure: Miscarriage and Stillbirth identification and disposition process.
d. For a stillbirth or neonatal death, please review the "Release of the Deceased form" with the family per PCS procedure: Miscarriage and Stillbirth identification and disposition process.

C. **DOCUMENTATION:**
1. Document the miscarriage and/or delivery information and other interventions in the mother's Electronic Medical Record, including the disposition of fetal remains.
2. If born alive, document admission **and care provided** ~~items per standards of care~~ in the Electronic Medical Record, including the disposition of the newborn.

D. **RELATED DOCUMENT(S):**
1. Patient Care Service Procedure: Miscarriage and Stillbirth Identification and Disposition Process
~~2. Women and Newborn Services Standards of Care for Intrapartum~~
~~3. Women and Newborn Services Standards of Care Postpartum~~
~~4. Women and Newborn Services Standards of Care Newborn Care~~
~~5.~~**2.** Authority for Miscarriage Remains Release Form Sample

E. **REFERENCE(S):**
1. Wilke, J. & Limbo, R. (2012) *Bereavement training in perinatal death (8th ed.)*. La Crosse: Gunderson Lutheran Medical Foundation, Inc.
2. Simpson, K. & Creehan, P. (2021) *AWHONN Perinatal nursing (5th ed.)*. Philadelphia: Lippincott, Williams & Wilkins.
3. Rosenbaum, J., Renaud-Smith, J., & Zollfrank, R. (2011) Neonatal end-of-life spiritual support care. The Journal of Perinatal and Neonatal Nursing 25(1), 61-69.
4. Mattson, S., & Smith, J.E. (2016). *Core-curriculum to maternal-newborn nursing (5th Ed.)*. Philadelphia: Saunders.

Authority for Release of the Deceased Form - SampIE

A miscarriage is validated when the Estimated Gestational Age (EGA) is less than 20 weeks and/or when the head to buttocks length is **less than 16.5 cm** and the **heel to toe length is less than 3.1 cm** per Patient Care Services Miscarriage and Stillbirth Identification and Disposition Process Procedure.

Do the pregnancy remains meet miscarriage criteria?

YES_____ Please transfer the miscarriage remains to the Laboratory and review disposition options below.

Nurse Name_____ Date_____ Provider Name _____Date_____

Please be advised that you have choices concerning the final disposition of miscarriage remains, if desired.

HOSPITAL DISPOSITION

According to regulations, the hospital will dispose of the miscarriage under the terms and conditions customarily used. The hospital cannot return the remains to you.

I wish for Tri-City Medical Center to arrange for the disposition of remains under the terms and conditions customarily used.
Patient Signature _____ Date_____

ARRANGED DISPOSITION

If you would like to make alternate arrangements, the remains must be released to an approved agency for proper burial or cremation by a licensed funeral director or mortuary. **PLEASE READ and INITIAL the items BELOW:**

1. I wish to make arrangements with a licensed funeral director or mortuary and understand that I am responsible for all expenses. YES____
2. I understand that if arrangements are not made with a funeral home/mortuary within 30 days, the Laboratory Department will dispose of the remains under the terms and conditions customarily used by the hospital. YES_____
3. Due to regulatory guidelines, there may be reasons the remains may not be able to be released. YES_____

I _____**hereby authorize Tri-City Medical Center to release the remains to:**

Patient

To: _____ (____)_____
Mortuary/Procurement Agency — Area Code/Phone Number

Date	Signature	Area Code/ Phone Number	Email address

Mortuary Notified: Date_____ **Time**_____ **Initials** _____

MORTICIAN'S RECEIPT OF REMAINS

Received from TRI-CITY MEDICAL CENTER, the pregnancy remains from, (Name) _____

_____ (Date) _____ (Time) _____ (Signature of Mortuary Transporter)

Released By: _____ Date: _____ Time: _____

Public Administrator Notified: _____ Date: _____ Time: _____ Initials _____

Affix Patient

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

AUTHORITY FOR MISCARRIAGE REMAINS RELEASE

8720-

White: Medical Record Make (4) copies (1) Patient, (2) Administrative Supervisor (3) Laboratory (4) Mortuary

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE
Patient Care

ISSUE DATE: **NEW**

SUBJECT: **~~Delivery of the~~ Conditions of Admission Consent Form Delivery**

REVISION DATE:

POLICY NUMBER: **8610-NEW**

Administrative Content Expert Approval:	**10/23**
Administrative Policies & Procedures Committee Approval:	**10/23**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**02/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. To ensure the standard Conditions of Admission (COA) form is appropriately communicated and signed by the patient or their authorized representative at time of admission to Tri-City Medical Center (TCMC). The COA form serves as the initial consent for treatment at Tri-City Medical Center and other consents may be obtained depending on the context of care.

B. **POLICY STATEMENT:**

1. Consent is necessary prior to any treatment or procedure, except in emergency situations. All facility admissions require the COA form signed by the patient or their authorized representative at the time of each hospital outpatient visit or bedded admission encounter.
2. For recurring hospital outpatient accounts, this form is required to be obtained at the initial visit of a treatment plan and/or after periods of more than 90 days between services for ongoing treatment.
3. The contents of the COA form are reviewed by patient access staff with the patient and/or the patient's authorized representative during the admission process.
4. The patient's or authorized representative's signature is obtained confirming consent for care, receiving a Patient Rights and Responsibilities, knowledge of billing information, and receipt of the Notice of Privacy Practices. The patient or their representative may be referred to appropriate administrative or clinical staff with questions about the COA form.
5. Changes to the COA form are not permitted.
6. Patient Access staff are responsible for explaining the contents of Conditions of Admission form and obtaining appropriate signatures, and proper labeling and scanning the form into the electronic **health~~-medical~~** record (EHMR) (if appropriate).
7. In the event a signature cannot be obtained at admission, a TCMC staff member will indicate the reason on the COA and follow-up will occur to ensure that each patient's **health~~medical~~** record contains a signed Conditions of Admission form.

C. **DEFINITIONS:**

1. **Workforce Member: Employees, Medical Staff, Allied Health Professionals (AHP), volunteers, trainees, Business Visitors, Covered Contractors and other persons whose**

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

~~2. Employees include TCHD officers, directors, employees, independent contractors, medical staff members and volunteers while performing services on behalf of or acting within the scope of their employment or duties for TCHD.~~

D. **PROCEDURES:**

1. Obtaining consent for COA form:
   a. The following steps are performed at the time of registration. These steps may also be performed on the unit if the patient is admitted directly to a room.
      ~~b.~~**i.** During admission, a Patient Access staff member reviews the Condition of Admission form with the patient or the patient's authorized representative.
   ~~c.~~**b.** Points to emphasize during COA review:
      i. Consent to receive medical care from the providers at Tri-City Medical Center.
      ii. If a staff member is accidently exposed to your blood or body fluids, you give consent to be tested for certain viruses so caregivers can be quickly treated.
      iii. The physicians are independent contractors. The hospital participates in the training of healthcare personnel.
      iv. TCMC is not responsible for personal items or valuables.
      v. Weapons, drugs, tobacco, and prohibited behaviors are not permitted on TCMC property.
      vi. Medical information may be disclosed to your insurance plan(s) for payment.
      vii. The patient may receive bills from other providers associated with their care at a Tri-City Medical Center facility.
      viii. The Notice of Privacy Practices brochure is offered to the patient and/or their representative to keep.
      ix. Patient Rights and Responsibilities information is offered to the patient and/or their representative.
      x. Changes to the COA form are not permitted.
      xi. The patient or their authorized representative signs COA form.
2. If no signature can be obtained at admission
   a. If patient is unable to sign COA form and no authorized representative can be reached at admission, then TCMC staff members will indicate the reason on the COA.
   b. Patient Access staff will make multiple attempts to communicate the content of the COA form and have the patient sign and/or reach their authorized representative for signature. Such attempts are documented in the Encounter Notes in the EH~~M~~R.
   c. During the attempts to gain a signature, Patient Access will continue to seek a signature until such time the patient is discharged. If patient is discharged without COA signed, clinical information in the chart should reflect the urgency of the admission and the patient's inability to receive COA communication throughout their encounter.
   d. Access staff may also seek assistance of the clinical unit staff to help obtain the COA signature.
3. Patient or patient's authorized representative guidelines
   a. In the event that a patient is not able to sign upon admission or is a minor who cannot consent for themselves, follow California Hospital Association (CHA) Consent guidelines to determine if the person with the patient meets criteria as a legal representative.
4. Follow CHA Minor Consent Guidelines to determine if a minor presenting for services is able to consent for themselves or consent is needed from an authorization representative.
5. If verbal consent is received from the patient or their authorized representative it must be documented on the COA form including the date, time and relationship to patient. The COA will be witness by two TCMC employees and documented in the Encounter Notes in the EH~~M~~R system.

E. **RELATED DOCUMENTS:**

1. Conditions of Admission (COA) form

2. **Patient Care Services Policy:** Patient Rights and Responsibilities
3. **Administrative Policy:** Notice of Privacy Practices **518**
4. **Administrative Policy:** Non-Retaliation **for Reporting Compliance Issues or Suspected Misconduct 560**

F. **REFERENCE(S):**

1. 45 C.F.R. parts 160 and 164
2. California Civil Code Section 56 et. seq.
3. California Health & Safety Code Section 123222.1
4. California Hospital Association Consent Manual

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE
INFORMATION TECHNOLOGY

ISSUE DATE: 12/00 **SUBJECT: Email Access**

REVISION DATE: 05/03, 02/05, 11/08, 05/10, 08/10, 07/12, 08/17 **POLICY NUMBER:** 8610-604

Administrative Policies & Procedures Content Expert~~Department Approval~~: ~~07/17~~10/23
Administrative Policies & Procedures Committee Approval: ~~07/17~~10/23
Medical Executive Committee Approval: n/a
Administration Approval: 02/24
Professional Affairs Committee Approval: ~~08/17~~ n/a
Board of Directors Approval: 08/17

A. **PURPOSE:**
1. To provide electronic mail to all employees and other Authorized Email Users associated with Tri-City Healthcare District (TCHD).

B. **DEFINITION(S):**
1. Email: Any form of electronic messaging currently sanctioned for use at TCHD. It encompasses electronic messaging among TCHD employees and to/from TCHD and external organizations or individuals.

C. **POLICY:**
1. This policy addresses Email, informs Authorized Email Users of their rights and obligations, and formally notifies Email Users of usage monitoring. With advance notice, Authorized Email Users will not be put in an embarrassing situation, and are notified that TCHD reserves the right, without notice, to:
   a. Monitor, access, retrieve, download, copy, listen to, or delete anything stored in, created, received or sent via Email, and
   b. Limit and/or restrict any Authorized Email User's use of Email Services, and to inspect, copy, remove or delete any unauthorized use, and
   c. Use and disclose any information in the system, including to law enforcement officials.
2. Authorized Email Users may communicate with each other or with outside persons or organizations via Email. Authorized Email Users should not have any expectation of personal privacy for information stored in, created, received, or sent via Email.
3. Email Services are intended for TCHD business related purposes only. TCHD encourages the use of Email to improve communications, to improve reliability of computer systems, and to improve productivity. However, Email Services are TCHD property, with the purpose of facilitating TCHD communications. Each Authorized Email User has a responsibility to maintain and enhance TCHD's public image and to use Email in a productive and legal manner. Electronic stationary or auto-signature with images is prohibited. Auto-signatures will be in TCHD standard format.
   ~~a. Email signature – Century Gothic font, size 10~~
      ~~i. All fonts in black~~
      ~~ii. Approved TCHD Confidentiality Notice must be added to the bottom of your email signature.~~
      ~~iii. Century Gothic font, size 8~~
      ~~iv. "CONFIDENTIALITY NOTICE" in all caps and in all bold~~
      ~~v. Example:~~

~~First Name Last Name | TCMC Official Title~~
~~Tri-City Medical Center | Department Name~~
~~Address of office | City, CA Zip Code~~
~~P 760.940.XXXX | F 760.940.xxxx~~
~~emailaddress@tcmc.com | www.tricitymed.org~~

~~CONFIDENTIALITY NOTICE~~
~~This message and any included attachments are from the Tri-City Healthcare District and are intended only for the addressee. The information contained in this message is confidential and may constitute non-public information under international, federal, or state securities laws and is intended only for the use of the addressee. Unauthorized forwarding, printing, copying, distributing, or using such information is strictly prohibited and may be unlawful. If you are not the addressee, please promptly delete this message and notify the sender of the delivery error by e-mail.~~

4. All TCHD policies and practices apply to Email Services, including those policies regarding intellectual property protection, privacy, misuse of TCHD resources, sexual harassment or other unlawful harassment, information and data security, and confidentiality. In addition, any communication that is sent via Email is a communication on behalf of TCHD. Therefore, any TCHD Email communication must be professional and business-related. E-mail should have a TCHD standard confidentiality notice.
5. ~~Each individual granted Email Services at TCHD is provided with a written copy of this policy.~~ The Authorized User of Email Services must submit an approved System Access Request Form (SAR). To reinforce this and other confidentiality policies, each employee must sign the TCHD Confidentiality Agreement **per Administrative Policy: Confidentiality 455**~~annually on his/her review date~~.
6. While use of Email offers significant benefits, it can also expose the TCHD computer systems to risks and compromise if appropriate security measures are not strictly followed. Each Email user is personally accountable for any action that results in a breach of TCHD security or confidentiality.
   ~~6.~~**a. The user will not click or open any links from unknown sources. IT will be informed if such an email is received and appropriate action will be taken.**
7. The transmission of any kind of sexually explicit information on any company system is a violation of our policy on sexual harassment. In addition, sexually explicit material may not be accessed, archived, stored, distributed, edited, or recorded using our network resources.
8. TCHD's Email facilities and computing resources must not be used knowingly to violate the laws and regulations of the United States or any other nation. Use of any company resources for illegal activity is grounds for corrective action or immediate dismissal, and we will cooperate with any legitimate law enforcement activity.
9. ~~It is the Authorized User's responsibility to periodically purge old e-mail from their Inbox/Sent/Deleted boxes. The e-mail system is not a storage system. Proper long-term storage methods and locations shall be used such as email archive.~~ Mailbox size limits will be enforced **per Information Technology**~~using the following size limits~~.
   ~~a. 1GB~~ **8GB** ~~– Executives and high-end users~~
   ~~b. 500MB~~ **8GB** ~~– Directors/Managers/Supervisors~~
   ~~c. 50MB~~ **2GB** ~~– Non-management staff~~
10. The distribution list All E-mail Users includes every e-mail user in the TCHD email system. This list was developed to distribute hospital-related information that truly affects everyone, rather than for distributing personal messages or non-TCHD sponsored events and advertisements.
    a. Use of the "All E-Mail Users" distribution list is restricted from all staff except for members of the C-Suite ~~(CEO, COO, CNE, CFO, CHRO, etc.)~~, individuals authorized by C-Suite and IT personnel.
11. Do not overuse Reply to All. Only use Reply to All if a message is needed to be seen by each person who received the original message.

D. **PROCEDURE:**

1. The System Access Request Form (SAR) is used to request Email Access provided by the

TCHD Information Technology Department. Blank forms are attached to this Policy.

2. Employee:
   a. A Department **Director/designee**~~Manager/Supervisor~~ may request Email Access for an employee by filling out, signing and submitting a System Access Request Form (SAR) – Non-Provider, to the Information Technology Department. "Outlook," "Webmail (Full)" or "Webmail (Internal)" must be checked.
   b. An Information Technology representative will provide instructions and password information to the requestor.
   ~~c. To reinforce this and other confidentiality policies, each employee must sign the TCHD Confidentiality Agreement annually on his/her review date.~~
3. Business Partners:
   a. An external case manager, authorized physician, vendor, or other person engaged in legitimate business at TCHD who believes he/she has a legitimate need for Email Access may obtain a System Access Request Form (SAR) – Provider/Provider Office. The form is to be filled out, signed by a Department Director/**designee**, and submitted to the Information Technology Department. "Outlook," "Webmail (Full)" or "Webmail (Internal)" must be checked.
   b. An Information Technology representative will provide instructions and password information to the requestor.

E. **MANAGEMENT AND ADMINISTRATION:**

1. The TCHD Information Technology Department is responsible for assuring security of the TCHD network. The Information Technology Department provides all network access, and must approve all requests for Email Services. All requests for hardware and software must be approved by Information Technology.
2. The TCHD Information Technology Department provides software virus protection. Notify the Information Technology Department immediately if a software virus is detected.
3. Remote **access**~~control software, such as PC Anywhere~~, is prohibited from being installed on any network-attached computer without the prior approval of the Information Technology Department.
   a. Official Records:
      i. All messages, message audit reports, and records of Email Services are official records and are the property of TCHD. TCHD reserves the right to access and disclose, at any time, all documentation of Email Services.
   b. Copyrighted Materials:
      i. Copyrighted materials belonging to entities other than TCHD may not be transmitted by employees via Email Services. All employees obtaining access to other companies' or individuals' materials must respect all copyrights and may not copy, retrieve, modify, download or forward copyrighted materials, except with permission, or as a single copy to reference only.
      ii. Computer programs are copyrighted material, and may not be copied without adhering to the requirements listed on the purchased product's software licensing agreement.
   c. User IDs and Passwords:
      i. User IDs and passwords help maintain individual accountability for Email usage. The Information Technology Department will assign a single password to a person to be used for Network Services, Email, and Internet access. Any employee who obtains a password or ID must keep that password confidential. Company policy prohibits the sharing of passwords.
   d. Security:
      i. The TCHD Information Technology Department may review Email activity and analyze usage patterns, and distribute periodic reports of this data to the Compliance Committee and Department Directors to assure that TCHD's Email resources are devoted to maintaining the highest levels of productivity. TCHD can monitor and record all Email usage. TCHD security systems are capable of

recording Email messages for each user, and TCHD reserves the right to do so at any time.

ii. Employees should not assume that Email Messages are totally private. E-mail communication within TCHD (all addresses currently within our "Global Address Book") is considered secure and is permitted for the purpose of sharing clinical information with or without patient identifiers. The use of e-mail for communication of clinical data internal to TCHD should follow guidelines similar to those related to other forms of communication. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the use of appropriate safeguards, such as encryption, for e-mail of patient-specific information transmitted via the Internet (outside of the TCHD Global Address Book). Internal email communication using the TCHD Global Address Book, is by default encrypted. External to TCHD containing patient-specific information, or other sensitive information, is not considered secure and therefore is strictly forbidden, unless using encryption technologies specifically approved and authorized by the Information Technology Department. (See Attachment A)

iii. TCHD has installed ~~a variety of firewalls, proxies, and Internet address screening programs and other~~ security systems to assure the safety and security of the networks. Any employee who attempts to disable, defeat, or circumvent any security facility will be subject to appropriate corrective action as defined by policies.

e. Violations:

i. Adherence to this Policy is neither voluntary nor optional. Violation of this policy may constitute grounds for formal counseling, up to and including termination, as described in Administrative Policy: 424 Coaching and Counseling for Work Performance. If necessary, TCHD also reserves the right to advise appropriate legal officials of any illegal violations.

f. Legal Notice:

i. California Penal Code 502 states that unauthorized use of a computer in the state of California is a felony.

g. Notification of Improper Use:

i. Each employee is expected to report unauthorized use or violation of this policy.

~~h. All E-Mail Users Distribution List:~~

~~i. Emails that need to be sent to all email users must be approved by any member of the C-Suite. Approved emails will be sent out by IT.~~

~~F. ATTACHMENT(S):~~

~~1. Attachment A: How to Send Encrypted Email~~

~~G.~~F. **FORM(S):**

1. System Access Request Form (SAR) – Non-Provider
2. System Access Request Form (SAR) - Provider/Provider Office

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

1. Administrative Policy: ~~8610-424~~ Coaching and Counseling for Work Performance **424**
~~1.~~2. **Administrative Policy: Confidentiality 455**
3. Administrative Policy: ~~8610-585~~ HIPAA Administration **585**
~~2.~~4. **How to Send Encrypted Email**

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

1. California Penal Code 502
2. Health Insurance Portability and Accountability Act of 1996 (HIPAA)

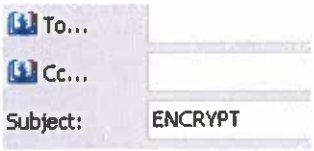
~~**Attachment A: How to Send Encrypted Email**~~

Move to Related Document

Email Security Encryption
MS Outlook or MS Outlook Web Access

Compose New Email

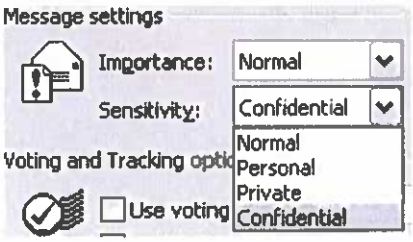
Type in the Subject field: ENCRYPT *Add subject after the ENCRYPT*



e.g ENCRYPT Let go get some food

Click Options in the tool bar

Click Sensitivity drop down menu
Click Confidential
Click Close



Type an **external email account**: example **@yahoo.com or @gmail.com**

Click Send
Your email notice will look like this:

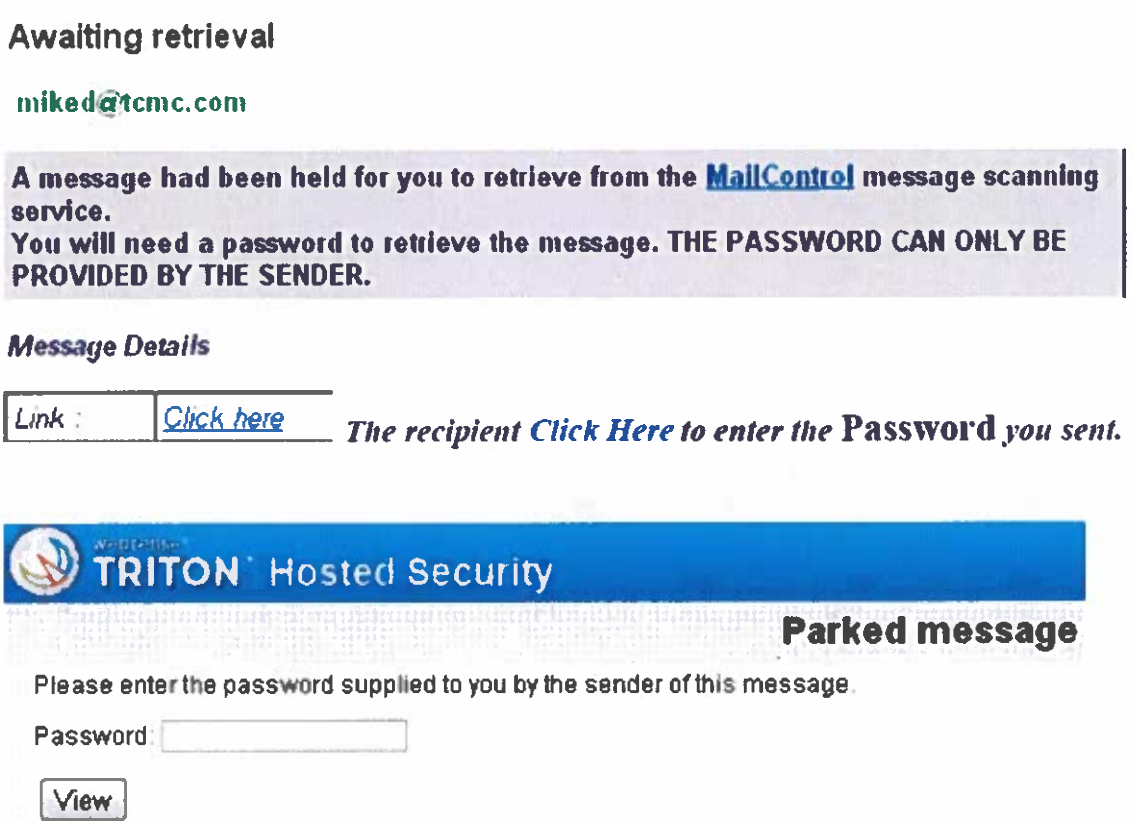
A message sent by you has been held by the MailControl message scanning service for secure retrieval. The recipient(s) will require the following password to retrieve the message. YOU MUST COMMUNICATE THIS PASSWORD TO THE RECIPIENT.

Message Details

Password :

Provide the Password *to your recipient to view the email.*

Your recipient of your email will see this:



Awaiting retrieval

mikeb@tcmc.com

A message had been held for you to retrieve from the MailControl message scanning service.
You will need a password to retrieve the message. THE PASSWORD CAN ONLY BE PROVIDED BY THE SENDER.

Message Details

Link :	Click here

The recipient Click Here to enter the* Password *you sent.

TRITON Hosted Security

Parked message

Please enter the password supplied to you by the sender of this message.

Password:

View

Type in the **Password** you send them and **click View** will be able to view the content of the email body.

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE COMPLIANCE

ISSUE DATE: 05/00

SUBJECT: EMTALA: Emergency Medical Screening

REVISION DATE: 06/03, 01/06, 08/09, 02/11, 04/17 09/20

POLICY NUMBER: 8610-506

Administrative Content Expert Approval:	~~05/20~~10/23
Administrative Policies & Procedures Committee Approval:	~~07/20~~10/23
Medical Executive Committee Approval:	n/a
Administration Approval:	~~09/20~~02/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	09/20

A. **PURPOSE:**

1. To ensure compliance with the Federal requirements contained in the Emergency Medical Treatment and Labor Act (EMTALA). EMTALA waiver allows hospitals to direct or relocate individuals which would normally be prohibited under EMTALA of individuals with unstable emergency medical conditions if necessitated by the circumstances of the declared emergency. Centers for Medicare and Medicaid Services (CMS) will provide notice of the waiver.

B. **DEFINITION(S):**

1. **Basic information obtained may include:**
   - a. **Patient's full name**
   - b. **Patient's date of birth**
   - c. **Social Security number**
   - d. **Family physician**
   - e. **Insurance plan information, if applicable**

~~1.~~2. Individual who presents with an emergency medical condition: An individual who presents with an emergency medical condition anywhere on Tri-City Healthcare District (TCHD) campus, even if the individual presents at a location other than the Emergency Department (ED). TCHD's campus includes ambulatory services departments located on or adjacent to the campus, as well as the medical center parking lots~~, sidewalks, and access roads~~.

~~2.~~3. Emergency Medical Condition:

- a. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in either placing the health of an individual (or with respect to a pregnant woman, the health of her unborn child) in serious jeopardy; serious impairment of bodily functions; or serious dysfunction of any bodily organ or part; or
- b. With respect to a pregnant woman who is having contractions, there is adequate time to affect a safe transfer to another hospital before delivery or the transfer may pose a threat to the health or safety of the woman or her unborn child.

4. Medical Screening Exam (MSE):

- a. The process required to reach, with reasonable clinical confidence, the point at which it can be determined whether an emergency medical condition does or does not exist.
- ~~3.~~b. -MSE requires an evaluation by a qualified medical provider, within the capability of the hospital's ED, to determine whether an emergency medical condition exists, or if the person is in labor. ~~The MSE is a dynamic process and represents a spectrum ranging from a simple process involving only a brief history and physical, to a complex process~~

~~that involves performing ancillary studies and procedures, depending on the patient's presenting symptoms.~~

5. Stabilization:
   a. Stabilization includes the provision of such medical treatment for the condition, necessary to assure within reasonable medical probability that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility, or that the woman has delivered the child and placenta.
   ~~4.~~b. Stabilization may include either stabilization for discharge or stabilization for transfer.
6. Triage:
   a. Determines the order in which patients will be seen.
   ~~5.~~b. **Triage does not qualify as an appropriate MSE.**

C. **POLICY:**

1. Collection of financial information in the ED must be performed in accordance with this policy.
2. Hospitals may not delay in providing a ~~medical screening examination (~~MSE~~)~~ or necessary stabilizing treatment by inquiring about an individual's ability to pay for care.
   a. Individuals who have an emergency medical condition must be offered, and if desired, receive a MSE regardless of answers the individual may give to questions asked during the registration process.
   b. ~~In addition, a~~**A** hospital may not delay screening or treatment to an individual while information is verified.
   c. ~~However, h~~**H**ospitals may continue to follow reasonable registration processes for individuals presenting with an emergency medical condition.
      ~~2.~~i. Reasonable registration processes may include requesting information about insurance as long as these procedures do not delay screening or treatment.
3. Each patient seeking treatment in the ED is entitled to an emergency MSE. When collecting financial information in the ED setting, the following guidelines must be followed:
   a. A MSE and necessary stabilization may not be refused by TCHD for any reason, even if a managed care plan refuses to authorize treatment or pay for services the MSE must be completed despite ability to pay.
   b. A MSE for an ED patient may not be delayed in order to:
      i. Inquire about an individual's ability to pay
      ii. Inform the patient that he/she must pay a co-pay or deductible if they choose to be treated
      iii. Perform insurance verification and authorization
      iv. Inform the patient that his/her care will be free or at a lower cost if another facility is used
   c. The MSE must be the same for all individuals presenting to the ED with the same condition, regardless of financial status or payment source.
      ~~c.~~i. ~~Triage does not qualify as an appropriate medical screening exam~~.
4. The registrar or Triage **Registered Nurse (RN)** must refrain from making any comments that the patient might interpret to mean that services might not be provided based on ability to pay. For example, the registrar must not say, "We don't accept XYZ insurance here."
5. The registrar shall not request co-pays, deductibles, or past due balances from the patient until the MSE and necessary stabilization have occurred.
6. If a patient expresses the intent to leave the ED, the patient shall be encouraged to remain in the ED until the MSE and necessary stabilization are completed. If a patient leaves TCHD as a result of questions asked prior to receiving the MSE, it may be interpreted that the there was a suggestion that the patient leave the ED. This **occurrence** must be ~~well~~ documented by the Triage RN.
7. If a patient presents to the ED with a life-threatening emergent condition (i.e., patient arrives via ambulance in cardiac arrest) the MSE and necessary stabilization will begin immediately. The registrar may obtain the **basic** information ~~identified in C.10 below~~ from a source other than the patient (i.e., next of kin). Otherwise, financial information shall be obtained after the patient has

received a MSE and necessary stabilizing treatment. Financial information may be discussed with the patient only after stabilization.

8. In case of an emergent situation or active labor identified after the MSE, stabilization and treatment will begin immediately. The registrar may obtain the **basic** information ~~identified in C.10 below,~~ as well as insurance verification ~~and authorization~~, provided that the necessary stabilization and treatment are not delayed. ~~When the physician determines that an emergency medical condition no longer exists, the patient may;~~

~~a.~~**9.** ~~Accept treatment and financial liability.~~

~~9.~~**10.** If the MSE determines that the patient does not have an emergency medical condition, or the patient is not in active labor, the patient shall be informed of his/her treatment options. The registrar may obtain the **basic** information ~~identified in C.10 below~~, as well as insurance verification ~~and authorization~~. After the MSE is completed, and once the physician has made the determination that an emergency medical condition does not exist, the patient may be informed of his/her potential financial **responsibility** ~~liability~~. ~~The patient may;~~

~~a. Accept treatment and financial liability.~~

~~b.~~**11.** ~~Refuse additional treatment. If treatment is refused, the physician may refer the patient to another facility.~~

~~10.~~**12.** The registration process may be initiated as long as the process does not cause a delay in the provision of a MSE and necessary stabilization for an emergency medical condition. Basic identifying information may be gathered and entered into ~~Affinity~~ **Cerner** to allow for processing of tests in the order entry system. ~~Basic information obtained may include:~~

~~a. Patient's full name~~
~~b. Patient's date of birth~~
~~c. Social Security number~~
~~d. Family physician~~
~~e. Insurance plan information, if applicable~~

~~11.~~**13.** If patient's information is already present in ~~Affinity~~**Cerner**, the registrar will verify the existing information.

~~12.~~**14.** An Advance Beneficiary Notification Notice (ABN) shall not be obtained when rendering emergency medical treatment.

~~13.~~**15.** Signage indicating payment is due at time of service, or indicating that the patient's insurance may not pay for the service may not be placed in the ED lobby or treatment area.

~~14.~~**16.** Registration/ patient access management personnel must educate all registration staff responsible for registering, billing, and maintaining patient records.

~~15.~~**17.** The Registration supervisor shall observe registrars ~~at regular intervals during the orientation period and at least annually thereafter~~ to ensure compliance ~~with this policy. Deviations from the policy will result in corrective action.~~

D. **REFERENCES:**

1. Social Security Act, Section 1867, 42 U.S.C. 1395dd, Examination and Treatment for Emergency Conditions and Women in Labor.
2. Social Security Act, Section 1867, 42 U.S.C. 1395cc, Emergency Medical Treatment and Active Labor Act.
3. **State Operations Manual Appendix V Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases** ~~Federal Register~~ §489.24, Special Responsibilities of Medicare Hospitals in Emergency Cases.
4. **Code of** Federal **Regulations Title 42 (Updated 10/2/2023).** ~~Register~~ §489.53 **Termination of CMS;** ~~, Terms of Provider Agreements, Acceptance of Program Beneficiaries.~~
5. Current California Hospital Association (CHA) Consent Manual. **(2021). Chapter 12 Discharge Planning, Patient Transfers and Related Issues.** ~~Chapter~~: ~~Patient Transfer, Discharge,~~ or ~~Temporary Absence~~
6. EMTALA Answer Book 2020, Author Mark M. Moy

Tri-City Healthcare District
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATION

ISSUE DATE: 06/94 **SUBJECT: Parking Program**

REVISION DATE: 09/02, 03/03, 07/04, 12/05, 04/08 09/10, 08/14, 06/17, 06/20, 11/20 **POLICY NUMBER: 8610-261**

Administrative Content Expert Approval:	**~~07/20~~07/23**
Administrative Policies & Procedures Committee Approval:	**~~08/20~~10/23**
Environmental Health and Safety Committee Approval:	**01/24**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~10/20~~02/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**11/20**

A. **PURPOSE:**

1. To provide adequate parking for patients and visitors by defining Tri-City Healthcare District's (TCHD) parking program.

B. **POLICY:**

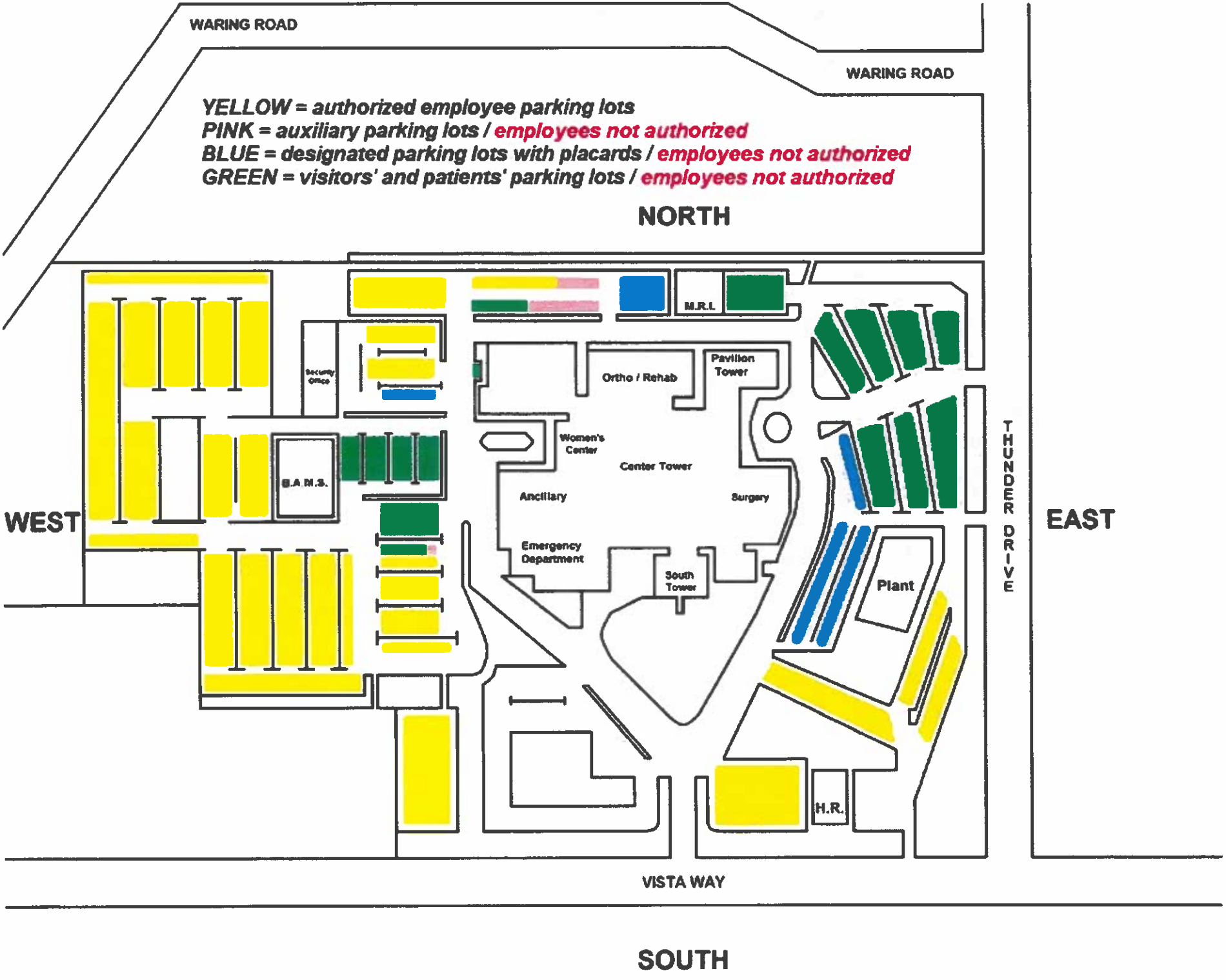
1. All TCHD Board Members, Medical staff, Executives, Directors and authorized administrative staff may park in the Medical Staff parking area.
2. Employees shall park in designated employee parking areas (Refer to Tri-City Healthcare District Parking Map).
   a. Employees or others who use a bike as their mode of transportation shall park and secure bikes in the designated bike parking areas.
   b. Volunteers may park either in reserved volunteer parking areas or in employee parking areas.
3. Construction personnel shall receive parking instructions from the Engineering Department during their orientation.
4. Non-compliance with parking standards results in the issuance of a Security Department Parking Violation.
   a. The department manager shall be notified if an employee receives a second parking violation. Corrective action follows Administrative Policy, Coaching and Counseling for Performance Improvement.

~~5. Valet services are provided to all District residents with a District benefit card. Valet services are provided Monday – Friday during designated hours and may be used for special events with notification one week prior to event.~~

~~6.~~**5.** The designated speed limit on campus is 15 MPH unless posted otherwise.

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

1. Tri-City Healthcare District Parking Map


WARING ROAD
WARING ROAD
YELLOW = authorized employee parking lots
PINK = auxiliary parking lots / employees not authorized
BLUE = designated parking lots with placards / employees not authorized
GREEN = visitors' and patients' parking lots / employees not authorized
NORTH
M.R.I.
Security Office
Ortho / Rehab
Pavilion Tower
Women's Center
Center Tower
B.A.M.S.
Ancillary
Surgery
Emergency Department
South Tower
Plant
THUNDER DRIVE
WEST
EAST
H.R.
VISTA WAY
SOUTH

Tri-City Medical Center

Quality Assessment Performance Improvement (QAPI) Plan ~~2022~~ 2023 & ~~2023~~2024

A. **INTRODUCTION:**

1. Tri-City Medical Center (TCMC) is a community owned and operated California District Hospital. TCMC is a full service, acute-care hospital and includes an Inpatient Rehab, Home Health Services, Outpatient Behavioral Health, Inpatient & Outpatient Physical/ Occupational/ Speech/ Wound Therapy Services, Orthopedic and Primary Care Clinics. TCMC embraces a culture of excellence, safety and continuous improvement. Governance, leadership, frontline staff and the organized medical staff work together to promote a culture of safety and reliability. The goal is to have a culture characterized by teamwork with open discussion about quality and safety with a particular focus on systems and processes, supported by robust data and benchmarking.

B. **MISSION:**

1. Mission: To advance the health and wellness of the community we serve.
2. Vision: Be recognized as a healthcare system of choice in our community.

C. **VALUES**

1. The needs of our patients come first.
   a. Quality
   b. Caring
   c. Innovation
   d. Safety
   e. Integrity
   f. Stewardship

D. **CULTURE OF SAFETY**

1. A patient safety culture can be defined as the shared values, beliefs, norms, and procedures related to patient safety among members of an organization, unit or team. Patient safety is an organization-wide, integrated and coordinated approach designed to avoid injuries to patients from the care that is intended to help them. Safety is a priority and a property of systems and processes.
2. TCMC is committed to the periodic assessment of the culture of safety within the hospital district using evidence-based perception surveys to evaluate the culture and the effectiveness of interventions to strengthen the culture of safety over time.
3. Priorities are identified and categorized based on the Institute of Medicine (IOM) Six Aims of Healthcare:
   a. Safe: The organization supports the Just Culture Model as a framework for event investigation and response to events
   b. Timely: (e.g. reducing wait times and delays, timely test results)
   c. Effective: (e.g. reducing preventable mortality, sepsis management, stroke care)
   d. Efficient: (e.g. timely data analytics, clinical documentation improvement)
   e. Equitable: (e.g. reducing variation in our care, cultural diversity strategy)
   f. Patient Centered: (e.g. Patient Rights and values guide all clinical decisions)

Administrative Content Expert	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
03/23, 12/23	06/23, 01/24	08/23, 02/24	n/a	08/23

E. **HOSPITAL ORGANIZATION:**

1. Scope of the Plan
   a. The scope of the plan includes all patient-care services in all settings provided by staff, or through contracted services, and encompasses those departments and services that support patient care. This plan is designed to measure key processes and outcomes in order to understand and ensure the reliability of systems and processes, to prioritize improvement of systems or processes.
2. Roles and Responsibilities:
   a. The Board of Directors (BOD)
      i. The BOD oversees the accountability of the Medical Staff for the overall quality of patient care. Through the Quality Assurance/Performance Improvement (QA/PI) Committee, the BOD oversees the implementation and continuous evaluation of an organization wide, data-driven, QAPI program. BOD responsibilities include overseeing the implementation of a QA/PI Plan that sets clear expectations for:
         1) Quality of Care
         2) Patient Safety
         3) Resource Allocation for measuring, assessing and evaluating organizational performance
         4) Eliminating harm to patients caused, in part, by complex processes and communication challenges
         5) Ensuring safe, timely, effective, efficient, equitable and patient-centered care
      ii. The BOD oversees the QA/PI program through regular reports that filter up through the Medical Quality Peer Review (MQPR) Committee. The BOD acts as appropriate based on the recommendations from the above-mentioned committees as well as the Executive Team to ensure high quality patient care. The BOD ensures that Performance Improvement projects are appropriately prioritized and effectively implemented, as determined by Administration in collaboration with the BOD. The BOD also ensures that the QAPI activities are aligned with the organization's Mission, Vision and Strategic Goals.
      iii. Reports shall be presented to the BOD on a schedule. Based on the findings outlined within the quality reports, the BOD shall act to improve quality of care. Variations within the reporting schedule are permissible as long as the BOD maintains oversight of all these functions.
3. Medical Staff
   a. The TCMC Medical Staff, as outlined within the Medical Staff Bylaws, shall remain accountable for the overall quality of patient care. As such, the Medical Staff shall receive reports from the various Medical Staff committees accountable for monitoring ongoing care processes.
4. Executive Team
   a. TCMC's Executive Team consists of the Chief Executive Officer (CEO), The Chief Operations Officer (COO), the Chief Medical Officer (CMO), the Chief Financial Officer (CFO), and the Chief Nurse Executive (CNE). The team actively oversees all QAPI activity within the organization. ~~The CMO oversees the Quality department.~~ The Executive Team is proactively assessing the effect of upcoming healthcare reform and positioning the organization for success within a continuously changing operating environment.
5. Quality Assurance/Performance Improvement Committee
   a. The Quality Assurance/Performance Improvement (QA/PI) Committee, as outlined within its scope of service maintains an active role in the evaluation of quality measures through regularly scheduled meetings.
   b. The following committees will be integrated into the hospital-wide QAPI program for oversight of quality initiatives which includes health outcomes, patient safety, and quality of care:
      i. Infection Control Committee

1) The Infection Control Committee is a medical staff committee which selects initiatives, monitors and evaluates the Infection Control Program, and reports to the Medical Executive Committee, Medical Quality Peer Review Committee and Quality Assurance/Performance Improvement Committee. The Infection Control Committee is a multidisciplinary committee that shall approve, establish, and oversee the program for surveillance, prevention, and control of infections in order to improve the quality of care provided.

ii. Pharmacy and Therapeutics
1) The Pharmacy and Therapeutics (P&T) Committee is a medical staff committee accountable for the safety and quality of medication and therapy as it relates to pharmaceuticals. The committee discusses the hospital formulary and antimicrobial stewardship among other issues.
a) The Medication Safety Committee also reports to P&T, which is multidisciplinary. Issues discussed at this level may be referred directly to the MEC, as well as going to the QA/PI Committee for discussion before advancing to the BOD.

iii. Patient Safety
1) TCMC maintains an active Patient Safety Program in accordance with TCMC's service standard "Safety". TCMC's Regulatory & Accreditation Manager oversees integration and coordination of patient safety activities, which supports and promotes the mission, vision and values of TCMC. Please refer to the Risk and Patient Safety Plans for additional detail.

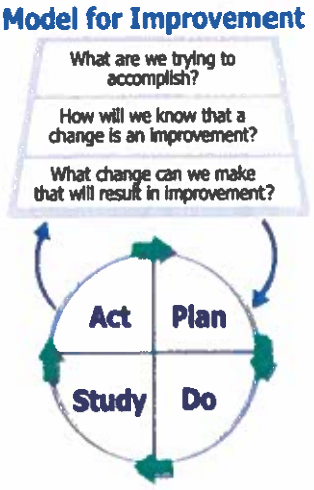
iv. Perioperative Surgical Home (PSH) Committee
1) The program establishes an interdisciplinary team to collaborate in the care of patients undergoing colorectal surgery. The committee works to provide a consistent high quality, safe approach to our PSH program across the continuum.

F. **PERFORMANCE IMPROVEMENT MODEL:**

1. FOCUS PDCA:

a. "PDCA process involves planning for change or improvement constantly, and prioritizing and reprioritizing your improvement efforts based on carefully defined measurements and whether or not the problem involves high-risk, high-volume, or problem-prone processes, and if it dovetails with the goals of the organization" (Dulgacz, Retifo, & Greenwood, 2004).

i. F= Find a process to improve
ii. O= Organize a team that knows the process
iii. C= Clarify current knowledge of the process
iv. U= Understand causes of process variation
v. S= Select the process improvement



b. Plan: During this stage, TCMC analyzes and examines services in order to anticipate improvements. This includes collection of data and analysis of the process. The outcome of the "Plan" phase is a list of objectives used to move forward with improvement. Objectives include; appropriate indicators, best practices, and identifying a baseline to

measure against. The recommended format for the PDCA cycle is the Institute for Healthcare Improvement (IHI) template. IHI uses the Model for Improvement as the framework to guide improvement work. The Model for Improvement, * developed by Associates in Process Improvement, is a simple, yet powerful tool for accelerating improvement.

c. Do: In the DO phase, TCMC develops a measure, including the numerator, denominator, sample size and sample population. Also included is how and from what source that data will be gathered. Finally, it identifies the method and frequency of data interpretation and reporting chain (QA/PI, and other committees).

d. Check: After gathering data, TCMC analyzes the information and measures the effectiveness of the improvements. This review includes whether data collected was reliable and whether the variation in the studied process is stable. At this point benchmarks and threshold can be reset and any studies modified to better identify any special cause variances. All measures should be analyzed against the baseline data. This stage looks at what improvements were implemented and if they were effective. If the measure needs refinement, the DO phase is revisited at this point.

e. Act: The ACT phase is where a refined and perfected process showing a desired outcome is then implemented on a broader scale throughout the organization. In this way success on one unit can beget similar success within the organization. The Act phase circles back to the Plan stage for new implementation, thus ensuring continuous process improvement.

2. TCMC employs a variety of professional resources for benchmarking and identifying best practices including the National Database of Nursing Quality Indicators (NDNQI), the Collaborative Alliance for Nursing Outcomes (CALNOC), Center for Medicare and Medicaid Services (CMS) Value Based Purchasing data, The Joint Commission (TJC)/CMS Core Measure rates, Center for Disease Control (CDC), National Quality Forum (NQF), Agency for Healthcare Research and Quality (AHRQ), Collaborative Healthcare Patient Safety Organization (CHPSO), the Institute for Healthcare Improvement (IHI), the National Healthcare Safety Network (NHSN), the National Association for Healthcare Quality (NAHQ), California Maternal Child Quality Collaborative (CMQCC), California Perinatal Quality Care Collaborative (CPQCC), Health Services Advisory Group Quality Improvement Organization (HSAG QIO), Health Services Advisory Group Improvement Innovation Network (HSAG-HIIN), and other evidence-based sources.

G. **PRIORITIZATION AND PLANNING:**

1. The Medical Center's Quality Department and Patient Safety Program facilitates an annual quality planning process which is transparent and inclusive to encourage a broad discussion across the medical center regarding quality improvement achievements, priorities for improvement in service, cost and outcomes. The process will be informed by a proactive risk assessment and review which includes the evaluation of:
   a. Performance on key quality outcomes, safety and process metrics compared to national benchmarks
   b. Patient and Family member feedback
   c. Pay for Performance metrics
   d. Regulatory requirements
   e. Event reporting, including near misses
   f. Results of survey data, including the Culture of Safety Survey and Leapfrog
   g. New legislative mandates
2. The Board of Trustees, Senior Leadership and Medical Staff Leadership working through the organization's standing committees shall establish priorities for performance improvement collaboratively. Criteria for prioritization are based on high-volume, high-risk, problem-prone, patient experience and cost-related issues. In addition, data collected from performance improvement and risk-reduction activities shall be considered in establishing priorities.

3. Established goals and priorities for improvement will be identified in the annually updated Quality and Patient Safety Plans which will be approved by the Quality Assurance/Performance Improvement Committee and BOD.

H. **DEPLOYMENT:**

1. The Medical Center charters multidisciplinary teams comprised of members with knowledge of the process to be improved.

I. **PERFORMANCE MEASUREMENT AND MONITORING:**

1. Measurement is conducted to establish the reliability of a process, to identify opportunities for improvement and to statistically evaluate clinical and organizational performance. Evaluation of clinical and organizational processes and outcomes is achieved through the development and ongoing monitoring of indicators based on aspects of performance, key organizational functions, identified dimensions of performance, and "best-practice" models or benchmarking. TCMC uses criteria to define its own performance measures including:
   a. The measure can identify the events it was intended to identify
   b. The measure has a documented numerator and a denominator statement or description of the population to which the measure is applicable. The measure has defined data elements and allowable values
   c. The measure can detect changes in performance over time
   d. The measure allows for comparison over time within the Medical Center or between the Medical Center and other entities
   e. The data intended for collection are available
   f. Results can be reported in a way that is useful to the organization and other interested stakeholders

J. **ERROR PREVENTION, RISK IDENTIFICATION, AND MITIGATION:**

1. Event Reporting, Trending and Analysis
   a. TCMC utilizes data from a variety of sources to identify areas of risk and to focus error-reduction initiatives. The areas monitored include:
   b. Hospital Trends: Event reports and generic trends are routinely analyzed by the Risk Management Department to identify harm or "near misses" or patterns of care that result in less-than-optimum outcomes.
   c. Patient Surveys: TCMC utilizes questions related to the patients' perception of their care and safety during their hospitalization. This information is analyzed and considered in developing risk-reduction strategies.
   d. Employees: Employees are encouraged to use the Chain of Command, Escalation process to report safety concerns to their supervisors, Senior Leadership and through the online reporting system (Patient Safety Tracker). TCMC supports a non-punitive reporting environment.
   e. Safety Committee Reports: The Safety Officer provides the Medical Board with an update regarding safety issues as presented and discussed at the Safety Committee. All issues that require additional review are referred to the appropriate Leadership.
2. Proactive Risk Assessment
   a. TCMC consistently seeks to reduce the risk of sentinel events and other medical/healthcare system harm occurrences by conducting its own proactive risk assessments, including but not limited to Failure Mode Effects Analysis (FMEA) and Hazard Vulnerabilities Assessment of selected, existing systems and processes. The Medical Center utilizes external agency reports, internal event reports, Leapfrog Survey, and any other recommendations related to patient safety. The purpose of the assessment is to identify a set of hazards, estimate how likely they are to occur, pick the most likely outcome, and prioritize improvement opportunities. TCMC closely monitors its compliance with TJC's National Patient Safety Goals. This proactive approach is undertaken so that processes, functions and services can be designed or redesigned to prevent harm to patients.

b. On an ongoing basis, the Chief Medical Officer and Director of Quality involve, as appropriate, members of the medical staff, senior leadership, hospital managers and hospital staff in risk analysis of major medical services/processes. Risk Management and Quality Department and Patient Safety Program manager collect error-reduction data from benchmark healthcare organizations and other industries. This information includes, but is not limited to, the following:
   i. The Joint Commission Sentinel Event Alerts
   ii. Institute for Safe Medication Practices (ISMP) Medication Safety Alerts
   iii. Emergency Care Research Institute (ECRI) Bulletins
   iv. CDC Bulletins
   v. CMS Hospital Compare Website

3. Utilizing the above data, as well as other internal and external metrics, the Director of Quality, in collaboration with Risk Management, makes recommendations to the Chief Medical Officer and the Quality Assurance/Performance Improvement Committee regarding priority aspects of care processes that are known to be high-risk or problem-prone. Collaboratively these individuals determine priorities for error reduction efforts and charter Teams/Committees to perform process redesign and improvements.

Tri-City Medical Center
Allied Health Professional

Nurse Practitioner – Oncology
Standardized Procedures

Approvals

Oncology Division (Signature):	~~September 15, 2021~~October 5, 2023
Medicine Department (Signature):	~~September 15, 2021~~October 5, 2023
Interdisciplinary Practice Committee (Date):	~~October 18, 2021~~January 15, 2024
Medical Executive Committee (Date):	~~November 22, 2021~~January 22, 2024
Administration (Date):	~~November 30, 2021~~February 20, 2024
Professional Affairs Committee (Date):	n/a
Board of Directors (Date):	Decmeber 9, 2021

NURSE PRACTITIONER STANDARDIZED PROCEDURES

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I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

A. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.

B. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.

C. Standardized procedures are maintained in the allied professional's file in the medical staff office.

1. All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
2. Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

A. **SETTING**

1. The NP may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privilege card. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

B. **SCOPE OF NP PRACTICE (FUNCTIONS)**

1. The Oncology NP will:
   a. Assume responsibility for the *Oncology* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
      i. Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.
   b. Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.
   c. Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.
   d. Obtain medical histories and perform overall health assessment for any presenting problem.
   e. Provide or ensure case management and coordination of treatment.

f. Make referrals to outpatient primary care practitioners for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.

g. Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.

h. Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

i. Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.

j. Formulate recommendations to improve patient outcomes.

k. Provide patient health education related to medications health issues.

III. MANAGEMENT OF CONTROLLED SUBSTANCES

A. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.

B. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.

1. Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.

a. This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.

2. When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the Division of Oncology.

IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

A. Supervision for purposes of this standardized policy is defined as supervision by and MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.

B. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.

C. No physician shall provide concurrent supervision for more than four NPs.

D. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.

E. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.

1. Additional Supervision occurs as described below under "Quality Improvement."

F. Supervisor notification and consultation is obtained under the following circumstances:

1. Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
2. Acute exacerbation of a patient's situation;
3. History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
4. Patient refusal to undergo a medical examination and/or appropriate medical monitoring.
5. Upon request of the patient, another clinician or Supervisor.
6. Upon request of the NP.
7. The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

V. **QUALIFICATIONS - EDUCATION AND LICENSING**

A. Education and training:
   1. Master's degree in Nursing from an accredited college or university; AND
   2. Completion of an approved Adult, Child, or Family Nurse Practitioner program.

B. Licenses and Certification:
   1. Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
   2. Currently certified by the State of California as a Nurse Practitioner;
   3. Possession of a California State-issued medication Furnishing Number;
   4. Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
   5. BLS or ACLS in accordance with the specialty requirement.
   6. CNOR Certification if assisting in surgery.

VI. **QUALITY IMPROVEMENT**

A. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
   1. The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
   2. The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
   3. NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
   4. The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.
   5. The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.

B. The NP will maintain and upgrade clinical skills as required to meet professional standards.
   1. Documentation of participation in relevant continuing education activities.

VII. **PRACTICE PREROGATIVES**

A. As determined by the NP – Oncology Card.

Acknowledgement Statements:

I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC.

As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
Supervising Physician Signature	Date
Supervising Physician Signature	Date
Supervising Physician Signature	Date
Supervising Physician Signature	Date
Supervising Physician Signature	Date

Tri-City Medical Center
Oceanside, California

CARDIAC REHABILITATION SERVICES

ISSUE DATE: 10/93 **SUBJECT: Patient Discharge Criteria**

REVISION DATE: 6/97, 3/03, 10/07, 01/13, 08/20

Cardiac Rehabilitation Approval:	~~02/20~~09/23
Division of Cardiology Approval:	~~07/20~~12/23
Medical Executive Committee Approval:	~~07/20~~01/24
Administrative Approval:	~~08/20~~02/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/20

A. **PURPOSE:**
1. To establish the requirements for patient discharge from the Cardiac Rehabilitation Program.

B. **POLICY:**
1. All Cardiac Rehab patients shall be evaluated prior to discharge and results of evaluation documented in the participant's medical record.

C. **GENERAL GUIDELINES:**
1. Patients shall be discharged from the Cardiac Rehabilitation Program when the following criteria are met:
   a. Normal hemodynamic responses to exercise, including appropriate blood pressure, normal or unchanged ECG at peak exercise with a stable or medically acceptable ischemic response.
   b. Stable or absent angina.
   c. Stable and/or controlled resting heart rate and blood pressure (~~i.~~e.**g**~~,~~. less than 90 beats per minute and 140/90 respectively).
   d. If above criteria is not met, physician shall be informed and an extension to the program shall be requested. If request or authorization for extension is denied, the patient shall be offered a continuation of program on cash basis.
2. Patients shall have adequate muscular strength, endurance, functional capacity and body composition for activities of daily living and occupational needs.
3. Patients shall have satisfactory understanding of the following:
   a. Basic pathophysiology of their cardiovascular disease.
   b. Rational for interventions and lifestyle modifications.
   c. Lifestyle characteristics associated with low risk of coronary artery disease.
   d. Medication information.
   e. Range of safe activities for sexual, vocational and recreational pursuits.
4. Patients shall demonstrate an ability to maintain the exercise prescription within the designed ranges and to recognize signs and symptoms of exertion intolerance, as demonstrated through their exercise session reports.
5. A discharge summary shall be sent to the referring physician upon completion of the program.
6. Supervising physician shall complete a discharge evaluation ~~with patient~~, which shall include options for continuation of exercise program~~,~~ **and** outcome results from quality measures.~~, and an education discussion utilizing the health knowledge test.~~
7. Patients shall complete a program evaluation form.
8. Patients may also be discharged at anytime due to lack of attendance at the discretion of staff.

Tri-City Medical Center
Oceanside, California

CARDIAC REHABILITATION SERVICES

ISSUE DATE: 01/13 **SUBJECT:** Scope of Service

REVISION DATE~~(S)~~: 08/20

Cardiac Rehabilitation Approval:	**~~02/20~~09/23**
Division of Cardiology Approval:	**~~07/20~~10/23**
Medical Executive Committee Approval:	**~~07/20~~01/24**
Administrative Approval:	**~~08/20~~02/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/20**

A. **GOALS:**
1. To provide individualized quality patient care in a safe environment.
2. To produce an optimal reduction of cardiac risk factors and build/maintain optimal physical conditioning.
3. To continuously evaluate and improve the service provided.
4. To participate in interdisciplinary care by working closely with other disciplines.
5. To educate participants and their family members about cardiovascular disease.

B. **BRIEF DESCRIPTION OF SERVICE:**
1. The Cardiac Wellness Center (CWC) provides progressive exercise, education, and risk factor modification training, under medical supervision, to individuals with or at risk for **cardiovascular** ~~coronary artery~~ disease **(CVD)**. Cardiac rehabilitation services are prescribed and initiated from the perspective of case management for the individual patient. Inherent within case management is giving attention to the patient's needs (including physical, social, psychological, and vocational ~~needs~~) as well as the patient's family system. The program provides the necessary screening and assessment to ensure appropriate care. Intervention is prescribed in stages during the patient's course of recovery.

C. **METHODS USED TO ASSESS PATIENTS' NEEDS:**
1. Initial patient assessments are performed by the CWC staff during the first monitored exercise and intake appointment. **An Individualized Treatment Plan (ITP) is created based on the initial assessment and reviewed and approved by** ~~T~~the supervising physician. ~~meets with the patient during his/her second monitored visit to create together an individualized treatment plan.~~ Reassessments are performed by the supervising physician every 30 days or when a change in status occurs. The CWC staff assesses the patient's exercise response and any signs and symptoms of cardiac insufficiency at each exercise visit, and adjusts the exercise prescription accordingly.

D. **SCOPE AND COMPLEXITY OF SERVICES:**
1. The program is designed to meet the needs of **individuals** ~~people~~ of all ages who have **CVD**~~CAD~~ or may be at risk for developing **CVD**~~CAD~~. The program is also open to **individuals**~~persons~~ who would prefer to exercise under medical supervision in a gym type setting. A physician referral and clearance is necessary for participation in all program phases. The services provided by the CWC include:
   a. Inpatient education and instruction for discharge, home exercise guidelines (phase I) and when to begin the outpatient program (phase II),

b. ~~O~~outpatient exercise program (phase II and phase IV), ECG monitoring, ~~M~~medically supervised exercise training sessions, ~~I~~individualized exercise prescription, ~~I~~initial, mid-point, and discharge evaluations by the CWC medical director/supervising physician, ~~B~~blood pressure monitoring, ~~P~~pre and ~~P~~post Program outcome measurements, ~~G~~group classes including strength training, stretching, balance, and yoga. ~~for beginners to advanced participants.~~

c. Program **also** includes **monthly education presentations,** ~~E~~educational DVD library, **and** ~~W~~written educational materials, including take home quizzes.~~,~~

~~1.~~**d.** Medicare/Medical covered diagnoses for cardiac rehabilitation include only the following: Stable Angina, Coronary artery bypass graft surgery (CABG), Coronary artery angioplasty (PTCA) and/or coronary artery stent placement, Myocardial infarction (MI), Heart Transplant, and Heart valve repair or replacement surgery**, congestive heart failure (EF <35%), and Supervised Exercise Therapy (SET) PAD**.

E. **TYPE AND AGE OF PATIENTS SERVED:**

1. The program is limited to adults (18+). Anyone can join the program with a signed referral from their physician.

~~1.~~**2.** The types of patients seen in the CWC or by the CWC staff fall into different described phases:

a. **Phase I:** Acute phase, inpatient status, patient is still **being treated for an** ~~suffering from~~ acute event

~~a.~~**b. Phase II:** The entry evaluation and achievement of specific safety and behavioral outcomes occur here, as well as close monitoring of HR, BP, and ECG monitoring. This phase is usually covered by insurance and can last **from** 12-36 sessions (3 days per week).

~~b.~~**c. Phase IV:** This is the maintenance phase. In this phase, patients continue their exercise training and receive necessary and appropriate support from the CWC staff in accordance with their individual needs. This is equivalent to a gym membership and is a self-pay program. ~~The age of the population served varies. Anyone can join the program with a signed referral from their physician.~~

F. **STAFFING AND THE AVAILABILITY OF STAFF:**

1. The CWC is staffed with: Board Certified and CA licensed physicians, Registered ~~n~~Nurses, Exercise Physiologists, Exercise Technicians, and Support staff which may include a registered dietician and licensed psychologist. Staffing is dependent upon the needs of the department, which is determined by patient volume and needs under the American Association of Cardiovascular and Pulmonary rehabilitation (AACVPR). AACVPR states cardiac rehabilitation programs must have a staff to ~~phase II~~ patient ratio of 1:4 **(phase II)** and a ~~phase IV~~ staff to patient ratio of 1:10 **(phase IV)**. BLS ~~and ACLS are~~**is** required of all **personnel and ACLS is required of all registered nurses and exercise physiologists** ~~nursing personnel~~ working in the Cardiac Wellness Center. Initial and annual competency requirements for staff are defined and updated on a yearly basis.

G. **ASSESSING DEPARTMENT SERVICES:**

1. The CWC ~~has two locations:~~**is located on** the hospital campus in Oceanside**, CA.** ~~and the Tri City Wellness center in Carlsbad.~~ -Hours of service are: ~~**Hospital campus** open M-T-TH~~ **Monday, Wednesday, and Friday from** 7am-3:30pm.~~ and W-F 7am-12 noon. **Carlsbad** opens M-T-TH 8:00am-11:00am~~

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

1. The level of care provided by the Cardiac Wellness Center meets the needs of both inpatients and outpatients through availability of staff who are competent to provide service for the current patient population and the coordination of nursing services with services of other disciplines.

I. **PERFORMANCE IMPROVEMENT**

1. In order to improve patient care, several indicators are monitored to measure care given and effect change. The CWC results are compared to national and/or system-wide benchmarks, when available, or the department's own historical data. Unmet goals, or measures of no change, are perceived as opportunities for improvement. The CWC patient surveys are designed to measure outcomes and quality of patient care and to seek ways to improve the services offered. The key outcomes measured are: MET level (physical fitness), Diet scores (decreased fat, increased fiber), Body Mass Index and waist circumference (weight loss), Beck inventory (depression), **Dartmouth COOP (quality of life),** Perception of cardiovascular health, mental health, muscular strength, and flexibility-, Compliance to an exercise program, Program satisfaction/recommendation to others, Satisfaction with education component of program (and improvement in health knowledge), and Confidence in staff's ability/safety of program.

J. **STANDARDS USED BY THE DEPARTMENT IN THE CARE OF PATIENTS:**

1. The policies, procedures, and standards of care are developed using the most recent scientifically valid practice guidelines. Sources include the American Heart Association (AHA), American College of Sports Medicine (ACSM), and the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR). ~~Both locations are~~**The CWC is a** nationally certified cardiac rehabilitation programs through AACVPR.

K. **MEDICATION ADMINISTRATION STANDARDS RELATED TO CARE OF THE PATIENT:**

1. Nitroglycerine is kept in a locked drawer at the nurses monitoring station in a box with the expiration date clearly marked. The key to open the drawer is found in the center drawer of the nurses' station. The supervising physician/medical director signs a written standing order for PRN NTG use on the initial patient evaluation treatment plan. Staff assesses and documents the administration/effectiveness and side effects when Nitroglycerine is administered.

Tri-City Healthcare District
Oceanside, California

ENGINEERING
EQUIPMENT

ISSUE DATE: 09/94

SUBJECT: Utility Management Plan

REVIEW DATE: 08/15
REVISION DATE: 02/97, 05/00, 05/03, 06/06, 05/09, 06/12, 06/15, 10/15, 01/17, 03/19, 03/22, 02/23

Department Approval:	~~04/22~~01/24
Environmental Health & Safety Committee Approval:	~~12/22~~01/24
Administration Approval:	~~02/23~~02/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/23

A. **EXECUTIVE SUMMARY:**

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

B. **PRINCIPLES:**

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

C. **OBJECTIVES:**

1. The objective of the Utility Management Plan is to assure the operational reliability and assesses the special risks and responses to failures of the utility systems, which support the facility's patient care environment.

D. **PROGRAM MANAGEMENT STRUCTURE:**

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

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

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

a. The Director of Facilities or Designee evaluates all utility system equipment to determine the appropriate maintenance strategy for assuring safety and maximum useful life. The Director of Facilities or Designee uses manufacturer recommendations, applicable codes and standards, accreditation requirements, and local or reported field experience to determine the appropriate maintenance strategy for assuring safety and maximizing equipment availability and service life. The strategies may include fixed interval inspections, variable interval inspections, preemptive maintenance, predictive maintenance, and corrective maintenance.

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

renovations, alterations, additions, and modernizations. Hard copies of the documentation are maintained in the Plant Operations department. Documents that are available in electronic format are maintained on the Facilities Shared Drive.

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

f. If a failure during a planned test occurs, a full retest will be performed after appropriate repairs are made and essential electrical system is functional again.

g. Each diesel engine powered motor/generator not loaded to 30% or more of its nameplate capacity during connected load tests undergoes further evaluation to determine if the exhaust gas temperature reaches or exceeds the manufacturer's recommended temperature to prevent wet stacking. Each diesel engine failing to meet the temperature recommendation will be exercised annually by connecting it to a dynamic load bank and performing the three-step test process specified by NFPA 99 and NFPA 110.

h. Batteries, fuel stored on site, controls, and other auxiliary emergency power equipment is inspected, maintained, and tested as required. The Director of Facilities or Designee Facilities staff and contracted service providers are responsible for assuring the reliability of each component part of the emergency power systems by performing all required calibration, inspection, maintenance, and testing in a timely manner.

12. Utility Systems Inventory and Initial Testing

a. The Director of Facilities or Designee establishes and maintains a current, accurate, and separate inventory of all utility systems equipment included in a program of planned inspection or maintenance. The inventory includes equipment owned by TCHD and leased or rented equipment.

b. The Director of Facilities or Designee is responsible for implementation of the program of planned inspection and maintenance. All utility systems equipment is tested for performance and safety prior to use.

13. Testing of Life Support Equipment

a. The Director of Facilities or Designee assures that scheduled testing of all utility systems that play a role in life support is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EHSC each quarter. If the quarterly rate of completion falls below 95%, the Director of Facilities or Designee will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

14. Testing of Infection Control Support Equipment

a. The Director of Facilities or Designee assures that scheduled testing of utility systems equipment that supports critical infection control processes is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EHSC each quarter. If the quarterly rate of completion falls below 95%, the Director of Facilities or Designee will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

15. Testing of Non-Life Support Equipment

a. The Director of Facilities or Designee assures that scheduled testing of all non-life support equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EHSC each quarter. If the quarterly rate of completion falls below 95%, the Facilities will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

16. Medical Gas System Testing

a. All medical gas systems are maintained and periodically tested to assure system performance. All testing and inspection are done in accordance with the requirements of the current edition of NFPA 99.

17. Modifying / Repairing Medical Gas Systems

a. When a new medical gas system is installed or an existing system is breached for any reason, the Director of Facilities or Designee coordinates certification of the system

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

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

F. **ANNUAL GOALS/OBJECTIVES ~~FOR 2023~~:**

1. Fully implement the new preventive maintenance system which means having every piece of equipment in the system and schedule for a preventative maintenance work order.
2. Update and modify existing air handler units to improve air flow throughout the facility.
3. Identify/locate any gaps in air ducts, seal the gaps and provide increased air flow.

G. **REFERENCE(S):**

1. The Joint Commission (~~2017~~**2024**). *Hospital Accreditation Standards ~~- Illinois: Joint Commission Resources.~~*

Tri-City Healthcare District
Oceanside, California

ENVIRONMENT OF CARE MANUAL

ISSUE DATE: 02/23 **SUBJECT:** Emergency Management Plan

REVISION DATE:

Environment of Care Content Expert Approval:	~~01/23~~01/24
Environmental Health and Safety Committee Approval:	~~01/23~~01/24
Medical Executive Committee Approval:	n/a
Administration Approval:	~~02/23~~02/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/23

A. **EXECUTIVE SUMMARY:**

1. The Environment of Care and the of patient care services provided to the patients served by Tri-City Healthcare District (TCHD) present unique challenges. The emergencies are identified by an all- hazards approach. The emergency management plan provides a systematic analysis for planning, shared decision-making, internal and external collaborations.
2. The Emergency Management Plan provides a comprehensive approach to meeting health, safety, and security needs of the facility, its staff and its patient population and community prior to, during and after an emergency.
3. The Emergency Management Plan critical components include emergency policies and procedures; communication and coordination of response activities; education and training; testing and evaluating exercises; and resources.

B. **PRINCIPLE(S):**

1. Emergency Management plays a significant role in guiding the hospital response to and recovering from a variety of emergencies and disaster incidents that could impact hospital operations and the ability to continue providing services.
2. Emergency Management plan utilizes an all-hazard approach. An all-hazard approach focuses on developing emergency preparedness capacities and capabilities that can address a wide range of emergencies or disasters that may significantly impact the hospital's ability to continue to operate and provide services.
3. Emergency Management Plan consists of four phases: Mitigation, Preparedness, Response, and Recovery.

C. **OBJECTIVE(S)**:

The objective of the Emergency Management Plan is to prevent incidents before they happen. If an incident occurs, the goal is to respond safely and effectively.

D. **PROGRAM MANAGEMENT STRUCTURE:**

1. Tri City Healthcare District multidisciplinary committee assures that an appropriate emergency management plan is implemented. The Safety Manager collaborates with the Environmental Health and Safety Committee (EHSC) committee to evaluate the program to ensure the hospital complies with all applicable federal, state, and local emergency preparedness laws and regulations.
2. Tri City Healthcare District (TCHD) utilizes the Hospital Incident Command System (HICS) structure for Incident Command.
3. The Board or designee receives regular reports of the activities of the Emergency Management Plan. The CEO or designee will collaborate with EHSC to address any

issues or concerns with the Emergency Management Plan.

E. **ELEMENTS OF THE EMERGENCY MANAGEMENT PLAN:**

1. Emergency Management Plan
   a. The Emergency Management Plan describes the procedures and approach to handling any emergencies or disasters that effect TCHD facilitates.
2. Processes for identifying emergencies and disasters.
   a. The Safety Manager or designee are responsible for coordinating the development of design, operations, and training processes to minizine the possibilities of emergency incidents or preparedness for disasters.
   b. Emergency Management is accomplished by hospital both as individual entity and integrated participant in a larger emergency response community.
3. Design
   a. The Safety Manager in collaboration with EHSC committee to ensure the plan consists of:
      i. Leadership Structure and program accountability
      ii. Hazard Vulnerability Analysis (HVA)
      iii. Mitigation and preparedness activities
      iv. Emergency Operating Plan (EOP), policies and procedures.
      v. Education and training
      vi. Exercises and testing
      vii. Continuity of operations plan
      viii. Disaster recovery
      ix. Program Evaluation
4. Management
   a. The Safety Manager or designee oversees the design, implementation and documentation of processes designed to assure optimal performance and continual compliance with standards of Emergency Management.

F. **EFFECTIVENESS:**

1. Program effectiveness will be regularly monitored using significant incidents as well as training activities. Performance monitoring and assessments of program effectiveness will be reported to EHSC committee. Significant events and outcomes of regular trending are reported by the Safety Manager to the EHSC committee annually or immediately as an expectation for serious events.

G. **ANNUAL GOAL(S)/OBJECTIVE(S) ~~2023~~:**

1. Complete a comprehensive inventory of all disaster supplies.
2. Complete Hazard Vulnerability Analysis for facility/ and off sites.
3. Complete Code Silver "Live-Action" exercise.

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

1. Emergency Operations Procedure Manual: Emergency Operations Plan

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE MANUAL

ISSUE DATE: 11/87

SUBJECT: Safety Management Plan

REVISION DATE: 05/96, 06/97, 07/00, 06/08, 03/11, 06/12, 06/15, 12/17, 03/19, 12/21, ~~03~~12/22

Department Approval:	~~09/22~~01/24
Environmental Health & Safety Committee Approval:	~~10/22~~01/24
Administration Approval:	~~12/22~~02/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/22

A. **PURPOSE:**

1. The Safety Management Plan is designed to address potential safety risks that the environment of Tri City Health District (TCHD) presents to patients, staff, and visitors. The plan should also assure compliance with all applicable local, state, and federal codes and regulations.

B. **POLICY:**

1. The scope of this management plan applies to all Tri City Health District (TCHD) facilities. It is the responsibility of the Safety Manager to assess and document compliance with elements of the safety management plan during environmental tour activities, and when Safety-related issues are brought to the attention of the Safety/EHSC committee.

C. **RESPONSIBILITIES:**

1. Leadership, Directors, Managers and staff have varying levels of responsibility relating to the Safety Management Plan as follows:
   a. EHSCCEO/Board of Directors: The CEO and Board of Directors support the Safety Management Plan by:
      i. Review and feedback if applicable of the Safety/Environmental Health and Safety Committee (EHSC) reports.
      ii. Endorsing budget support as applicable, which is needed to implement safety improvements.
   b. Facility Compliance and Regulatory: Reviews Environmental, Health and Safety reports from ESHC committee, and provides broad direction in the establishment of performance monitoring standards. Provides direction if there is a safety- related issue that has impact on the care and treatment of patient(s).
   c. Environmental, Health, and Safety Committee (EHSC): EHSC members review and approve the Environmental, Health, and Safety reports, which contain a Safety Management Component. Members also monitor and evaluate the Safety Management Plan, and afford a multidisciplinary process for reviewing issues related to safety issues and or failures. Committee members represent clinical, nursing, administrative and support services. The committee addresses Environment, Health, and Safety issues in a timely manner, and makes recommendations as appropriate for approval. Environmental, Health and Safety issues are communicated to the organization's leaders through quarterly and annual evaluation reports. EHSC.
   d. Directors/Managers: Directors/Managers are responsible for implementing policy and procedures at the unit level and ensuring that unit-specific education and annual education is provided to staff. Directors/Managers are responsible for ensuring their staff

members know how to report a safety issue or concern.

e. The Human Resources Department with assistance from the Education Department and other leadership staff is responsible for the development and presentation of appropriate safety and infection control materials for New Hire Orientation training, department training, and task-specific training.

f. Staff: Staff members are responsible for actively participating in all required safety training, practicing work behaviors that promote a proactive safe environment, reporting any observed or suspected unsafe conditions to department management as soon as possible.

D. **PROCEDURES:**

1. The hospital has a library of information regarding inspection, testing, and maintenance of its equipment and systems. (EC.01.01.01 EP3)
   a. Each department responsible for inspection, testing and maintenance, keeps logs and records as well as manuals, manufacturer's procedures, technical bulletins, and other information in their respective departments. For example:
      i. Biomedical Engineering is responsible for maintaining all medical equipment maintenance records and they keep all records in an electronic database
      ii. Facilities Management keeps all utility equipment inventory and maintenance records in the Computerized Maintenance Management System (CMMS)
2. The hospital has a written plan for managing the following: The environmental safety of patients and everyone else who enters the hospital's facilities. (EC.01.01.01 EP4)
   a. The Illness and Injury Prevention Program (IIPP) outlines the overall safety program for the hospital's facilities.
      i. The IIPP outlines the following:
         1) Responsibility
         2) Compliance
         3) Communication
         4) Hazard Assessment
         5) Accident/Exposure Investigation
         6) Hazard Correction
         7) Training and Instruction
         8) Recordkeeping
      ii. Staff members are trained to report all incidents, potential hazards, injuries, patient events and near misses immediately to their supervisors, the EOC/Safety Manager, or anonymously to the Health Care Values compliance hotline at 844-521-7862
   b. The hospital implements its process to identify safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital's facilities. (EC.02.01.01 EP1)
      i. The EHSC performs proactive risk assessments to identify risks in the environment. The information gathered is used to develop procedures and controls to minimize these risks that could negatively affect staff, patients, contractors, and visitors
         1) The EHSC coordinates the risk assessment process with the EOC/Safety Manager, department directors, and others as appropriate.
      ii. Information used to create the risk assessments include, but are not limited to the following:
         1) EOC Rounds
         2) Root Cause Analyses (RCA)

3) Incident Reports
4) External reports such as The Joint Commission Sentinel Event Alerts, CDPH All Facilities Letters (AFLs), Cal/OSHA standards, and FDA product recall notices

c. The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment (EC.02.01.01 EP3)
   i. Risk assessment data, injury report data, and all reported incident data is used to improve the environment and minimize risk. This data is also used to procure equipment, supplies, or other technology that can minimize identified risks.

d. EOC rounds are conducted throughout the year on a prepared schedule. Each patient care area is scheduled for EOC rounds.
   i. The EOC/Safety Manager, or designee, coordinates the identified deficiencies with the EHSC and the appropriate department director(s).
   ii. EOC rounds are performed when construction or other activities create unusual risks that may require the design and implementation of a plan to manage Interim Life Safety Measures, Infection Control Risk Measures, Proactive Construction Risk Management Measures, or other temporary issues.
   iii. The EHSC analyzes the results of the EOC rounds to determine if deficiencies are corrected in a timely manner and to determine trends that require action to improve practices or environmental conditions.

e. The hospital maintains all grounds and equipment (EC.02.01.01 EP5)
   i. The Director of Facilities is responsible for managing the appearance and safety of the hospital grounds.

f. The Director of Facilities is responsible for scheduling the work required to maintain the environment and safety of hospital grounds.
   i. The Engineering staff and Security Officers make regular rounds of the grounds to identify unsafe conditions.
   ii. The Security Manager and Engineering staff report all deficiencies to the Director of Facilities for appropriate action.

g. The hospital responds to product notices and recalls (EC.02.01.01 EP11)
   i. The EOC/Safety Manager and the Director of Materials Management coordinate a product safety recall system. TCHD utilizes the National Recall Alert Center (NRAC) E-Class system that is designed to quickly assess safety recall notices, respond to those that affect TCHD, and assure all active safety recalls are completed in a timely manner.
   ii. A quarterly report of safety recall notices that require action to eliminate defective equipment or supplies from TCHD is presented to the EHSC Committee by the EOC/Safety Manager.

h. The hospital collects information to monitor conditions in the environment (EC.04.01.01 EP1, EP3, EP4, EP5, EP6, EP8, EP9, EP10, EP11)
   i. The hospital establishes a process for continually monitoring, internally reporting, and investigating the following:
      1) Injuries to patients or others within the hospital's facilities
      2) Occupational illnesses and staff injuries
      3) Incidents of damage to its property or the property of others
      4) Security incidents involving patients, staff, or others within the facilities
      5) Hazardous materials and waste spills and exposures
      6) Fire safety management problems, deficiencies, and failures

7) Medical or laboratory equipment management problems, failures, and use errors
8) Utility systems management problems, failures, or use errors

ii. The Manager of Risk Management coordinates the incident reporting and analysis process.
iii. The EOC/Safety Manager works with Risk Management to design appropriate processes to document and evaluate patient and visitor incidents, staff incidents, and property damage related to environmental conditions.

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

j. Development and Management of Policies and Procedures (LD.04.01.07 EP1)
i. The EOC/Safety Manager follows the administrative policy for the development of organization-wide and department-specific policies, procedures, and controls designed to eliminate or minimize identified risks.
ii. The EOC/Safety Manager assists department leaders with the development of department or job-specific environmental safety procedures and controls.
iii. The organization-wide policies, procedures, and controls are available to all staff members on the organizational intranet.
iv. Depart specific procedures and controls are maintained by department directors.

1) The department directors are responsible for ensuring that all staff is familiar with organizational, departmental, and appropriate job-related policies, procedures, and controls.
2) Department directors are also responsible for ensuring implementation of these policies, procedures, and controls
3) Individual staff members are held accountable for implementing the policies, procedures, and controls related to their specific work duties and tasks

v. The policies, procedures, and controls are reviewed when significant changes occur when new technology or space is acquired, and at least every three years.
vi. The EOC/Safety Manager assists with the reviews of policies and procedures with department directors and other appropriate staff.

k. Every twelve months the hospital evaluates each environment of care management plan including a review of the plan's objectives, scope, performance, and effectiveness. (EC.04.01.01 EP15)
i. The EOC/Safety Manager coordinates the annual evaluation of the Environment of Care management plans.
ii. The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks.
1) The review also evaluates the operational results of each Environment of Care program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable.
2) The annual evaluation uses a variety of information sources. The sources include aggregate analysis of EOC rounds and incident reports, findings of external reviews, benchmarking programs or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of the EHSC Committee meetings, and analytical summaries of other activities.
3) The findings of the annual review are presented to the EHSC Committee by the end of the first quarter of the fiscal year.
4) Each report presents a balanced summary of an EOC program for the preceding fiscal year.
5) Each report includes an action plan to address identified gaps.
iii. The annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review (PPR). Any deficiencies identified on an annual basis are immediately addressed by a plan for improvement.
iv. Effective development and implementation of the plans for improvement will be monitored by the EOC/Safety Manager.
v. The results of the annual evaluation are presented to the EHSC Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes.
vi. The annual evaluation is distributed to the CEO, BOD, organizational leaders, the Patient Safety Committee, the Quality Assurance Performance Improvement Committee, and others as appropriate.
vii. The manager of each EOC Management Plan is responsible for implementing the recommendations in the report as part of the performance improvement process.

l. The hospital analyzes identified environment of care issues. (EC.04.01.03)

i. Identified EOC issues are communicated through the EHSC Committee and the EHSC to senior leadership, the BOD and the CEO for analysis.
ii. The hospital uses the results of data to identify opportunities to resolve environmental safety issues (EC.04.01.03 EP2)
    1) Once the data has been presented to leadership and appropriate committees, a team is appointed to manage the improvement project.
    2) The EHSC Committee works with the team to identify the goals, establish a timeline, a budget, if needed, priorities, and establish objective measurements of improvement.
    3) The EHSC Committee also established a schedule for the team to report progress and results.
    4) All final improvement reports are summarized as part of the annual review of the overall program and presented to hospital leadership, the performance improvement team, and patient safety leadership.

m. Orientation and Ongoing Education and Training – (HR.01.04.01 EP1 & 3, & EC 01.05.03, EC.03.01.01 EP1 – EP3)
    i. Orientation and training addressing the EOC programs is provided to each staff member, contractor, and volunteer.
    ii. All Licensed Independent Practitioners (LIP) receive an orientation to the Environment of Care in accordance with the Medical Staff policies and bylaws.
    iii. Annual EOC training is provided and documented via NetLearning.
    iv. The Human Resources Department with participation from the Education Department coordinates the general New Employee Orientation (NEO) program.
        1) New staff members are required to attend the NEO program within 30 days of their date of employment.
        2) The Human Resources Department with participation from the Education Department maintains attendance records for each new staff member completing the general orientation program.
    v. New staff members are also required to participate in orientation to the department where they are assigned to work.
        1) The departmental orientation addresses job related patient safety and environmental risks and the policies, procedures, and processes to minimize or eliminate them during routine daily operations.
    vi. The EOC/Safety Manager collaborates with the department managers, the Manager of Risk Management/Quality, the Manager of Regulatory Compliance and Infection Control, the Patient Safety Officer, and others as appropriate to develop content materials for general and job-related orientation and continuing education programs.
    vii. The EOC/Safety Manager gathers data during EOC rounds and other activities to determine the level of competency of staff and licensed independent practitioners related to their ability to describe or demonstrate how job-related physical risks are to be managed or eliminated.
    viii. The EOC/Safety Manager evaluates the level of competency of staff and LIPs related to understanding and demonstrating the actions to be taken when environmental incidents occur and how to report environmental hazards or incidents.
    ix. Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating EOC risks are reported to the EHSC Committee.

When deficiencies are identified, action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

E. **GOALS/OBJECTIVES:**

1. Safety risk assessment for all departments throughout the facility and off-site locations.
2. Continuing educating and raising awareness to Covid-19 protocols.

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

1. Code Adam (Infant Abduction) Policy
2. Code Blue/Pink (Adult/Infant Arrest) Policy
3. Code Caleb Policy
4. Code Dr. Strong (Violent Person) Policy
5. Code Gray (Hostage Situation) Policy
6. Engineering: Code Green (02 Emergency) Policy
7. Emergency Operations Procedure (EOP): Chemical Disaster Emergency Dpt Specific 4078
8. Code Red (Fire) Policy
9. Code Silver (Active Shooter) Policy
10. Code Yellow (Radiation Disaster) Policy
11. Environment of Care (EOC): Audit Tool – Clinical Rounds
12. Environmental Health and Safety Committee Charter
13. Environment of Care (EOC): Audit Tool – Non-clinical Rounds
14. Environment of Care (EOC): Security Management Plan
15. Environment of Care (EOC): Waste Management Plan
16. Environment of Care (EOC): Engineering: Utility Management Plan
17. Environment of Care (EOC): Life Safety Management Plan
18. Environment of Care (EOC): Medical Equipment Plan
19. Environment of Care (EOC): Emergency Management Plan
20. Hazardous Materials and Waste Management Plan
21. Illness and Injury Prevention Program (IIPP)

G. **REFERENCE(S):**

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

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE:	**11/20**	**SUBJECT:**	**Medical Staff Funds & Medical Staff Representation by Legal Counsel**
REVISION DATE:	**11/20**	**POLICY NUMBER:**	**8710 – 572**

Medical Staff Department Approval:	**~~10/20~~12/23**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~10/20~~01/24**
Administration Approval:	**~~11/20~~02/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**11/20**

A. **MEDICAL STAFF FUNDS**

1. Medical Staff funds, regardless from what source (i.e. medical staff dues, hospital funds) shall be under the sole control and oversite of the Medical Staff. All medical staff members may at all reasonable times copy and inspect all bank statements and the quarterly financial statements prepared by the Treasurer, Section 8.6-3. The medical staff and/or their elected representatives (MEC) must be notified of and provided with the opportunity to comment upon impending significant expenditures of medical staff funds of amounts which exceed $10,000.
2. Hospital provided funds, subject to District Board consideration and approval, shall be deposited into the Medial Staff account from the hospital to assure the medical staff the financial ability to solely administer those functions required under the bylaws[1].

B. **MEDICAL STAFF REPRESENTATION BY LEGAL COUNSEL**

1. Upon the authorization of the medical staff, or of the medical executive committee acting on its behalf, the medical staff may retain and be represented by independent legal counsel who, to the extent practicable, shall not be employed by a law firm representing the hospital. The medical staff shall enter into a written engagement letter with the individual selected to be independent legal counsel affirming that the medical staff, not the hospital, is the counsel's client, that the counsel represents solely the interests of the medical staff, and the attorney-client privilege of confidentiality applicable to all communications between the counsel and the medical staff is held solely by the medical staff, regardless of whether the medical staff or a third party pays the counsel's fees. In the event the counsel is paid for by a third party, the counsel shall also provide a written assurance to the medical staff that there will be no interference by the third party with the counsel's independence of professional judgment or with attorney-client relationship, as required by State Bar of California Rules of Professional Conduct, Rule 3-310[2].

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[1] This provision requires that any funds be granted to the medical staff by the hospital for medical staff operations are placed solely under the control of the medical staff. This assures the medical staff oversees and regulates the performance of officers, department chairs or others receiving a stipend for medical staff administration. It also assures that the hospital is not in a position to abuse its position as trustee of medical staff funds by sequestering those funds away from medical staff control, as occurred during the dispute that led to litigation between the medical staff of Ventura Community Memorial Hospital and the hospital's board of directors in 2002.

[2] This section is added to reflect the medical staff's right to retain legal representation as one of the rights of medical staff self-governance under SB 1325. See Business & Professions Code 2282.5(a)(5). See also section 10.3-2 Duties, "Duties" of the Medical Executive Committee, " enumerating duties of the MEC to affirmatively exercise and protect the medical staff's rights of self-governance.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 02/01	**SUBJECT:** Professional Behavior Policy & Committee
REVISION DATE~~(S)~~: 08/17, 01/13, 04/17, 03/20	**POLICY NUMBER:** 8710 – 570

Medical Staff Department Approval:	~~03/17, 02/20~~12/23
Medical Staff Committee Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~03/17, 02/20~~01/24
Administration Approval:	~~03/20~~02/24
Professional Affairs Committee Approval:	~~04/17,~~ n/a
Board of Directors Approval:	~~04/17,~~ 03/20

~~A. POLICY:~~

~~1. It is the policy of Tri-City Healthcare District (TCHD) Medical Staff to support and encourage appropriate professional behavior and a safe working environment at all times, and to evaluate allegations of behavior that undermines the culture of safety by physicians, and to intervene when appropriate. The Medical Staff of TCHD recognizes the right of all individuals within the TCHD organization to be treated with dignity, courtesy and respect. Behavior that undermines the culture of safety compromises the ability of the healthcare team to perform effectively, and may create a hostile work environment inhibiting optimal communication and performance.~~

~~B.~~A. PURPOSE:

1. **To provide guidelines for identifying, reporting and managing behavioral concerns within the medical staff while** ~~To~~ promoting e a professional atmosphere and a safe work environment.
   ~~where all Medical Staff members and Allied Health Professionals (AHP) shall conduct themselves in a professional manner when interacting with colleagues, hospital staff, patients, and guests. The Medical Staff, via the Medical Executive Committee (MEC) and in accordance with the Medical Staff Bylaws, shall be responsible for implementing and maintaining standards of behavior to promote and maintain a professional atmosphere.~~

B. POLICY:

1. **The Professional Behavior Committee (PBC) serves as the formal behavior review committee for all medical staff departments and divisions.**
2. **Professional Behavior Committee (PBC) will be composed of the PBC chairperson, current chief of staff and immediate past~~former~~ chief of staff.**
3. **It is the policy of Tri-City Healthcare District (TCHD) Medical Staff to support and encourage appropriate professional behavior and a safe working environment at all times, and to evaluate allegations of behavior that undermines the culture of safety by physicians, and to intervene when appropriate. The Medical Staff of TCHD recognizes the right of all individuals within the TCHD organization to be treated with dignity, courtesy and respect. Behavior that undermines the culture of safety compromises the ability of the healthcare team to perform effectively, and may create a hostile work environment inhibiting optimal communication and performance.**
4. **All Medical Staff members and Allied Health Professionals (AHP) shall conduct themselves in a professional manner when interacting with colleagues, hospital staff, patients, and guests. The Medical Staff, via the Medical Executive Committee (MEC) and in accordance with the Medical Staff Bylaws, shall be responsible for implementing and maintaining standards of behavior to promote and maintain a professional atmosphere.**

5. **Acceptable behavior may include, but is not limited to the following attributes and behavior patterns:**
   a. **Consistent adherence to hospital and/or Medical Staff policies and procedures.**
   b. **Treatment of all persons with courtesy, respect, and dignity.**
   c. **Appropriate response to inquiries.**
   d. **Timely response to pages and staff requests.**
   e. **Civil communication – i.e. well-mannered responses, appropriate language and tone, and a team-centered approach.**
   f. **Utilization of chain of command to express concerns or to report issues.**
6. **Unacceptable behavior may include, but is not limited to, the following attributes and behavior patterns:**
   a. **Disregard of hospital and/or Medical Staff policies and procedures.**
   b. **Verbal or physical threats against anyone.**
   c. **The use of demeaning or insulting remarks.**
   d. **Aggressive or violent actions.**
   e. **The use of profanity or excessive sarcasm.**
   f. **Sexual or ethnic innuendos or harassment.**
   g. **Inappropriate critiquing of hospital and/or Medical Staff members in public.**
   h. **Inappropriate delay in responding to concerns and issues from hospital staff members.**
   i. **Retaliation**

~~1.~~

C. **DEFINITION(S):**

1. Complainant: Any individual who **experiences or** witnesses a behavior and perceives it to be significant and worthy of intervention based on the Guidelines below.
2. Attributed Individual: Any Medical Staff member or AHP about whom a behavior concern has been reported.
3. Direct Supervisor: -Hospital staff member (**Non-Medical Staff** Director or Service Line Leader) who is responsible for initially investigating the alleged unprofessional behavior **with the complainant and documenting the findings in the hospital's incident reporting system.**

~~3.~~**4.** ~~, and initiating the process as defined below.~~

~~D. POLICY:~~

~~1. Acceptable behavior may include, but is not limited to the following attributes and behavior patterns:~~
   ~~a. Consistent adherence to hospital and/or Medical Staff policies and procedures.~~
   ~~b. Treatment of all persons with courtesy, respect, and dignity.~~
   ~~c. Appropriate response to inquiries.~~
   ~~d. Timely response to pages and staff requests.~~
   ~~e. Civil communication – i.e. well-mannered responses, appropriate language and tone, and a team-centered approach.~~
   ~~f. Utilization of chain of command to express concerns or to report issues.~~
~~2. Unacceptable behavior may include, but is not limited to, the following attributes and behavior patterns:~~
   ~~a. Disregard of hospital and/or Medical Staff policies and procedures.~~
   ~~b. Verbal or physical threats against anyone.~~
   ~~c. The use of demeaning or insulting remarks.~~
   ~~d. Aggressive or violent actions.~~
   ~~e. The use of profanity or excessive sarcasm.~~
   ~~f. Sexual or ethnic innuendos or harassment.~~
   ~~g. Inappropriate critiquing of hospital and/or Medical Staff members in public.~~
   ~~h. Inappropriate delay in responding to concerns and issues from hospital staff members.~~
   ~~i. Retaliation~~
~~3. The Professional Behavior Form provides a suggested sequence of procedural steps that creates~~

~~a framework to document and resolve issues.~~

~~E.~~D. SPECIAL CONSIDERATIONS:

1. **Cases involving provider behavior that are significant or undermine a culture of safety (ex: threat of physical force, harassment, throwing objects, etc.) warrant an immediate referral to the Professional Behavior Committee (PBC).**
   a. **These incidents will be forwarded to the PBC Chair, Chief of Staff, Department/Division Chair and the Director~~/Manager~~ of Medical Staff Services.**
   b. **If the incident warrants immediate administrative suspension (due to potential harm to patients and/or staff), the practitioner will be suspended pending formal investigation to be initiated by the MEC.**
2. **Cases involving criminal level behavior will be referred to the appropriate law enforcement authorities.**

~~1.~~3. Communication:
   a. All parties involved, except when mandatory reporting is required by State or Federal regulations, will maintain confidentiality.
   b. Involved parties will limit discussion of the alleged issue to appropriate and/or formal venues.
   c. When there is suspicion the behavior is related to chemical dependency, or physical, psychological, or emotional impairment, refer to Physician Well-Being policy, 8710-511.
   d. Education of Medical Staff and TCHD organization members will be provided to promote awareness of the policy.
   e. All new Medical Staff applicants will be informed about the policy.

~~2.~~4. Flexibility:
   a. The Medical Staff leadership retains the prerogative to respond in an alternative manner other than by the Procedural Guidelines set forth below. In its discretion, leadership may direct a more immediate approach to an instance or a pattern of unacceptable behavior. Such a response may not utilize some or all of the elements of the Procedural Guidelines, or may use them in a different order. A situation may also necessitate a non-programmed response. Within the framework of the Medical Staff Bylaws and the operation of law, this policy is not intended to limit the responses of the Medical Staff to any prescribed formula or sequence of action.

~~F.~~E. PROCEDURE GUIDELINES:

1. This guideline is a suggested course of action, subject to deviation, based upon unique circumstances:
   a. Alleged unacceptable behavior ~~occurs and~~ is identified by the Complainant. ~~(Box 1 of Professional Behavior Form).~~ **and entered into the hospital's incident reporting system.**
   ~~b. Complainant and Attributed Individual will attempt to resolve the issue in an amicable and timely manner. Direct communication between the Attributed Individual and the Complainant may be encouraged. If the issue is resolved then no further action will be needed.~~
   ~~c. If Complainant is unable or unwilling to resolve the incident directly with the Attributed Individual, then the Direct Supervisor will become involved.~~
   b. The Direct Supervisor **and Medical Staff Quality Coordinator** will **be notified of the unacceptable behavioral event via the hospital's incident reporting system.**
   c. **The Medical Staff Quality Coordinator will screen for any potential quality concerns and route any identified quality concerns for peer review accordingly.**
   d. **The Direct Supervisor will** investigate the perceived unacceptable behavior **with the complainant and any witnesses (if applicable)** and document the findings **in the hospital's incident reporting system.**
   e. **The Direct Supervisor will request a written statement from the complainant/witness (as deemed necessary) and attach the statement to the incident report.**

f. **The Medical Staff Quality Coordinator will enter the unacceptable behavior event into the peer review database and notify the PBC Chair.**

~~d. on the Professional Behavior (PB) Form, and assesses whether further intervention is required. (Box 2 of Professional Behavior Form).~~

~~e. If the Direct Supervisor determines further intervention is not required, the completed Professional Behavior form will be forwarded to the Medical Staff Office for review by the Chief of Staff and for filing. Professional Behavior form will be labeled "No Intervention Required" and process will end.~~

~~f. If the Direct Supervisor determines that further intervention is warranted, the Direct Supervisor and the Attributed Individual will meet to discuss the incident (Complainant may be present).~~

~~g. If the issue is resolved, then an action plan, with identified goals for all involved parties, will be documented on the Professional Behavior Form and forwarded to the Medical Staff Office for review by the Chief of Staff, and placement in the Professional Behavior Chair file.~~

~~h. If the issue is not resolved, the Director of the Direct Supervisor will contact the Director of the Medical Staff Office and relevant Hospital Administration (CEO, COO/CNE, and VP of Human Resources) if appropriate. The Chief of Staff will be notified.~~

g. ~~The Chief of Staff will notify and confer with the Chair of the Professional Behavior Committee.~~ **The PBC chair will review and investigate the unacceptable behavior event and document behavior score/findings in the peer review database.**

2. An action plan will be developed that is tailored to the circumstances of the situation~~.~~.

a. **As noted above under special considerations, cases involving provider behavior that are significant or undermine a culture of safety (ex: threat of physical force, harassment, throwing objects, etc.) will warrant an immediate referral to the Professional Behavior Committee (PBC).**

b. **Behavioral events that are found to have minimally or moderately violated the physician code of conduct will typically be addressed as follows:**
   - **1st Occurrence: Provider will receive a verbal warning from the PBC chair.**
   - **2nd Occurrence of the same nature: Provider will receive a written letter from the PBC chair.**
   - **3rd Occurrence of the same nature: Provider will be referred to the PBC Committee for further action.**

~~i.~~c. The ~~Authority of the~~ Professional Behavior Committee ~~Chair will be the following~~: **will have the following authority:**

i. Attempt further mediation and resolution by counseling the Attributed Individual.

ii. Arrange meetings of relevant parties, at which they may attend or preside.

~~iii.~~ If voluntary measures fail to resolve the situation satisfactorily, the Chair, after consulting with the Professional Behavior Committee, may ~~make any recommendations to the~~ **refer the Attributed Individual to the MEC for corrective action.** ~~MEC, including:~~

~~1) Mandatory psychological/medical evaluation and treatment,~~

~~2) Restriction of privileges by the MEC and the Board of Directors,~~

~~3)~~iii. ~~Suspension and/or termination of membership by the MEC and the Board of Directors.~~

d. All Professional Behavior ~~Forms~~**outcomes** will be maintained in the Attributed Individual's Professional Behavior Committee file for confidential review by the Chief of Staff, Professional Behavior Committee Chair, **Department/Division Chair** and the Director of Medical Staff Services. The information contained therein will be considered at the time of reappointment of Attributed Individual, and may be shared on a strict-need-know basis with the Credentials Committee, the MEC, or ad-hoc committees, all meeting in executive session. The pertinent Department Chair or Division Chief may be invited to those sessions.

~~j.~~e. **The PBC chair will report periodically to the MEC.**

~~k.~~f. Non-confidential feedback may be provided to the Complainant regarding resolution of the

issue, but only from the Chief of Staff, the Professional Behavior Committee Chair, or their designees.

F. **CATEGORY OF ASSIGNMENTS (Behavioral Only):**

1. **No Identified Physician Behavioral Issue**
2. **Violation of Hospital Policy (Includes poor communication and inadequate documentation)**
3. **Violation of Physician Code of Conduct**
   - a. **Minimal Violation of Code of Conduct**
     - i. **These events reflect behavior that minimally violates physician code of conduct (HIM suspension, angry outbursts, name calling, loud or inappropriate arguments, inappropriate comments in medical record, etc).**
   - b. **Moderate Violation of Code of Conduct**
     - i. **These events reflect behavior that moderately violates physician code of conduct (Belittling, berating, intimidating, swearing, shaming others for negative outcomes, discriminatory comments, etc.)**
   - c. **Significant Violation of Code of Conduct**
     - i. **These events reflect behavior that significantly violates physician code of conduct (Physical boundaries violation or sexual harassment, threat of physical force, unwanted physician or sexual contact, throwing objects, etc.)**

G. **DOCUMENTATION:**

1. Documentation will be prepared as objectively as possible, utilizing factual information.
2. ~~Completion of the Professional Behavior Form (PB form).~~

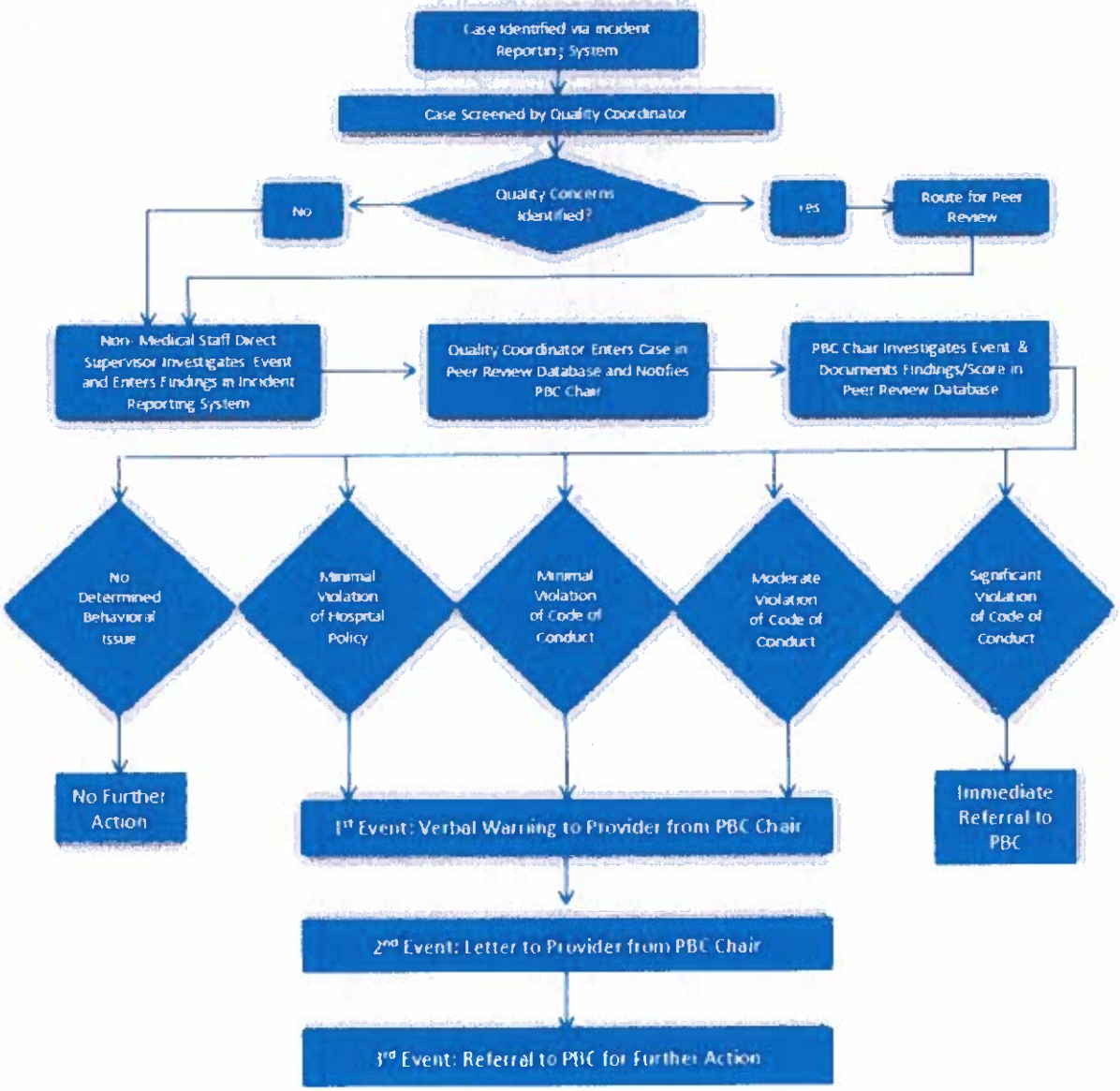
H. **ATTACHMENT(S):**

1. ~~Professional Behavior (PB) Form - Sample~~
2. **PBC Case Review Flowchart**

~~I.~~ **H. REFERENCES:**

~~1.~~ **1.** The Joint Commission Standards, 2017

Attachment A
PBC Case Review Flowchart



***Flowchart reflects customary process. PBC Chair has the flexibility to respond to events in an alternative manner.**
***PBC cases are tracked/trended through the OPPE Process. The PBC Chair reports to the MEC periodically/as deemed warranted.**

Tri-City Medical Center

Professional Behavioral Form - Sample
(PB Form)
Confidential Report

Abbreviations Used:
PBC: Professional Behavior Committee
MSO: Medical Staff Office
COS: Chief of Staff
AI: Attributed Individual
MEC: Medical Executive Committee

Box 1 (refers to step 1 of Procedural Guidelines)

I. **Complainant will describe issues of concern:**

_____

_____

_____

_____

_____

_____

_____

Signature: _____ **Date:** _____

Complainant Printed Name: _____

Box 2 (refers to step 4 of Procedural Guidelines)

II. **Direct Supervisor Investigation and Documentation:**

A. **Is intervention with the AI necessary?** ☐ **Yes** ☐ **No**

If NO, forward this completed form to the MSO for review by the COS and the PBC Chair, and filing.

If YES, proceed with meeting the AI.

B. **Did the meeting with the AI resolve the issue(s)?** ☐ **Yes** ☐ **No**

If Yes, forward this completed form with an action plan and goals for all involved parties to the MSO for review and filing.

If No, COS and PBC Chair shall be informed immediately. Refer to step 8 of the Procedural Guidelines.

Documentation and narrative of meeting between AI and Direct Supervisor. Include Action Plan/Goals/and Resolution if they were achieved.

Signatures

Direct Supervisor:_____ Date:__

Direct Supervisor Printed Name:___

AI:_____ Date:__

AI Printed Name:____

Tri-City Health Care District
Oceanside, California

RETIRE – no longer perform this procedure

Administrative Procedure

ISSUE DATE: 12/2012 **SUBJECT:** Value Link Audit Procedures

REVISION DATE: 11/20

Administrative Content Expert Approval:	01/24
Administrative Policies & Procedures Committee Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~10/20~~02/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	11/20

~~A. **PURPOSE:**~~
~~To establish the procedures for auditing the Cardinal Value Link orders at Tri-City Healthcare District to determine the accuracy of the orders.~~

~~B. **SCOPE OF THE PROCEDURE:**~~
~~All Departments which receive Value Link orders will be subject to this audit.~~

~~C. **DEFINITIONS:**~~
~~1. Low Unit of Measure (LUM) – The smallest quantity that a supply can be ordered as, typically an "each" or "box."~~
~~2. Value Link (VL) – The name of Cardinal Health's LUM program~~
~~3. Totes – The plastic bins that the VL products are shipped in from Cardinal Health's distribution center~~

~~D. **PROCEDURE:**~~
~~1. The Supply Chain Manager (or Director) develops an audit schedule each month by assigning TCMC employees (auditors) to randomly audit totes each week~~
~~2. The assigned auditor will report to the Main Distribution Center and intercept the product in the totes before it is delivered to point of use~~
~~3. The auditor will find the packing list label inside the tote and use it as an inventory count sheet to inventory the contents of the tote~~
~~a. The auditor will count the quantity (qty) of each line item in the tote, annotate the qty counted beside the qty listed by Cardinal for every product line item each tote~~
~~*NOTE: Any qty discrepancies will be immediately brought to the attention of a Cardinal Health Supervisor or Manager for correction with the distribution center*~~
~~b. Each audit, the auditor will inventory at least 20 line items with at least 3 line items having a quoted qty of at least 15 each~~
~~i. The minimum is 20 (at least 2% of total) and will vary depending on the running accuracy percentage of the previous month as per the inventory matrix below in Section E.~~
~~c. The annotated labels that were used for counting are be affixed to a piece of paper and given to the Purchasing Clerk for filing and completing the inventory result spreadsheet~~
~~4. The Purchasing Clerk will record the audit results, calculate the inventory accuracy and report it week~~
~~5. Care will be given to ensure that audits are "random" in nature, cover a majority of the departments on an annual basis, and which totes will be chosen for audit is reasonably~~

unpredictable by Cardinal Health

6. The inventory accuracy will be determined by number of line items with correct quantities

E. **Inventory Matrix:**

Inventory Accuracy	Min # Line Items
99.5%-100%	20
99.0%-99.4%	25
98.5%-98.9%	30
98.0%-98.4%	35
97.5%-97.9%	40
97.0%-97.4%	45
Below 97%	50

Home Care Manual Table of Contents

	document name	approved on
1	Administrative On Call Supervision	7/5/2022
2	Admission to Service	8/29/2022
3	Agency Evaluation	7/5/2022
4	Agency Right of Refusal of Care	8/29/2022
5	Anticoagulation Therapy	11/18/2022
6	Comprehensive Assessment	8/29/2022
7	Budget Policy	7/5/2022
8	Care Coordination	8/30/2022
9	Certified Home Health Aide Supervision Policy	7/5/2022
10	Communication with the Sensory Impaired	8/29/2022
11	Contracted Services	7/5/2022
12	Critical Lab Values	8/29/2022
13	Culturally and Linguistically Appropriate Services (Hispanic)	8/29/2022
14	Discharge	8/29/2022
15	Clinical Records	8/29/2022
16	Dress Code	7/5/2022
17	Emergency Preparedness Management Disaster Plan	11/18/2022
18	Emergent Care	7/5/2022
19	End of Life Decisions	8/29/2022
20	Face to Face Encounter	8/29/2022
21	Fall Prevention	8/29/2022
22	Hand Off Communication	8/29/2022
23	Hazardous Infectious Materials Management	2/24/2023
24	Home Health Advance Beneficiary Notice (HHABN)	7/5/2022
25	Influx of Infectious Patients	8/29/2022
26	Infusion Program	8/30/2022
27	Interruption of Services	8/29/2022
28	Laboratory Services	6/30/2023
29	Late Entry Documentation	8/30/2022
30	Medication Management	11/18/2022
31	Mileage Expense Reimbursement	7/5/2022
32	Notice of Medicare Non Coverage HMO	7/5/2022
33	Notice of Medicare Non Coverage	7/5/2022
34	Orientation and Competency Validation	7/5/2022
35	Outcome and Assessment Data Set Submission (OASIS)	7/5/2022
36	Pain Symptom Management	8/30/2022
37	Patient Complaint and Grievences	7/5/2022
38	Patient Education	7/5/2022
39	Patient Safety	8/29/2022
40	Patient Rights and Responsibilities	7/5/2022
41	Philosophy	7/5/2022
42	Physician Orders	8/29/2022
43	Policy Development	7/5/2022
44	Recertification	7/5/2022
45	Resumption of Care	8/29/2022
46	Risk Management and Patient Safety Reporting	7/5/2022
47	Scope of Services - Description of Setting	7/5/2022

Home Care Manual Table of Contents

	document name	approved on
48	Significant Change in Condition (SCIC)	8/29/2022
49	Staff Development	7/5/2022
50	Staff Safety	7/5/2022
51	Staffing	7/5/2022
52	Transfer	8/29/2022
53	Wound Assessment	8/29/2022
54	Central Venous Access Devices Procedure	11/18/2022
55	Disposal of Needles & Syringes, Hazardous Materials	8/30/2022
56	Home Total Parenteral Nutrition TPN	8/30/2022
57	Hypoglycemic Management (Symptomatic)	8/29/2022
58	KCI Wound VAC Therapy Clinical Guidelines	8/29/2022
59	Laboratory Orders	12/16/2022
60	Elsevier Clinical Index of Nursing Skills	7/5/2022
61	Procedure for Use of Home Care Nursing Bag	8/30/2022
62	Unna Boot Application	8/29/2022
63	Plan of Care	8/29/2022
64	Infection Prevention Guidelines for Home Health Care Policy	6/30/2023

NICU Manual Table of Contents

	document name	approved on
1	Admission and Discharge Criteria for the NICU	6/29/2020
2	Blood Transfusion, Emergency Procurement and Preparation Of	12/16/2022
3	Cardio-Respiratory Monitoring in the NICU	9/9/2019
4	Criteria for Case Referrals to Morbidity and Mortality (M & M) Policy	3/2/2022
5	Cue Based Feeding	8/31/2020
6	Neuro-Developmental Supportive Care in the NICU	6/29/2020
7	Eye Examinations for Retinopathy Prematurity other High Risk Disorders	4/26/2019
8	High Risk Infant Follow up Program	6/29/2020
9	Intrafacility Transport of the NICU patient	12/16/2021
10	Measuring Infant Length in the NICU	9/9/2019
11	Nasogastric (NG) and Orogastric (OG) Tube Insertion, Maintenance, and Removal Procedure	6/28/2019
12	Neonatal Abstinence Syndrome, Management of	12/11/2020
13	Orientation of the Professional Nursing Staff to the NICU	5/31/2019
14	Pain Management, Neonates & Infants	11/5/2019
15	Palliative Care Of the Neonates at the End of Life	6/29/2020
16	Patient Classification (Acuity) in the NICU	4/28/2023
17	Peripheral Arterial Line Insertion, Maintenance and Removal of	8/3/2018
18	Central Line: Insertion, Management, and Discontinuation of	9/24/2020
19	Formula, Preparation and Storage of	6/2/2020
20	Staffing Ratios for Social Services in the NICU	9/27/2019
21	Thermoregulation for VLBW infants	8/28/2020
22	Transfer of Neonates and Infants	12/17/2019
23	Visitation Guidelines in the NICU	12/16/2021
24	Weaning from Thermal Support	5/4/2020
25	Oxygen Hood; Neonate	12/11/2020
26	Postural Drainage, Percussion and Vibration of the Neonate	12/11/2020
27	Breast Milk Management in the NICU	12/11/2020
28	Sedation/ Analgesia Used During Therapeutic or Diagnostic Procedures for the NICU Patient	9/13/2021
29	Replogle Tube Insertion and Maintenance	5/5/2020
30	Pre/Post Weights for Breastfed Infants in NICU	4/26/2019
31	NICU Disaster Procedure	6/2/2020
32	Pulse Oximetry, NICU	12/19/2019
33	Infection Prevention - NICU	9/1/2020
34	Standards of Care - NICU	12/11/2020
35	Consultation to Perinatal Unit	12/16/2021
36	Cleaning And Sanitizing of Specialty Bottles/Nipples	9/4/2018
37	Donor Breast Milk Use Policy	3/2/2022
	Forms/Related Documents	
1	Equipment List for NICU Patients in Alternate Areas	1/1/2015
2	CCS HRIF Program Medical Eligibility Criteria (High Risk Infant Follow-Up Program Referral Proces	3/13/2020
3	Rub Hands for Hand Hygiene! Wash Hands When Visibly Soiled (Infection Prevention NICU Policy	8/27/2020
4	Wash Hands When Visibly Soiled! Otherwise Use Hand Rub (Infection Prevention - NICU)	8/27/2020
5	NICU Acuity Tool (Patient Classification in the NICU)	9/27/2022

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	document name	approved on
1	Adoption	2/6/2019
2	Amniocentesis	9/14/2021
3	Balloon Cervical Ripening Catheter	9/14/2021
4	Breast Milk Misadministration	12/19/2019
5	Car Seat Challenge Test Procedure	6/28/2019
6	Cord Gas Collection	11/18/2022
7	Dinoprostone [Cervidil]	12/16/2021
8	Discharge Process	12/16/2022
9	Elective Delivery Under 39 Weeks	8/29/2022
10	Emergency/STAT Cesarean Section Notification Process	9/14/2021
11	Epidural Spinal Management	1/30/2017
12	Fetal Heart Rate (FHR) Surveillance/ Monitoring	9/14/2021
13	Group Beta Streptococcal (GBS) Prevention and Treatment in Labor and Newborn Follow Up	11/18/2022
14	Hearing Screening Program: Newborn and Infants	11/18/2022
15	Human Immumodeficiency Virus (HIV) Intrapartum, Postpartum and Newborn Management	4/28/2023
16	Hypertension in Pregnancy Guidelines	11/18/2022
17	Infant Feedings	6/1/2018
18	Infant Safety and Security	11/5/2019
19	Infant Transport- Intrafacility	8/29/2022
20	Instrument Cleaning Process and Transport to Sterile Processing Department (SPD)	6/2/2020
21	Laminaria	12/16/2021
22	Misoprostol [Cytotec]	4/28/2023
23	Neonatal Delivery Room Attendance Policy	11/18/2022
24	Newborn Hearing Screening: Scheduling Outpatient Hearing Screening	8/3/2018
25	Newborn Sepsis Care Guidelines	9/9/2019
26	Obstetrical Hemorrhage	12/15/2021
27	Oxytocin Administration	11/18/2022
28	Partners in Care for WNS	2/24/2023
29	Placenta Release to Patient/Family Except For Those Sent To Pathology	4/26/2019
30	Release of Minor to Other than Birth Mother	2/6/2019
31	Scheduling Process for Procedures Policy	5/27/2022
32	Skin to Skin Contact after Birth	12/16/2022
33	Sponge and Sharps Counts for Vaginal Deliveries	4/1/2022
34	Standards of Care: Antepartum	2/24/2023
35	Standards of Care: Intrapartum	8/29/2022
36	Standards of Care: Newborn	12/16/2022
37	Standards of Care: Postpartum	8/29/2022
38	Surrogacy	4/29/2022
39	Trial of Labor after Cesarean (TOLAC) Vaginal Birth after Cesarean Birth (VBAC)	9/13/2021
40	Umbilical Cord Blood Banking Private Collection	4/28/2023
41	Uterine Tamponade Devices	4/2/2019
42	Vibroacoustic Stimulation (VAS) (FetalL Acoustic Stimulation Test - FAST)	8/29/2022
43	WNS Admission Registration Policy	4/29/2022
44	WNS Disaster Response Plan	4/29/2022
Folder	Forms	
1	Umbilical Cord Blood Sample Collection Consent #7400-1072	7/31/2014
2	Information on Supplementing the Breastfeeding Baby - English	5/14/2018

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

January 25, 2024 – 2:00 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 2:00 p.m. on January 25, 2024.

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

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

Absent: Director Sanchez

Also present were:

Dr. Gene Ma, Chief Executive Officer
Donald Dawkins, Chief Nurse Executive
Jeremy Raimo, Chief Operations Officer
Janice Gurley, Chief Financial Officer
Eva England, Sr. Director, Ancillary Services
Henry Showah, M.D., Chief of Staff
Susan Bond, General Counsel
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant

1. The Board Chairperson, Director Younger, called the meeting to order at 2:00 p.m. with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Mizell and seconded by Director Gleason to approve the agenda as presented. The motion passed (6-0-0-1) with Director Sanchez absent.

3. Oral Announcement of Item to be discussed during Closed Session

   Chairperson Younger made an oral announcement of the items listed on the January 25, 2024 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included two matters of Potential Litigation and Reports Involving Trade Secrets.

6. Motion to go into Closed Session

   It was moved by Director Coulter and seconded by Director Gleason to go into Closed Session at 2:05 p.m. The motion passed (6-0-0-1) with Director Sanchez absent.

7. At 3:20 p.m. the Board returned to Open Session with attendance as previously noted.

8. Report from Chairperson on any action taken in Closed Session.

The Board met in closed session to discuss two matters of litigation and took no action.

The Board also heard Reports Involving Trade Secrets and took no action.

9. Open Session

a) Consideration to approve an expenditure of $450,000 to add an orthopedic physician through an addendum to the existing Professional Services Agreement between Tri-City Healthcare District and Tri-City Orthopedic Surgery Medical Group, Inc.

It was moved by Director Chavez to approve an expenditure of $450,000 to add an orthopedic physician through an addendum to the existing Professional Services Agreement between Tri-City Healthcare District and Tri-City Orthopedic Surgery Medical Group, Inc. Director Gleason seconded the motion.

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

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

b) Consideration to approve the sub-lease office space agreement between Tri=City Healthcare District and Trias MD, LLC, beginning February 1, 2024 for a term of one (1) year.

It was moved by Director Chavez to approve the sub-lease office space agreement between Tri=City Healthcare District and Trias MD, LLC, beginning February 1, 2024 for a term of one (1) year. Director Gleason seconded the motion,

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

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

9. Adjournment

There being no further business, 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
January 25, 2024 – 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 January 25, 2024.

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 Tracy M. Younger

Absent was Director Adela Sanchez

Also present were:

Dr. Gene Ma, Chief Executive Officer
Donald Dawkins, Chief Nurse Executive
Jeremy Raimo, Chief Operating Officer
Janice Gurley, Chief Financial Officer
Roger Cortez, Chief Compliance Officer
Dr. Henry Showah, Chief of Staff
Susan Bond, General Counsel
Jeffrey Scott, Board 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 Coulter and seconded by Director Gleason to approve the agenda as presented. The motion passed (6-0-0-1) with Director Sanchez absence.

3. Pledge of Allegiance

   Director Chavez led the Pledge of Allegiance.

4. Public Comments – Announcement

   Chairperson Younger read the Public Comments section listed on the January 25, 2024 Regular Board of Directors Meeting Agenda.

5. Report –

   LAFCO Municipal Service Review (MSR) Report Update

a) Carolanne Leromnimon, Analyst and Project Manager with San Diego LAFCO presented on behalf of Adam Wilson, LAFCO Consultant, the LAFCO Municipal Service Review (MSR) which is required by Government Code Section 56430. Ms. Leromnimon provided background on LAFCOs, which were established in 1963 and are political subdivisions of the State of California responsible for providing regional growth management services in all 58 counties. Ms. Leromnimon explained that service reviews attempt to capture and analyze information about the governance structures and efficiencies of service providers, and to identify opportunities for greater coordination and cooperation between providers.

The Municipal Service Review Breakdown is broken down into three chapters as follows:

- Chapter One – Introduction
- Chapter Two- Executive Summary
- Chapter Three – Agency Profiles

Ms. Leromnimon also provided the timeline for the MSR process as follows:

- Intro Meeting
- Data Gathering
- Administrative Draft
- Administrative Draft Feedback
- Commission Hearing 1st Draft
- Comment Period (45 days)
- Commission Hearing Final Draft

Director Chavez thanked Ms. Leromnimon for her presentation but added he was disappointed that Adam Wilson was unable to attend. Director Chavez stated he is very interested in the MSR and what effects it will have on our District. He requested that LAFCO provide the District with the dates of the hearings when they become available.

6. Recognition of Retiring CFO, Ray Rivas

Dr. Ma, CEO presented a plaque and expressed his appreciation to Mr. Ray Rivas for his 12 years of service to the District. He added that Mr. Rivas has overseen the organization through every audit and there have been no adjustments during that time.

Mr. Rivas stated the past 12 years have gone by very quickly and he is excited about the future for Tri-City.

a) Appointment of Janice Gurley, CFO

Dr. Ma announced the appointment of Janice Gurley to CFO.

7. Foundation Report – Jennifer Paroly

The Foundation Report was deferred to next month's meeting.

8. December, 2023 Financial Statements – Janice Gurley, Chief Financial Officer

Janice Gurley, Chief Financial Officer reported on the fiscal year to date financials as follows (Dollars in Thousands):

- Net Operating Revenue – $137,945
- Operating Expense – 168,086
- EBITDA – ($16,179)
- EROE – ($26,131)

Janice reported on the fiscal year to date Key Indicators as follows:

- Average Daily Census – 109
- Adjusted Patient Days – 30.233
- Surgery Cases – 2,291
- ED Visits – 22,019

Janice reported on the current month financials as follows (Dollars in Thousands)

- Net Operating Revenue – $21,056
- Operating Expense – $27,257
- EBITDA – ($3,926)
- EROE – ($5,468)

Janice reported on the current month Key Indicators as follows:

- Average Daily Census – 109
- Adjusted Patient Days – 6,555
- Surgery Cases – 381
- ED Visits – 3,919

9.. New Business - None

10. Old Business -

a) Affiliation Update –

Dr. Ma stated the due diligence is continuing and we await a preliminary agreement from UC San Diego Health. Dr. Ma stated there is still a lot of work to be done.

11. Chief of Staff –

Dr. Henry Showah, Chief of Staff presented the January 2024 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Practitioners. No concerns or "red flags" were raised by the Credentials Committee. Dr. Shoah stated the physicians are excited about the possibility of an affiliation with UCSD and moral is approving.

It was moved by Director Coulter to approve the January 2024 Credentialing Actions and Reappointments Involving the Medical Staff

as recommended by the Medical Executive Committee on January 22, 2024. Director Gleason seconded the motion.

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

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

12. Consideration of Consent Calendar

It was moved by Director Gleason to approve the Consent Agenda as presented. Director Chaya seconded the motion.

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

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

13. Discussion of items pulled from Consent Calendar

There were no items pulled from the Consent Calendar.

14. Comments by Members of the Public

Chairperson Younger recognized Donna Rencsak. Ms. Rencsak commented on an experience she had in the Emergency Department.

15. Comments by Chief Executive Officer

Dr. Ma, CEO stated we are on the verge of our remodel of the ED. We were fortunate to bring in Team Health and they have helped analyze the flow in the ED.

Dr. Ma reported the Psychiatric Healthcare Facility is moving forward as planned with an anticipated opening date in late summer to early fall.

In Jennifer Paroly's absence, Dr. Ma spoke regarding a donation of two new portable imaging radiology machines that will make a big impact for the ED. The donor, who chose not to be acknowledged, also supported the purchase of new equipment for the Electrophysiology lab. Dr. Ma expressed his appreciation to the Foundation and donor for their gracious support.

Dr. Ma stated we will be holding an offsite event on February 15th to recognize several of our physicians that are retiring including:

- Dr. Neville Alleyne
- Dr. Bart Day
- Dr. Jim Helgager

- Dr. John Kroener
- Dr. Yung Le
- Dr. Eric Rypins
- Dr. David Spiegel

Dr. Ma invited Board members to attend the celebratory event.

Lastly, Dr. Ma recognized the entire C-Suite team for the sacrifices they have made and willingness to take on additional tasks. He also recognized Sandra Doiley and Miava Sullivan for their help in the voluminous due diligence process with UCSD Health.

16. Board Communications

Director Chavez stated he has enjoyed his time here with Mr. Rivas and wished him well in his retirement.

17. Adjournment

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

_____
Tracy M. Younger, Chairperson

ATTEST:

_____
Gigi Gleason, Secretary

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending January 31, 2024

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	LeaseTerm Beginning	LeaseTerm Ending	Services & Location	Cost Center
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	$3.59	(a)	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)	37,541.94	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)	21,811.67	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)	15,620.89	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 Cairsbad** 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)	31,749.00	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				**248,577.58**				

(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 January 2024

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
8740	Charge	110623EDU	200.00	80037	MELISSA P. MENDOZA
8740	AABH TRAINING	11224EDU	200.00	71410	TONY VITRANO
8740	Charge	11224EDU	110.00	84371	NEIL DOMAYO
8740	Charge	120823EDU	110.00	81061	HIMELRIGHT, TAMARA
8740	ACLS	11824EDU	125.00	77871	MING YIN
8740	PALS	11824EDU	150.00	81595	SUSAN COLCOL INES

**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.