TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
May 2, 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	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)	2 min.	Chair
3	Roll Call / Pledge of Allegiance		
4	Approval of Agenda	2 min	Standard
5	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
6	March 2024 Financial Statement Results	10 min.	CFO
7	New Business – a) Consideration to approve the renewal of an agreement with Nandan Prasad, M.D. as the Medical Director of Quality/Chairperson of Medical Quality Peer Review Committee for a term of 12 months, beginning May 1, 2024 and ending April 30, 2025, not to exceed a total term cost of $51,500.	5 min.	CNE
8	Old Business – a) Affiliation Update – Information Only	5 min.	CEO

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

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

	Agenda Item	Time Allotted	Requestor
9	Chief of Staff - a) Consideration of April 2024 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on April 22, 2024.	5 min. .	COS
10	Consent Calendar (1) Board Committee **(a) Finance, Operations & Planning Committee** **Director Younger, Committee Chair** *(No Meeting)* (2) **Administrative Policies & Procedures** **A. Patient Care Services** 1. Nephrostomy Drain, Care of Procedure 2. Patient Valuables Liability and Control 3. Sharps Injury Prevention & Disposal, Procedural Areas Policy 4. Surgical Skin Stapling **B. Administrative 200/300 Patient Care** 1. Assignment of Medical Record Numbers and Standard Naming Guidelines 390 2. Business Visitor Visitation Requirements 203 3. Unclaimed Property – Financial 280 **C. Emergency Department** 1. Release of a Minor Under 18 Years of Age Policy **D. Laboratory** 1. Hematology, Coagulation and Urinalysis Department Quality Assurance Plan **E. Surgical Services** 1. Disaster and Emergency Preparedness Policy 2. Intraoperative Deaths Policy 3. Scheduling Surgical Procedures Policy 4. Visitors in PACU Policy (3) Minutes a) Special Meeting – March 28, 2024 b) Regular Meeting – March 24, 2024 c) Special Meeting – April 17, 2024 (4) Reports – (Discussion by exception only) a) Building Lease Report – March, 2024) b) Reimbursement Disclosure Report – (March, 2024)	10 min.	
11	Discussion of Items Pulled from Consent Agenda	10 min.	Standard

	Agenda Item	Time Allotted	Requestor
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 hour	
16	Adjournment		

Tri-City Medical Center

TCHD BOARD OF DIRECTORS

DATE OF MEETING: May 2, 2024

Medical Quality Peer Review Committee Chair and Quality Medical Director Agreement Renewal

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

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

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

Term of Agreement: 12 months, Beginning, May 1, 2024 – Ending, April 30, 2025

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

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

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

Description of Services/Supplies:

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

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

Person responsible for oversight of agreement: Donald Dawkins, CNE

Motion:

I move that the Tri-City Healthcare Board of Directors authorize the renewal of the agreement with Nandan Prasad, M.D., as the Medical Director of Quality/Chairperson of Medical Quality Peer Review Committee for a term of 12 months, beginning May 1, 2024 and ending April 30, 2025, not to exceed a total term cost of $51,500.00

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT
April 10, 2024

Attachment A

Initial Appointments

Any items of concern will be "red" flagged in this report. Verification of education, training, experience, current competence, health status, current licensure, liability coverage, claims history and the National Practitioner Data Bank, the following practitioners are recommended for a 2-year appointment with delineated clinical privileges, to the Provisional Staff or Allied Health Professional Staff with customary monitoring.

Medical Staff:

Department of Medicine:

Practitioner Name	Group	Specialty	Staff Status	Initial Appointment Term
BUCKLEY, David, MD	Radiology Medical	Teleradiology	Provisional	4/26/2024 – 4/26/2026
DAWOOD, Farah, MD	Sherev Heart	Cardiology - EP	Provisional	4/26/2024 – 4/26/2026
JEAN-BAPTISTE, Jean, MD	StatRad	Teleradiology	Provisional	4/26/2024 – 4/26/2026

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
April 10, 2024

Attachment B

Reappointments:

Any items of concern will be "red" flagged in this report. The following practitioners were presented to members of the Credentials Committee for consideration for reappointment to the Medical Staff or Allied Health Professional Staff, 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. Reappointment is for 2-years unless otherwise noted below.

Medical Staff

Department of Family Medicine:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
HURD, Melissa MD	Family Medicine	Refer and Follow	4/27/2024 – 4/27/2026	
REEN, Sandeep MD	Family Medicine/ Hospitalist	Active	4/27/2024 – 4/27/2026	

Department of Medicine:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
RAJAMANICKAM, Anitha, MD	Cardiology	Active	4/27/2024 – 4/27/2026	
BALBUENA-ROOT, Melissa, MD	Teleneurology	Active Affiliate	4/27/2024 – 4/27/2026	Change in staff status from Provisional to Active Affiliate.
CHIAO, Hellen, MD	Gastroenterology	Active	4/27/2024 – 4/27/2026	
CLANCY, John,	Internal Medicine	Refer and Follow	4/27/2024 – 4/27/2026	
DILLARD, Kira L, MD	Teleneurology	Active Affiliate	4/27/2024 – 4/27/2026	Change in staff status from Provisional to Active Affiliate.
FUSSNER, Steven, MD	Teleneurology	Active Affiliate	4/27/2024 – 4/27/2026	Change in staff status from Provisional to Active Affiliate.
SAUNDERS, Phillip. DO	Oncology	Refer and Follow	4/27/2024 – 4/27/2026	Change in staff status from Provisional to Refer and Follow.
LEE, Robert, MD	Internal Medicine	Active	4/27/2024 – 4/27/2026	
DELANEY, Michael, MD	Neurology	Active	4/27/2024 – 4/27/2026	

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
April 10, 2024

Attachment B

SHABANIAN, Leila, MD	Internal Medicine	Active	4/27/2024 – 4/27/2026	
KAYAL, Anas, MD	Nephrology	Active	4/27/2024 - 4/27/2026	
BUTLER, Ian, MD	Critical Care	Active	4/27/2024-4/27/2026	
TADROS, Emad, MD	Psychiatry	Active	4/27/2024-4/27/2026	Change in staff status from Provisional to Active.

Department of Ob/Gyn:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
PURCOTT, Kari L., MD	OB/GYN	Active	4/27/2024 – 4/27/2026	Change in staff status from Provisional to Active.

Department of Pediatrics:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
PERTL, Ursula G., MD	Pediatrics	Active	4/27/2024 – 4/27/2026	

Department of Radiology:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
FARRELL JR., Robert MD	Teleradiology	Active Affiliate	4/27/2024 – 4/27/2026	
SHABRANG, Cyrus MD	Interventional Radiology	Active	4/27/2024 – 4/27/2026	

Department of Surgery:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
FIERER, Adam, MD	Surgery/ General Vascular	Active	4/27/2024 – 4/27/2026	
JAIN, Atul, MD	Surgery/ Ophthalmology	Active Affiliate	4/27/2024 – 4/27/2025	Change in staff status from Active to Active Affiliate. 1-year reappointment due to the significant accumulation of MR suspension days. One (1) chart remains incomplete.

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
April 10, 2024

Attachment B

YOO, Frank K, MD	Surgery/ Neurological Surgery	Active	4/27/2024 – 4/27/2026	
SPRINGER, Dewain N, DPM	Surgery/ Podiatric Surgery	Active	4/27/2024 - 4/27/2026	
JESWANI, Sunil P, MD	Surgery/ Neurological Surgery	Active	4/27/2024 - 4/27/2026	

Resignation/s:

Practitioner Name	Department/Specialty	Reason for Resignation
CARLTON, Adam, MD	OB/GYN	Voluntary Resignation – Per practitioner's letter, effective 10/28/2023
DESADIER, Jason, DO	Emergency Medicine	Voluntary Resignation – Per practitioner's letter, effective 04/04/2024
GOELITZ, Brian, MD	Radiology / Interventional Radiology	Voluntary Resignation – Per practitioner's letter, effective 02/29/2024
PENRY, Jackson W., MD	Radiology / Diagnostic Radiology	Voluntary Resignation – Per practitioner's letter, effective 03/07/2024
TADLAOUI, Karim., MD	Medicine/Critical Care	Voluntary Resignation – Per practitioner's letter, effective 03/19/2024

MBOC (Medical Board of California): No new information at this time

NPDB (National Practitioner Data Bank): No new information at this time

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
April 10, 2024

Addition/Deletion of Privilege(s)

The following practitioners have requested addition/deletion of privilege(s) as noted below. Effective **[4/26/24]**.

Practitioner Name	Department/Specialty	Change in Privilege/s
FERNANDEZ, Genaro, MD	Medicine/Interventional Cardiology	Additional privileges: TAVR and Watchman WITH proctoring
MCKNIGHT, Braden, MD	Surgery/Orthopedic Surgery	Additional privilege: Vertebral Augmentation WITH proctoring
PARKS, Monica, MD	Cardiology	Relinquish Venous cut down & Percutaneous Central Venous Pressure Catheters

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
April 10, 2024

Proctoring Recommendations

The following providers have successfully completed their initial FPPE (Focused Professional Practice Evaluation) and are being recommended for release of their proctoring requirements for the privilege(s) as noted below.

Practitioner Name	Department/Specialty	Privilege(s)
LaREAUX, Daniel, MD	Emergency Medicine	General Patient Care
MOSER, Michael, MD	Radiology	Teleradiology: Ultrasound, Magnetic Resonance Imaging, General Nuclear Medicine, General Radiology and Computed Tomography.
NASIRI, Arian, MD	Interventional Radiology	Endovascular AAA Repair
PARKS, Monica, MD	Cardiology	Cognitive Privileges, Elective Cardioversion, Transesophageal echocardiography, EKG, Stress Echo and Thoracic Echo.

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
IDPC INITIAL CREDENTIALS REPORT
April 15, 2024

Attachment A

Initial Appointments

Any items of concern will be "red" flagged in this report. Verification of education, training, experience, current competence, health status, current licensure, liability coverage, claims history and the National Practitioner Data Bank, the following practitioners are recommended for a 2-year appointment with delineated clinical privileges, to the Provisional Staff or Allied Health Professional Staff with customary monitoring.

Allied Health Staff:

Practitioner Name	Group	Specialty	Staff Status	Initial Appointment Term	Comments
CLOOKIE, Jeremy, NP	TeamHealth	ER	Allied Health Professional	4/26/2024 – 4/26/2026	Supervisor: Cary Mells, MD

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE CREDENTIALS REPORT – 1 of 1
April 15, 2024

Attachment B

Reappointments:

Any items of concern will be "red" flagged in this report. The following practitioners were presented to members of the Interdisciplinary Practice Committee for consideration for reappointment to the Allied Health Professional Staff, 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. Reappointment is for 2-years unless otherwise noted below.

Allied Health Practitioner(s)

Department of Emergency Medicine:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
CANSECO, Edilberto, PA	Emergency Medicine	Allied Health Professional	4/27/2024 – 4/27/2026	

Department of Family Medicine:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
KAUP, Allison R, PHD	Clinical Psychologist PH, D.	Allied Health Professional	4/27/2024-4/27/2026	

Department of Surgery:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
GUTHRIE, Lesli A, AuD	Surgery/ Audiology	Allied Health Professional	4/27/2024-4/27/2026	

Resignation/s:

Practitioner Name	Department/Specialty	Reason for Resignation
CARLTON, Vivian W., PAC	Emergency Medicine / Physician Assistant	Voluntary Resignation effective 05/01/24 – Per practitioner's e-mail
SCHMITT, Ryan PA-C	Surgery/Physician Assistant	Voluntary Resignation effective 4/09/24 – Per practitioner's e-mail
SERRA, Natalie CRNA	Anesthesiology / CRNA	Voluntary Resignation – Per employer's letter, effective 02/19/2024
SIDLINGER, Kelly CRNA	Anesthesiology /CRNA	Voluntary Resignation – Per employer's letter, effective 02/19/2024

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 2 of 3
April 15, 2024

Modification of Privilege(s)

The following practitioners failed to complete their proctoring requirements and therefore the listed privileges will automatically expire as of **April 25th, 2024**.

Practitioner Name	Department/Specialty	Change in Privilege/s
CANSECO, Ediberto PAC	Emergency Medicine	Arterial Line, Arthrocentesis, Central IV, includes midline catheters, Endotracheal intubations, Intraosseous line placement, in adults and infants/children, Lumbar puncture, Reduction of major joints, Repair of complex lacerations, Thoracentesis, Paracentesis, Tube/needle thoracostomy, Limited abdominal ultrasound, Ultrasound guidance for approved procedures.

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 3 of 3
April 15, 2024

Proctoring Recommendations

The following providers have successfully completed their initial FPPE (Focused Professional Practice Evaluation) and are being recommended for release of their proctoring requirements for the privilege(s) as noted below.

Practitioner Name	Department/Specialty	Privilege(s)
GOHL, Mark CRNA	Anesthesiology	All granted CRNA privileges
KELLER, Mark CRNA	Anesthesiology	All granted CRNA privileges
ORDUNO, Ramon CRNA	Anesthesiology	All granted CRNA privileges
SZULAKOWSKI, Mary CRNA	Anesthesiology	All granted CRNA privileges

PRACTICE AGREEEMENT BETWEEN SUPERVISING PHYSICIAN AND PHYSICIAN ASSISTANT

This Practice agreement has been developed through collaboration among physician(s) and surgeons and physician assistants(s) in _____**(department) at Tri-City Medical Center**, for the purpose of defining the medical services which each and every physician assistant ("PA") who executes this Practice Agreement is authorized to perform and to meet the statutory requirement set forth in Business & Professions Code (BPC) §3502.

AUTHORIZED SERVICES. The PA is authorized to perform medical services which are consistent with this Practice Agreement and as specified in the individual PA's Delineation of Privileges (appended hereto) and are performed under the supervision of a supervision physician, consistent with the Supervising Physician's Responsibility for Supervision of Physician Assistants Form [appended hereto]. At a minimum, supervision will include the physician and surgeon being available by telephone or other electronic communication method at the time the PA examines the patient. Pursuant to BPC §3502, the PA is authorized to perform only those medical services for which the PA has demonstrated competency through education, training or experience, under physician supervision as noted in this Practice Agreement, and only those privileges that have been specifically granted by Tri-City Medical Center.

ORDERING AND FURNISHING OF DRUGS

In compliance with State and Federal prescribing laws, the PA may order and furnish those drugs and devices, including schedule II through V controlled substances, as indicated by the patient's condition, the applicable standard of care, and in accordance with the PA's privileges, education, training, experience, and competency, under physician supervision as noted in this Practice Agreement. The furnishing and ordering of schedule II drugs shall be only for those illnesses, injuries, and/or conditions for which the standard of care indicates the use of such schedule II drugs. The PA may dispense drugs and devices as provided for in BPC §4170.

To order or furnish controlled substances pursuant to this Practice Agreement, the PA must have satisfactorily met the requirements found in Business and Professions Code Section 3502.1.

(CHECK ONE OF THE FOLLOWING)

2a.

_____ The PA is authorized to order and furnish **Schedule II** controlled substances **WITH OR WITHOUT** patient-specific order by the Supervising Physician.

(Attached Certificate) showing proof of a completed Controlled Substances Education Course commensurate with California Code of Regulations Sections: 1399.610 and 1399.612 or BPC Section 3502.01(e)(3)

OR

_____ The PA is authorized to order and furnish **Schedule II** controlled substances **ONLY WITH** patient-specific order by the Supervising Physician.

PATIENT CARE POLICIES AND PROCEDURES. PA shall consult with, and/or refer the patient to, a supervising physician or other healthcare professional when providing medical services to a patient which exceeds the PA's competency, education, training, or experience.

COMPETENCY AND QUALIFICATION EVALUATION: Through a peer review process based on the standard of Care applicable to a PA, the hospital, through the Medical Staff, shall regularly evaluate the competency of a PA in a manner consistent with the Medical Staffs peer review and evaluation processes. Tri-City Medical Center will credential and privilege the PA to ensure that the PA has the qualifications, training, and experience, to perform the medical services, procedures and drug and device ordering and furnishing authorized under this Practice Agreement. Proctoring for new procedures must meet the minimum established standards for each new procedure as noted on the Delineation of Privileges Form.

PRACTICE SITE. All medical services consistent with this Practice Agreement and as specified in the PA Delineation of Privileges Form may be performed for care of patients in Tri-City Medical Center located at 4002 Vista Way Oceanside, CA 92056

REVIEW OF PRACTICE AGREEMENT. This Practice Agreement shall be reviewed during each reappointment process and updated by the Hospital when warranted by a change in conditions or circumstances.

PHYSICIAN ASSISTANT DECLARATION
My signature below signifies that I have read the entirety of this Practice Agreement and fully understand the foregoing Practice Agreement, having received a copy of it for my possession and guidance, and agree to comply with its terms without reservations.

The physician and PA named below collaboratively approve this Practice Agreement governing the medical services of PA in the Hospital, on behalf of the Hospital, and authorize the physicians on the staff of the Hospital to supervise the PA named below as of the date signed by the PA. The physician signing the Practice Agreement is authorized to approve the Practice Agreement on behalf of the staff of the physicians and surgeons on the staff of the Hospital, which is an organized health care system.

_____ _____
Date Physician Assistant's Signature

_____
Physician Assistant's Printed Name

_____ _____
Date Physician's Signature

_____
Physician's Printed Name

Tri-City Medical Center
MEDICAL STAFF

SUPERVISING PHYSICIAN'S RESPONSIBILITY
FOR SUPERVISION OF PHYSICIAN ASSISTANT

SUPERVISOR NAME:_____,
Consistent with BPC §3501(e), a supervising physician referred to in this Practice Agreement means a physician licensed by the Medical Board of California or by the Osteopathic Medical Board of California who supervises one or more physician assistants, who possesses a current valid license to practice medicine, and who is not currently on disciplinary probation prohibiting the employment or supervision of a physician assistant. A supervising physician may provide supervision of PA pursuant to this Practice Agreement.

All references to "PA" in this document refers to the physician assistant named in the attached Practice Agreement. The PA understands and agreed that PA may only provide those medical services which PA is competent to perform, for which the PA is being supervised and which are consistent with the PA's education, training, and experience. PA shall consult with, and/or refer a patient to, a supervising physician or other healthcare professional when providing medical services to a patient which exceeds the PA's competency, education, training, or experience or in situations when a patient desires to see a physician.

SUPERVISION REQUIRED. The PA will be supervised by the supervising physician in accordance with these guidelines, which have been read by the physician whose signature appears below.

Consistent with BPC §3502(f), supervision means that a licensed physician oversees the activities of, and accepts responsibility for, the medical services rendered by a PA. Supervision shall not be construed to require the physical presence of the physician but does require supervision consistent with the Practice Agreement and the physician being available by telephone or other electronic communication method at the time PA examines a patient.

The supervising physician agrees to comply with any conditions placed on the PA's practice in the Hospital and to ensure that the PA also complies. The supervising physician understand that failure to comply with any conditions of practice may be grounds for termination of the PA's authority to practice and for corrective action against the supervising physician.

The supervising physician agrees to answer any questions regarding the PA's practice and provide information to any Medical Staff or Hospital committee or member that may be reviewing the practice of the PA. Further, the supervising physician agrees to notify the Chief of Staff or Hospital Chief Executive Officer immediately if for any reason the PA should not be permitted to practice in the Hospital. The supervising physician understands that he/she will continue to be responsible for the PA until written notice is given.

MEDICAL RECORD REVIEW. Jointly, the PA and the supervising physician may agree upon additional mechanisms to ensure adequate supervision of those clinical activities performed by the PA. The review methods may occur in person, by telephone, by electronic messaging, or by use of video conferencing technology. Any audits/evaluations shall be documented on the appropriate form (obtained from Medical Staff Office). Upon completion, forms are to be submitted to the Medical Staff Office. These are considered "confidential" and should not be copied.

_____ _____
Date Physician's Signature

Tri-City Medical Center

ADMINISTRATION CONSENT AGENDA
April 15th, 2024

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services		
1. Nephrostomy Drain, Care of Procedure	3 year review	Forward to BOD for Approval
2. Patient Valuables Liability and Control	3 year review, practice change	Forward to BOD for Approval
3. Sharps Injury Prevention & Disposal; Procedural Areas Policy	3 year review, practice change	Forward to BOD for Approval
4. Surgical Skin Stapling	3 year review	Forward to BOD for Approval
Administrative 200/300 Patient Care		
1. Assignment of Medical Record Numbers and Standard Naming Guidelines 390	Practice change	Forward to BOD for Approval
2. Business Visitor Visitation Requirements 203	3 year review, practice change	Forward to BOD for Approval
3. Unclaimed Property – Financial 280	3 year review	Forward to BOD for Approval
Emergency Department		
1. Release of a Minor Under 18 Years of Age Policy	3 year review	Forward to BOD for Approval
Laboratory		
1. Hematology, Coagulation and Urinalysis Department Quality Assurance Plan	2 year review, practice change	Forward to BOD for Approval
Surgical Services		
1. Disaster and Emergency Preparedness Policy	3 year review	Forward to BOD for Approval
2. Intraoperative Deaths Policy	3 year review	Forward to BOD for Approval
3. Scheduling Surgical Procedures Policy	Practice change	Forward to BOD for Approval
4. Visitors in PACU Policy	3 year review	Forward to BOD for Approval

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**NEPHROSTOMY DRAIN, CARE OF**
Purpose:	To outline the nursing responsibilities in the care of nephrostomy drains.
Supportive Data:	A nephrostomy drain is a percutaneous tube inserted into the renal pelvis for temporary diversion of urine associated with urinary obstruction, to allow healing fistula or leaks secondary to injury, malignances or inflammatory fistula or hemorrhagic aptitis.
Equipment:	1. Gloves 2. Face Shield or Mask or Goggles 3. Collection Container 4. Biohazard disposal bag available 5. Tegaderm dressing 6. Chlorhexadine swab 7. Fenestrated gauze

A. **POLICY:**

1. Ensure locking mechanism of drainage tube in locked position to maintain proper and secure placement of the nephrostomy catheter or as ordered by the physician.
2. Maintain the drainage bag at a lower level than the kidney at all times.
3. Ensure the nephrostomy tube does not kink or otherwise become compressed.
4. Secure drainage bag, via a safety pin connection or leg strap, to prevent tension, accidental dislodgement or contact with the floor.
5. When bathing a patient with a nephrostomy tube in place, ensure insertion site remains dry.
6. Nephrostomy drain may only be removed by Interventional Radiology (IR) provider or physician

B. **PROCEDURE:**

1. Assess nephrostomy output as ordered or at least every four (4) hours and as needed
   a. Notify physician if output changes from baseline output.
2. Empty the drainage bag when it becomes half full or every shift
   a. Don clean gloves. If splashing is anticipated, wear mask, eye protection, and/or gown.
   b. Empty the drainage bag into a measuring container and carefully avoid touching the spout to the drainage container.
   c. Dispose of the drainage in the toilet, taking care not to splash contents.
   d. Document the amount and type of fluid drained in the electronic health record (EHR) on appropriate Intake and Output form.
3. Change the dressing every other day and PRN or as ordered.
   a. Perform hand hygiene.
   b. Don clean gloves., change gloves or perform hand hygiene as necessary throughout the procedure..
   c. Place the following supplies on a clean surface:
      i. Tegaderm dressing
      ii. Chlorhexadine swab
      iii. Fenestrated gauze
   d. Remove the soiled dressing.
   e. Assess insertion site for redness and oozing of fluid. Notify the primary care or Interventional Radiology (IR) provider if these signs are noted.
   f. Scrub the exit site with chlorhexadine swabs (or povidone iodine swabs if the patient is allergic to chlorhexadine) for 30 seconds. Allow to dry for 60 seconds.
   g. Place fenestrated gauze around the insertion site.

Patient Care Services Content Expert	Clinical Policies & Procedures	Nursing Leadership	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
6/09, 10/10, 7/14, 12/19, 07/23	03/11, 8/14, 01/20, 07/23	03/11, 8/14, 02/20, 08/23	08/15, 09/20, 02/24	n/a	04/11, 01/16, 10/20, 03/24	12/20, 04/24	05/11, 02/16, n/a	08/09, 05/11, 02/16, 12/20

h. Apply Tegaderm dressing on top of the gauze and over the tube, and apply additional tape to secure tube as needed to prevent dislodgement.
i. Document date and time of dressing change and your initials on the dressing
j. Document in the EHR.

4. Monitor dressing after removal of drain by IR provider or physician
   a. Maintain dressing over drain site until site is healed. Secure gauze dressing with tape and change PRN.
5. If drain removed accidentally:
   a. Cover drain site with gauze dressing.
   b. Visually inspect the drain to ensure it is intact. If the drain is not intact collect drain, tubing and other associated products to send with patient to IR.
   c. Notify IR provider or physician
   d. Notify Risk Management regarding accidental withdrawal.
      i. If drain not intact, obtain instructions on where to send the product for further evaluation.
   e. Document incident in EHR.

C. **REFERENCES:**

1. Gottrup, F., Nix, D. P. & Bryant, R. A. *The multidisciplinary team approach to wound management.* In R. A. Bryant & D. P. Nix (Eds.), Acute & chronic wounds: Current management concepts (3rd ed., pp. 23-38). St. Louis, MO: Mosby.
2. Mosby's Nursing Skills Procedure: Nephrostomy Tube Care and Flushing. Retrieved June 9, 2014 from TCMC Intranet.

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**01/76**	**SUBJECT:**	**Patient Valuables, Liability and Control**
REVISION DATE:	**09/91,~~;~~ 06/94; ,6/97,~~;~~ 05/00,~~;~~ 06/03,~~;~~ 04/06,~~;~~ 6/09,~~;~~ 02/11, 03/15, 08/20**		

Patient Care Services Content Expert Approval:	**~~04/20~~10/23**
Clinical Policy & Procedures Committee Approval:	**~~05/20~~03/24**
Nursing Leadership Approval:	**~~06/20~~04/24**
Medical Staff Department or Divisions Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~07/20~~04/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/20**

A. **PURPOSE:**

1. To establish a consistent method for the collection and disbursement of patient valuables during the admitting process. In the event that a patient arrives to the floor in possession of valuables, this policy provides prudent and reasonable safekeeping of these items. Valuable items include, but are not limited to:
   a. Money
   b. Credit cards
   c. Jewelry
   d. Watches
   e. Hearing aids
   f. Eyeglasses
   g. Dentures

B. **POLICY:**

1. During the admission process, ~~all~~**the** patient is strongly encouraged to leave items of value at home or to send them home with family members. ~~If this task is accomplished on the nursing unit,~~ ~~d~~Documentation **disposition of belongs** ~~must be completed~~ in the electronic health record.
   a. While in the hospital, patients may retain their eyeglasses, hearing aids, and dentures as needed however, these valuables will be the responsibility of the patient and/or family.
2. Patients are informed on the Conditions of Admission that the District will not be responsible for valuables kept in patient rooms or at the bedside.
3. Under no circumstances will a weapon be accepted from a patient for storage in the hospital safe. In these instances, security must be notified.
4. If the decision is made to admit the patient, the nurse will strongly encourage the patient to send valuables home with the family/friend.
5. If the patient is unable to remove any piece of jewelry due to physical constraints, the jewelry will be secured with tape as appropriate
6. If sending valuables home is unacceptable to the patient, the nurse will call Security to lock such valuables in the hospital safe.

C. **PROCEDURE:**

1. The responding Security Officer will first encourage the patient to send the item(s) home with a family member for safe keeping.
2. If the patient is unable or unwilling to send the item(s) home for safe keeping, the Officer will bring a grey UniVault bag to the location of the patient.

3. The Officer will collect the item(s) with the patient's nurse as a witness to the collection process.
   a. Once the item or items are collected, the Officer will inventory them and write a complete and accurate description of the item(s) on the outside of the UniVault bag using a sharpie or other permanent type marker, then place the item(s) in the bag securing it.
   b. Only valuables will be collected and placed in the bag (i.e. if the patient is securing a wallet, the valuables are removed from it in the patient's presence, and placed in the UniVault bag, then the wallet is returned to the patient.)
   c. All information on the bag must be filled out completely, and signed by the patient. If the patient is unable to sign, the patient's nurse will sign as a witness.
   d. The top flap portion of the bag is to be removed and filled out, then given to the patient as receipt of collection.
   e. Two (2) copies of the completed inventoried bag must be made by placing the bag directly on a copy machine, one copy is to be given to the patient's nurse to be included in the patient's chart and the second copy is to be placed in the "For Copies Only" tray located on the counter above the Small (Drop) Safe in the Lost and Found office.
   f. The Officer must verify the patient's phone number with the patient (***not collected from the chart***) to ensure current and accurate contact information.
4. All applicable information will be logged into the Patient Valuables Property Logbook ~~#4~~ including the patient's name, phone number, and bag serial number. The bag will be placed in the slot and dropped with the Officer verifying the bag fully dropped in.
5. Documentation of the UniVault bag number must be documented in Cerner on the Valuables/Belongings Powerform.
6. Returning Patient Valuables.
   a. When requested to return a patient's valuables, every attempt will be made to ensure ~~that~~ the item is being returned to the proper owner.
   b. The Officer will collect the UniVault receipt from the owner, or if it has been lost or misplaced, will receive the copy of the bag from the patient's chart.
   c. The Officer will take the UniVault receipt or chart copy and contact the Cashiering Department or Administrative Supervisor (after hours) to meet and open the small (Drop) Safe to collect the patient's valuables.
   d. The Officer will return to the floor and in the presence of the patient and nurse, will cut the bag open on the dotted line of the bag.
   e. The Officer will inventory the contents of the UniVault bag and compare them to the inventory listed on the outside of the bag while checking off the inventory items.
   f. When the patient is satisfied that all their valuables are accounted for, the Officer will have the patient sign the UniVault bag and the copy.
   g. The Officer will make two copies of the signed inventory sheet and give one to the patient's nurse to be included in the patient's chart as a permanent record of receipt.
   h. The Officer will return the signed UniVault bag and the signed inventory sheet and place both in the "For Copies Only" tray located on the counter above the small (Drop) safe.
   i. The Lost and Found Administrator will collect the signed receipts and attach them to the copy filed in Lost and Found, then file them together in the Disposition section of Patient Valuables filing cabinet.
7. Destruction of Patient Valuables Property
   a. If any patient valuables are not claimed within 180 days of the patient leaving the hospital, the items will be disposed of in a manner specified by the Directors of the Risk, Legal, and or Regulatory Departments.

D. **LIMITATIONS AND LIABILITY:**

1. The limitation on liability does not extend to those situations in which the hospital or its employees are responsible for a loss when valuables are given to the hospital for safekeeping. Although, the extent of possible liability is limited by statute to $500.00, unless a written receipt for a greater amount has been given to the patient (Civil Code, Section 1859). The amount of liability for those items whose use or availability are required while hospitalized that have been lost or damaged due to willful wrongdoing or negligence on the part of the hospital or its employees shall not

exceed $1,000 (Civil Code 1859).

E. **RELATED DOCUMENTS:**

1. Administrative Policy: Lost and Found Articles 202
2. Administrative Policy: Unclaimed Property – Financial 280
3. Patient Care Services Policy: Patient Complaints and Grievances

F. **REFERENCES:**

1. Title 22, California Code of Regulations, Section 70755
2. CA Civil Code Section 1859
3. CHA Consent Manual (2019) pages 20.1-20.3

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**6/09**	**SUBJECT:**	**Sharps Injury Prevention & Disposal; Procedural Areas**

REVISION DATE(~~S~~): 11/12, 03/13, 09/18

Patient Care Services Content Expert Approval:	**~~03/18~~06/23**
Clinical Policies & Procedures Committee Approval:	**~~04/18~~08/23**
Nursing Executive Committee Approval:	**~~04/18~~08/23**
Operating Room Committee Approval:	**~~07/18~~02/24**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~08/18~~03/24**
Administration Approval:	**~~09/18~~04/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**09/18**

A. **PURPOSE:**
1. To provide guidelines for safe handling and disposal of sharps pre-operatively, intra-operatively and post-operatively to minimize the potential for injury and reduce bloodborne pathogen exposure.

B. **DEFINITION:**
1. Sharp: Any disposable or reusable item that has the potential to cause a cut or puncture injury. Examples include, but are not limited to:
   a. Needles
   b. Stylets
   c. Pins and wires
   d. Knife blades
   e. Cautery tips
   f. Disposable sharp instruments (e.g., clip appliers, scissors, staplers, dissectors)
   g. Reusable sharp instruments (i.e., sharp retractors)
   h. Trocars
   i. Vial and bag decanters with a spike
   j. Saw blades
   k. Drill bits
   l. Broken glass (e.g., ampules, broken vials and bottles)
2. Bloodborne pathogens: Pathogenic microorganisms that are present in human blood and can cause disease (e.g., hepatitis B virus [HBV], hepatitis C virus [HCV], human immunodeficiency virus [HIV])

C. **PRE-OPERATIVELY:**
1. All sharps will be opened onto the sterile field so they are visible to the scrub personnel during case setup.
2. An instrument shall be used to load blades onto knife handles.

D. **INTRA-OPERATIVELY:**
1. Surgical team members should use a neutral zone or hands-free technique when possible and practical for passing sharp instruments, blades and needles.
   a. Designate an area as the neutral zone where the scalpel, needle or other sharp object is laid down.

b. Only one person at a time touches an instrument or sharp in the neutral zone.
c. A basin/container (i.e., emesis basin) can be used to pass the scalpel between the surgeon and scrub. The scalpel is placed in the basin/container, and then can be set in the neutral zone. The surgeon removes the scalpel; uses and returns it to the basin. The scrub then removes the basin/container from the neutral zone as soon as is safely possible.
~~c.~~**d. Give verbal notification when a sharps is in the neutral zone**
~~d.~~**e.** The neutral zone must be kept free from clutter. Remove sharps or other instruments as quickly as is safely possible.

2. When hands free technique is not possible or practical due to the requirements of the procedure, use extreme caution when passing sharps to avoid injury. ~~Maintain situational awareness of all sharps on the sterile field.~~ **Use a limited hands-free passing technique by placing the sharp in the surgeons hand and having the surgeon return the sharp to the neutral zone.**
3. ~~Control and identify the location of sharps to avoid injury.~~ **Maintain situation awareness of all sharps on the sterile field** ~~Know how many and where sharps are~~ at all times during the surgical procedure.
   a. Sharps should be confined and contained in specified areas of the sterile field or within a sharps containment device.
   b. Keep sharps visible. DO NOT place sharps where they cannot be seen (i.e., under basins, towels or instrument pans).
   c. When a scrub person is relieved, either temporarily or permanently, both the oncoming and off-going staff members are to identify the location and type of sharps. Identification of sharps can be confirmed with the count.
4. When feasible, perioperative team members should use syringes, needles and intravenous (IV) catheters that incorporate safety-engineered features, such as needle-free IV systems and retractable syringes and scalpel blades.
5. Suture needles are passed and retrieved with a needle holder.
   a. Load needles from the suture package with minimal handling and as close to the time of use as possible.
   b. Return used needles to the appropriate needle container. Do not handle or reposition needles before or after placing them in the needle container. Bury the sharp end of the needle in the foam mat, when possible.
   c. Encourage the surgeon to cut the needle off the suture before tying the suture.
   d. Use caution when loading free needles.
6. Syringe needles are not to be re-capped, unless the medical procedure dictates recapping the needle, and then only by a one-handed technique.
   a. Syringes with needles are placed in the neutral zone for passing between surgical team members.
   b. If refilling of the syringe is necessary, remove and replace the needle with an instrument.
   c. After use, place the needle and syringe in a visible and safe place. The needle may be removed from the syringe with an instrument and placed in the needle container.
7. An instrument should be used to pick up sharp items (e.g., scalpel blades, suture needles) that have fallen off the sterile field.
8. Whenever possible, scrubbed team members should wear two pairs of surgical gloves, one over the other, during surgical and other invasive procedures that have the potential for exposure to blood, bodily fluids, or other potentially infectious materials.
   a. Double gloving minimizes bloodborne pathogen exposure.
   b. When double gloves are worn, a perforation indicator system is preferred, using a colored pair of gloves worn beneath a standard pair of gloves.
~~b.~~**9. If percutaneous injury occurs, immediately wash the area with soap and water and refer to ~~TCMC~~ Employee Health and Wellness Policy: Management of Bloodborne Pathogen Exposure for reporting and follow up.**

E. **POST-OPERATIVELY:**
1. All disposable sharps shall be disposed of in an appropriate puncture-proof container.

a. The scrub person is responsible for disposing sharps from the sterile field.
b. The circulating nurse is responsible for disposing sharps used off the sterile field.
c. The anesthesiologist/anesthesia tech is responsible for the disposal of sharps used by him/her during the procedure.

2. Disposable sharps are placed in a bio-hazardous puncture proof container.
   a. Needles are placed in the needle container, which is carefully secured before being placed in the puncture proof biohazardous waste container.
   b. Knife blades are removed from the handle using an instrument. DO NOT remove a knife blade by hand.
   c. Disposable sharps that do not fit in the needle book (i.e., staplers, trocars, used k-wires, etc.) are placed in an appropriate puncture-proof container (i.e., recycling bin or sharps container). DO NOT leave exposed disposable sharps on the case cart.
   d. Reusable sharp instruments (e.g., sharp retractors) shall be separated into a basin prior to sending the case cart to the decontamination area.
3. Puncture resistant sharps disposal containers are to be routinely replaced and not allowed to overfill. Containers should be replaced when ¾ full.

F. RELATED DOCUMENT(S);

1. Employee Health and Wellness Policy: Management of Bloodborne Pathogen Exposure

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

~~1. Conner, R. (2018). Guidelines for Perioperative Practice, 2018 Edition. Denver, CO: Association of PeriOperative Registered Nurses.~~

1. Kyle, Erin, DNP, RN, CNOR, NEA-BC, AORN Guidelines for Perioperative Practice: Sharps Safety, Denver, CO., 2023, pg. 946-968.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 01/17 **SUBJECT: Surgical Skin Stapling**

REVISION DATE: 01/17, 06/20

Patient Care Services Content Expert Approval:	~~03/20~~08/23
Clinical Policies & Procedures Committee Approval:	~~03/20~~09/23
Nursinge Leadership~~Executive Council~~ Approval:	~~04/20~~10/23
Operating Room Committee Approval:	~~04/20~~02/24
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~05/20~~03/24
Administration Approval:	~~06/20~~04/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	06/20

A. **POLICY:**
1. Surgical Technologists and Registered Nurses may utilize an automatic skin stapler under the direct supervision of the physician/Allied Health Professional (AHP) for the purpose of skin closure.
    a. Deep tissue stapling is not allowed.

B. **PROCEDURE:**
1. Under the direction of the physician/AHP, lightly position the automatic skin stapler over the approximated skin edges at the desired position.
    a. It is not necessary to press the stapler into the skin to get a proper placement; lightly touch the skin.
2. Center the staples over the incision line using the locating arrow or guideline on the stapler.
3. Press the stapler anvil to deploy the staples as the physician/AHP approximates the skin edges.
4. Place staples approximately ¼" apart, as directed by the physician/AHP.

C. **REFRENCES:**
1. Rothrock, J. C. & McEwen, D. R. (2019). *Alexander's Care of the Patient in Surgery, 16th Edition*. St. Louis, MO: Elsevier.

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY
PATIENT CARE

ISSUE DATE:	**09/05**	**SUBJECT:**	**Assignment of Medical Record Numbers and Standard Naming Guidelines**
REVISION DATE:	**05/09, 09/12, 01/18, ~~01~~6/22**	**POLICY NUMBER:**	**8610-390**

Administrative Policies & Procedures Content Expert:	**~~03/22~~04/24**
Administrative Policies & Procedures Committee Approval:	**~~04/22~~04/24**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~06/22~~04/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**06/22**

A. **PURPOSE:**

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

B. **SCOPE:**

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

C. **POLICY:**

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

D. **PROCESS:**

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

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

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

~~Pre-admitted newborns will be entered as: Intended Parent(s) Last Name, and Baby. See the WNS policy: Surrogacy~~

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

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

   ~~Downtime procedures direct Registration personnel to the Affinity system to identify a previous medical record number, when necessary.~~
5. If the patient's identification is unknown (e.g. John or Jane Doe):

   ~~Do a patient search for John or Jane Doe~~
   a. ~~If the search returns no patients~~ **E**enter the name as Doe, John (or Jane)~~, leave a space, then use the letter A (as in Doe, John A)~~
   b. Subsequent John or Jane Does will use letters **A,** B, C, D, etc. to differentiate between patients.

      ~~If the search returns other John or Jane Does, look to see the last letter used in the first name (e.g. Doe, Jane C)~~

      ~~Register the next Jane Doe as: Doe, Jane D~~
   c. If the date of birth of John or Jane Doe is not known **use the following format.**

Type	Example	Report Date of Birth as
Age Only = Known	**The patient is known to be 65 years old and the**	**01/01/1954**

	year ~~be~~ service received ~~medical service~~ is 2023. (2023-65=1958)	
Month = Unknown Day of Birth = Unknown Year = Known	**The patient was born in 1948.**	**01/01/1948**
Month = Unknown or Known Day of Birth = Unknown or Known Year = Unknown	**If the patient's day of birth, month, and year are all unknown or if all are unknown**	**01/01/and estimate the year of birth based on age provided by clinical staff If the month and day of birth are known – enter this into the encounter notes until the full DOB can be verified**

~~Use the current day and month as the day and month of Jane/John Doe's birthday~~
~~Example: Today is 2/24/04~~
~~John/Jane Doe's birthday to be entered as: 02/24~~
~~The birth year is calculated as follows:~~
~~If you think the patient's age is XX, use this birth year a) 0-10 Year 2000~~
~~b) 11-20 Year 1990~~
~~c) 21-30 Year 1980~~
~~d) 31-40 Year 1970~~
~~e) 41-50 Year 1960~~
~~f) 51-60 Year 1950~~
~~g) 61-70 Year 1940~~
~~h) 71-80 Year 1930~~
~~i) 81-90 Year 1920~~
~~j) 91 and over Year 1910~~

~~c.~~**d.** A "John Doe" medical record will be generated through the Registration process.

~~d.~~**e.** Continuous efforts will be made to establish correct identification throughout the patient's hospitalization.

~~e.~~**f.** After the patient's identification has been determined and if the patient has no previous medical record number, the assigned temporary number will remain as the patient's permanent medical record number.

~~f.~~**g.** After the patient's identification has been determined and if the patient has a previous medical record number, the individual in charge of the patient will notify the Medical Records or Registration Department.

6. Correction of Duplicate Medical Record Numbers:
   a. The Medical Records/HIM Department is responsible for correcting any duplicate medical record number. This will be implemented in the following manner:
      1) Request for correction of duplicate medical record number will be made **via~~in writing~~ email** to the Medical Records/HIM Department. Submissions may be made by any staff member who identifies possible duplicate medical record numbers.
      2) ~~The Data Correction sheet is faxed to the Medical Records Department (fax number 3414) or email MPI Specialist~~.
      3) The Medical Records/HIM Department follows a Prioritization Matrix to determine which duplicates are combined first.
      4) The Medical Records/HIM Department reports duplicate assignments by medical service for departmental follow-up.

~~Note: Patient information entered into the Cerner system is passed through to the Affinity~~

~~Patient Accounting system. When documents are printed from Affinity (i.e. Facesheets, bills, reports) patient name information is displayed in all CAPS without hyphens or spaces.~~

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
DISTRICT OPERATIONS

ISSUE DATE: 9/07

SUBJECT: Business Visitor Visitation Requirements

REVISION DATE: 01/08~~;~~, 07/11~~;~~, 05/12, 06/16

POLICY NUMBER: 8610-203

Administrative Content Expert~~Department~~ Approval ~~Date(s)~~:	~~11/1502/2004/24~~
Administrative Policies & Procedures Committee Approval:	~~01/1604/24~~
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	04/24
Professional Affairs Committee Approval:	~~06/16~~ n/a
Board of Directors Approval:	06/16

A. **PURPOSE:**
1. To outline expectations for business visitors at Tri-City Health Care District (TCHD)
2. To ensure all business visitors are pre-authorized to visit with appropriate identification; understand all practices as they relate to contracts, products, loaner instrumentation, new/borrowed equipment, dress code, conduct while in the hospital, and confidentiality in the hospital setting.

B. **DEFINITIONS:**
1. Business ~~V~~visitors: Any non-credentialed supplier, vendor or community service provider.
   a. Suppliers: A person who provides sales or sales support of products or services to TCHD. Examples of suppliers include but are not limited to representatives of equipment, supply, or medical materials.
   b. Vendors: A person who provides contracted services to departments or patients at TCHD. Examples of vendors include but are not limited to dialysis services or equipment service technicians.
   c. Community service provider: may include, but not be limited to providers of Home Health, Hospice, and Skilled Nursing & Acute Rehabilitation Services who may present to TCHD upon invitation from patient or family or Case Manager/Social Worker staff for purposes of assessing patient for appropriate admission to their service.

C. **POLICY:**
1. TCHD's selection of contractors and business visitors shall be made on the basis of objective criteria including:
   a. Group Purchasing Organization affiliation
   b. Quality
   c. Technical excellence
   d. Price
   e. Delivery
   f. Service
2. TCHD's purchasing decisions shall be made based on the business visitor's ability to meet our needs.
3. Prior to entering any patient care area, all business visitors must meet all established requirements in **TCMC approved vendor management system (VMS)**~~Reptrax~~ as determined by TCHD Leadership.
4. Supplier or vendor visitation within the hospital shall be by appointment only.
5. All business visitors must sign in at the **VMS**~~Reptrax~~ kiosk in the main lobby.

a. Business visitors visiting the Surgical Services division are required to check in at the front desk of the Main Operating Room (OR) or the Sterile Processing Department (SPD), and must always be identifiable by badge.
b. Business visitors denied access in **VMS**~~Reptrax~~ must report immediately to Supply Chain Management to receive a temporary badge before visiting any areas.
   i. After hour business visitors to report to **Main Distribution Center (MDC)**~~Security~~ and receive a temporary badge.

6. Business visitors must wear the **VMS**~~Reptrax~~ printed badge or other appropriate TCHD vendor/visitor identification and check in with the charge nurse prior to entering any clinical area.
7. Suppliers whose product competes with products covered by a sole or multiple source contracts already in use at TCHD shall not be seen unless the hospital is in the process of re-negotiating for these items and has requested representation.
8. Suppliers who are awarded national contracts with the hospital's affiliated Group Purchasing Organization may only discuss those products covered under the agreement.
   a. These discussions shall only take place after the Supply Chain Management department has completed the initial review and the business visitor has received authorization to proceed.
9. No products shall be left in hospital departments without approval from Clinical Value~~s~~ Analysis Team.
10. TCHD employees and business visitors are expected to employ the highest ethical standards in business practices regarding source selection, negotiation, determination of contract awards, and administration of all purchasing activities to foster public confidence in the integrity of the procurement process.
    a. Neither party shall disclose third party confidential information including contract pricing, information to any outside party, or use of confidential information for actual or anticipated personal gain without express consent by the other party or as required by law.

~~a.~~**11. The Contractor shall take appropriate steps to ensure that neither the Contractor nor any TCHD Staff is placed in a position where, in the reasonable opinion of the court, there is or may be an actual conflict, or a potential conflict, between the pecuniary or personal interests of the Contractor and the duties owed to TCHD under the provisions of the Contract. The Contractor will disclose to TCHD full particulars of any such conflict of interest which may arise before entering into said contract. If a conflict does arise, please notify the Chief Compliance and Privacy Officer at 760-940-5381.**

~~11.~~**12.** Any business visitor not complying with these rules shall be issued a warning in **VMS**~~Reptrax~~. If a second offense occurs, TCHD reserves the right to ban that particular business visitor representative from doing business with TCHD.

~~12.~~**13.** TCHD employees are prohibited from being vendors or suppliers of any product or service at TCHD.

D. **PRODUCT REMOVAL AND REPAIRS:**

1. No TCHD owned equipment or instrumentation shall be removed from the Hospital unless accompanied by authorized paperwork.
2. No instruments or trays (hospital or vendor owned), **will** be removed from SPD without SPD staff's knowledge and consent.

E. **PRODUCT INTRODUCTIONS:**

1. All products being brought into the hospital for review/evaluation must be 501K/FDA approved and at no cost to TCHD. All products for review, replacement, and/or evaluation must be submitted through the Supply Chain Management Department or Supply Chain Director in advance.
2. No in-service or product demonstration shall occur without the prior knowledge of the Unit Manager and Supply Chain Management.
   a. Under no circumstances are products used on patients without in-service/education for Medical Staff and Health Care providers prior to use of the product/equipment.

F. **DRESS CODE:**

1. All business visitors conducting business must dress according to unit policy.
   a. If the business visitor representative is required to wear scrubs, his/her temporary identification badge shall be clearly visible on the front left pocket of the scrub shirt
   b. Scrub tops shall be tucked in at all times.
   c. All TCHD owned surgical scrubs must be returned before leaving the hospital.
2. Hair covers must be worn properly. All head and facial hair, including sideburns and necklines shall be covered (all hair enclosed), and masks must be worn whenever entering an area where sterile supplies are open.
3. No open toed shoes are allowed.

G. **PRICING:**

1. All suppliers must submit pricing to Supply Chain Management Director and receive approval prior to bringing the product to TCHD regardless of who requested the product to be brought in.
2. Product brought in without TCHD Supply Chain Director previously agreeing upon pricing TCHD will be considered a "donation" to TCHD and will not be paid for.
3. All suppliers and vendors with an on-going relationship with TCHD must have a current and approved pricing agreement on file.
   a. List pricing is never accepted

H. **LOANER INSTRUMENTS:**

1. All loaner trays must be delivered to SPD no less than 24 hours prior to the procedure start time to allow for proper inventory and sterilization. **SPD will not accept any loaner surgical instruments or trays that are stained, corroded, pitted or rusted.**
   a. All loaner trays shall include up-to-date count sheets listing all contents.
   b. All loaner trays must be labeled accurately with the name of the tray, physician intending to use the tray, and date and time of procedure.
   c. Trays must be checked in and picked up at SPD.
      i. When picking up loaner instrumentation, suppliers shall visually inspect all items and request additional cleaning if items do not meet cleanliness standards.
      ii. Missing instruments must be identified at the time of pick-up and verified with a sterile processing technician.
      iii. No replacements shall be made for instrument loss identified after the loaner instruments have left SPD.
      iv. Loaner instruments and trays must be picked up within 24 hours after the use.
      v. TCHD is not responsible for any loaner trays and instruments left over 24 hours

I. **CONDUCT IN SURGICAL SERVICES/PROCEDURAL AREAS:**

1. A distance of three feet shall be maintained from all sterile fields. Laser pointers may be used to identify items on the sterile field
2. Suppliers NEVER scrub in or assist in the surgical procedure.
3. Suppliers are not to open any sterile supplies onto a sterile field.
4. Suppliers shall not operate autoclaves or assist with any patient care.
5. All pagers and mobile phones must be placed on vibrate while in the operating suites.
6. At no time shall a business visitor operate a surgical suite phone, copier or fax machine.
7. Vendors representatives may not operate any patient care equipment except under the following circumstances:
   a. Contracted service with TCHD (i.e., laser, lithotripter)
   b. Demonstrated evidence of specialized training (i.e., pacemaker, AICD) shall be allowed to adjust devices to surgeon specifications.
8. Business visitor representatives may not market products in the OR department to include physician lounges and surgical suites. Only pre-approved products may be demonstrated. All physician sales calls must be arranged through the physician's office.
9. TCHD will not pay for any product opened by a supplier or vendor during surgical procedures. Only TCHD staff will open product.

10. Suppliers and vendors must remain present during surgical procedures to support use of their product.
11. Once the patient has entered the OR, the business visitor representative is not allowed in the OR until surgical drapes are applied and the procedure is ready to commence. The business visitor is allowed in the OR ONLY for the portion of the procedures related to use of the business visitor's product. Business visitor representatives shall minimize the number of times they enter/exit an operating suite once a procedure has started.
    a. Only one business visitor shall be permitted in the OR, Catheterization Lab, and/or Interventional Radiology Room during a procedure unless authorized by the department Director or designee.
    b. Business visitor names/information is recorded on the intraoperative record.

J. **TRIAL EQUIPMENT:**
1. All non-TCHD owned equipment for trial must be pre-approved by Supply Chain Management and Clinical Engineering prior to the day of use.
2. All equipment must be safety checked by the Clinical Engineering department prior to being brought into clinical areas.
3. Any consumable supplies required for use during the trial of equipment must be FDA approved and at "no cost" to TCHD.
4. The business visitor/vendor must obtain a "no cost" purchase order from Purchasing before the product can be left for trial and complete a vendor trial agreement form.

K. **CONFIDENTIALITY:**
1. All business visitors with access to patient health information must read and follow all TCHD policies, sign a confidentiality agreement and submit to TCHD contracting for file.
2. Access to specific health data and information shall be limited to the medical record number.
3. Discussion of patient medical information must be limited to work or patient care related discussions and must take place in a private area.
    a. Discussions in public areas (i.e., elevators, restrooms, lounges, and cafeteria) are strictly prohibited.
4. Business visitor representatives shall only enter an operating suite after the patient is under the effect of anesthesia and draped for surgery.
5. Business visitor representatives shall not be granted access to the surgical schedule.
6. Photographs are prohibited.
7. Patient Health Information (PHI) will only be possessed and transported by TCHD staff.
8. Patients should be informed and provide consent of the possibility of business visitors being present during their procedure to support the equipment and/or products used during the case.

L. **COURTESIES:**
1. TCHD employees may not accept gifts, entertainment, or anything else of value from current or potential business visitors of goods and services or from consultants to the organization except for items that are clearly promotional in nature, mass produced, or nominal in value.
    a. Perishable or consumable gifts may be accepted from business visitors currently providing supplies or services.
2. Cash or cash equivalents such as gift cards shall not be given to staff.
    a. Business meals and/or nominally valued sporting tickets are permissible by business visitors currently providing supplies or services. (Refer to Administrative Policy, Conflict of Interest Acceptance of Gifts)
3. Items presented to TCHD employees/staff shall not be intended to evoke any form of reciprocation.

M. **RELATED DOCUMENT:**
1. Administrative Policy ~~#483~~: Conflict of Interest Acceptance of Gifts **483**
2. **Administrative Policy: Identification of Employees and Non-TCHD Employees 436**

Tri-City Healthcare District
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATIONS

ISSUE DATE: 07/03 **SUBJECT:** Unclaimed Property - Financial

REVISION DATE: 06/09, 06/17 **POLICY NUMBER:** 8610-280

~~Department Approval~~Administrative Content Expert Approval: ~~01/17~~03/24
Administrative Policies & Procedures Committee Approval: ~~01/17~~04/24
Pharmacy & Therapeutics Committee Approval: n/a
Medical Executive Committee Approval: n/a
Administration Approval: 04/24
Audit, Ethics and Compliance Committee Approval: ~~06/17~~ n/a
Board of Directors Approval: 06/17

A. **PURPOSE:**
1. To establish the procedures by which Tri-City Healthcare District (TCHD) shall comply with the unclaimed property laws set forth in Government Code Sections 50050 through 50053.

B. **DEFINITIONS OF TERMS:**
1. Unclaimed property has the meaning in Government Code Sections 50050-50053 and includes vendor checks, payroll checks, refunds, overpayments and credit balances.
2. Proper Notice – After three years, publication once a week for two successive weeks in a newspaper of general circulation published in the TCHD area.

C. **POLICY:**
1. The Assistant Controller of TCHD shall cause Proper Notice of unclaimed property to be published as set forth in Government Code Sections 50050 and 50051.
2. All unclaimed property held by TCHD that is not claimed (or no verified complaint is filed and served) within the sixty (60) day time period set forth in the Proper Notice is the property of TCHD.
3. Consistent with Government Code section 50056, the Treasurer of TCHD hereby delegates his/her responsibilities under this policy to the Assistant Controller, as the appropriate person within the Finance Department, which maintains the supporting records of unclaimed money initially received by or deposited with TCHD.

D. **PROCESS FOR NOTICE PUBLICATION AND CLAIMING OF FUNDS:**
1. Publication:
   a. TCHD's Assistant Controller shall cause Proper Notice to be published. The notice will include: the identity of persons or entities who deposited the unclaimed property, the amount of unclaimed property, the fund in which it is held (e.g. refunds, overpayments, etc.) and that it is proposed that the unclaimed property will become the property of TCHD sixty (60) days after the first publication of the notice.
2. Submission of Claims:
   a. Claimants may upon or prior to publication, file a claim with the TCHD Assistant Controller c/o of the Finance Department. Claims should be submitted to the TCHD Assistant Controller, c/o TCHD Finance Department as specified in the notice on TCHD's Unclaimed Property Claim Form which includes the claimant's name, address, amount of claim, grounds on which the claim is founded and other information required by the Assistant Controller. Claimants have sixty (60) days after first publication to claim the funds.

3. Proof of Ownership:
   a. Claimants must provide appropriate documentations that demonstrate their identity and legal ownership for the unclaimed property. In the event that the party claiming the unclaimed property is not the identified owner, or if the identified owner is deceased, he or she will be required to provide documentation sufficient to demonstrate their identity and legal ownership of the unclaimed property.
4. Assistant Controller Determination on Claim:
   a. The Assistant Controller will accept or reject the claim. In the event that a claim is rejected by the Assistant Controller, and the party who submitted the claim files and serves a verified complaint upon the Assistant Controller as provided in Government Code Section 50052, the Assistant Controller shall withhold release of the portion of the Unclaimed Property for which the action was filed until a decision is rendered by the court in the action.
5. Transfer to General Fund:
   a. Unclaimed Property held by TCHD that remains unclaimed (or no verified complaint is filed and served) within the sixty (60) day time period set forth in the Proper Notice shall be transferred to TCHD's General Fund.

E. **ATTACHMENT(S):**
1. Public Notice Format
2. Unclaimed Property Claim Form

F. **REFERENCE(S):**
1. California Government Code, Section 50050-50053
2. California Code of Civil Procedure Section 1502(2)(a).

Public Notice

PUBLIC NOTICE

Notice of Names of Persons appearing to be owners of unclaimed money being held by Tri City Hospital District.

Pursuant to Government Code sections 50050 et. Seq., Tri City Hospital District hereby gives notice to the below listed individual(s) that it is holding, and has held for a period of three or more years, unclaimed money allegedly belonging to said individual(s). It is proposed that the money will become the property of Tri City Hospital District on the below stated date; such date not more than sixty (60) days after the first publication of this notice.

Date on which money shall become the property of Tri City Hospital District:_____.

TO CLAIM THESE FUNDS:

If your name or the name of your company is listed below:

1. Cut out and complete the Unclaimed Property Claim Form.
2. Attach one photocopy of three different pieces of current identification, i.e. driver's license or other picture ID's.
3. Mail to address listed below.
4. Allow 90)days from receipt of documents by Tri City Hospital District to receive your check or notice of denial.

Inquiries and claims should be mailed to:

Tri City Hospital District
Finance Department – ATTN: Accounting
4002 Vista Way
Oceanside, CA 92056

Unclaimed Property Claim Form

TRI CITY HOSPITAL DISTRICT
UNCLAIMED PROPERTY CLAIM FORM

Claim to recover monies being held by Tri City Hospital District pursuant to Government Code sections 50050 et.seq.

Name as advertised: _____ ID# _____

Address as advertised _____
(Attach proof you received mail at the advertised address)

Name of Claimant/Business: _____

Current Address of Claimant/Business _____

ATTACH PHOTOCOPY OF DRIVERS LICENSE OR OTHER PICTURE I.D. AND PROOF OF CURRENT ADDRESS.

If claimant is not the original owner or owner is deceased, attach documents supporting claim and check one of the following:

_____ 1. As heir or survivor, attach copy of death certificate and a copy of will or notarized list of heirs including address.
_____ 2. As guardian, executor, administrator or other representative capacity. (If appointment is currently in force, enclose document evidencing such authority)
_____ 3. If name of company is advertised, attach copy of articles of incorporation, etc. to identify individual having authority to sign for company.

I agree, that if for any reason it is found that I am not entitled to this payment or receive a duplicate payment, I will return the funds to Tri City Hospital District within 15 days of such finding.

Signature:_____Date_____Phone #_____

(If Joint Account, both must sign)

Signature:_____Date_____Phone #_____

Tri-City Medical Center
Oceanside, California

EMERGENCY DEPARTMENT

ISSUE DATE:	**SUBJECT:** **Release of a Minor Under 18 Years of Age**

REVISION DATE~~(S)~~: 08/05~~,~~, 02/11, 08/20

Emergency Department Approval:	**~~02/20~~02/24**
Department of Emergency Medicine Approval:	**~~06/20~~04/24**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~07/20~~04/24**
Professional Affairs Committee Approval Date:	**n/a**
Board of Directors Approval Date:	**08/20**

A. **PURPOSE:**
1. To provide guidelines as to releasing a minor under eighteen (18) years of age to a parent or legal guardian.

B. **DEFINITIONS:**
1. Minor – a person younger than 18 years of age.
2. Authorized individual: parent, legal guardian or other person with the authority to consent to medical treatment for the minor per California Hospital Association (CHA) Consent Manual (2017), Chapter 4.

C. **POLICY:**
1. Minors shall only be discharged to the custody of an authorized individual.,.

D. **PROCEDURE:**
1. Prior to the release of a minor to a designated person, that person must complete a receipt or an Acknowledgement of Release of a Minor.
2. Place the original in the patient's chart and a copy is given to the person who receives the minor.
3. A Department of Health Services (DHS) form is completed and the original forwarded to the DHS within forty-eight (48) hours, with the name and address of the organization to whom the physical custody of the minor is surrendered, unless the surrender is to one of the following:
   a. A parent.
   b. A person who has legal custody or authorization.
   c. A relative by blood or marriage.
   d. An agent of a public welfare, probation or law enforcement agency if the minor comes within Welfare and Institutions Code.
   e. Pursuant to a transfer of the minor to another health facility for further care.
4. The form needs to be completed by the authorized individual..

E. **FORM(S):**
1. Acknowledgement of Release of a Minor - Sample

F. **REFERENCES:**
1. California Hospital Association Consent Manual (2017), Chapter 4

FORM 10-2

ACKNOWLEDGMENT OF RELEASE OF A MINOR

I/we have on this date, *(insert date)* _____, received
(name of child) _____.

I/we understand that the signature below authorizes only the release of this child from the hospital. This is not a consent or relinquishment of this child for adoption.

Date: _____ Time: _____ AM / PM

Signature: _____
(person receiving child)

Print name: _____
(person receiving child)

_____
(organization)

_____
(address)

Signature: _____
(witness)

Print name: _____
(witness)

COMPLETE THE FOLLOWING:

IDENTIFICATION OF PERSON(S) RECEIVING CHILD

Name: _____

Address: _____

_____

Phone Number: _____

Driver's License No: _____ State: _____

Other: _____

Tri-City Medical Center
Oceanside, California

LABORATORY HEMATOLOGY
QUALITY ASSURANCE FOR HEMATOLOGY, COAGULATION, AND URINALYSIS

SUBJECT: Hematology, Coagulation and Urinalysis Department Quality Assurance Plan

ISSUE DATE: 07/96
REVIEW DATE(S): 10/07, 05/19, 05/10, 05/13
REVISION DATE(S): 10/98, 03/00, 12/02, 09/03, 110/04, 09/06, 11/07, 01/08, 05/08, 10/08, 11/09, 09/10, 05/11, 08/12, 05/15, 08/16, 11/17, 12/22, 05/23

Department Approval:	**~~12/19~~03/24**
Laboratory Director Approval:	**~~12/19~~03/24**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~01/20~~04/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/20**

A. **DEFINITION(S):**

1. **Hematology Department: unique within the Laboratory, the Hematology Department encompasses the Hematology, Coagulation, and Urinalysis sections. Therefore, when this policy refers to Hematology activities, these activities are extrapolated to Coagulation and Urinalysis unless otherwise noted.**

B. **POLICY:**

1. Purpose:
   a. The purpose of the Hematology Quality Management Plan is to objectively and systematically monitor the quality and appropriateness of laboratory services in the Hematology section in supporting the hospital wide strategic plan and to evaluate and pursue opportunities to resolve problems and improve patient care.
   b. The Hematology section actively participates in a Quality Assurance Program for the primary goal of providing the highest possible quality of medical care in a cost-efficient manner and with regard for the safety of patients and employees. A focus of the plan is monitoring the Hematology department function and reliability through external agencies for proficiency testing and contracted quality assurance services. In addition, patient results are monitored for accuracy, clinical correlation, correct format and timeliness of reporting.
   c. The Plan provides the system design and evaluation of proper patient identification and preparation; specimen collection; identification; preservation; transportation and processing; accurate result reporting and documentation. The system ensures optimal patient specimen and result integrity throughout the pre-analytical, analytical and post analytical processes.
      i. Opportunities for improvement are identified throughout the review process and through individual staff input using the strategic plan.
      ii. Opportunities are evaluated and improvement proceeds ~~using~~ **through** the FOCUS/PDCA model used throughout the organization.
   d. Hematology Department Quality Assurance is also monitored through review of the Laboratory Director. The Director reviews the Hematology's overall performance through in-house generated quality incident reports in the RL system, in lab generated Supervisor's Investigation of QA problems entered in the RL system, turnaround time

reports, quality assurance reports, quarterly quality review reports and feedback at Medical Quality Assurance and medical division meetings.

e. The safety of staff and visitors within the Hematology **and** Urinalysis Departments is maintained through the Hospital Safety Committee. All state and federal employees~~'~~ safety requirements are ~~satisfied~~ **fulfilled** and training and enforcement **are** ~~is~~ carried out by the Laboratory Operations Manager.

f. The effectiveness of the Hematology/Urinalysis Quality Assurance Plan is evaluated by the Hematology Department Technical Specialist using key monitors. These indicators are:
   i. Turn-around time reports for critical tests to critical care areas
   ii. Review of monthly QC reports and charts
   iii. Proficiency Test results
   iv. Customer (clients/patients) complaints
   v. Number of reporting errors
   vi. Critical Values Not Called

2. Quality Assurance Responsibilities for Hematology and Urinalysis:
   a. Laboratory Director:
      i. The Laboratory Director is responsible for ensuring the Quality Assurance Plan is implemented in the Hematology Department.
      ii. The Director or designee reviews and approves all technical procedures; receives, reviews and approves all reports regarding quality assurance activities; participates in the Laboratory Leadership Meetings; is responsible for ensuring policies and procedures are established for monitoring the competency of personnel (responsibility for performing competency assessment is delegated to the **Hematology** Technical Specialist and**/or** Lead CLS ~~of Hematology~~).
   b. Hematology Technical Specialist
      i. Reviews all Quality Incident Tracking Forms Reviews (RL Solutions)
      ii. Responsible for daily and monthly QA activities.
      iii. Reports to Laboratory Leadership Team Meetings problems and corrective action plans.
      iv. Responsible for maintaining documentation of QA monitors.
      v. Responsible for performing competency assessment along with the Lead CLS and for monitoring the effectiveness of the assessment.
      vi. Responsible for forming section Quality Management Teams when indicated.
      vii. Facilitates CQI activities in their section.
      viii. Responsible for documenting CQI activities and reporting at Lab Leadership Team meetings.
      ~~ii.~~ **ix.** Reviews all Quality Incident reviews (RL Solutions) pertaining to the Hematology section.
   c. Refer to the Laboratory Organizational Chart for additional information.
3. Quality Control Program:
   a. Quality control management for the Hematology section is the responsibility of the Laboratory Director and is delegated to the Technical Specialist and**/or** Lead CLS.
   b. Quality Control Management includes review of patient results, quality control values, and instrument performance records. The Hematology section has a defined and organized system of Quality Control, which describes the review process, its timeliness and the person(s) responsible for implementing it. The Quality Control system for each section also defines the tolerance limits, corrective actions, and documentation policies.
   c. Monitoring Analyte Performance:
      i. The purpose of the Quality Control Program is to ensure the precision and accuracy (~~,~~ and therefore reliability) of analytic test results reported from the laboratory. The Laboratory uses the multi-rule Westgard method for determining control status. Control results are selected for each method/control/test combination and are chosen to readily detect random and systematic errors while

at the same time maintain a low level of false rejections (rejecting the run when in fact there was no analytical error) and high probability of error detection.

ii. All controls specimens are tested in the same manner as patient samples.

d. Number and Frequency of Controls:

i. For quantitative tests, a minimum of two levels of controls are used on at least a day-of-use basis. Analytic run is defined as the interval between acceptable quality control results or the time interval within which the accuracy and precision of the measuring system is expected to be stable. The time interval between runs is determined by the control frequency.

e. Establishing Tolerance Limits:

i. Whenever new controls, new control lot numbers, or new tests are introduced, the protocol for establishing tolerance limits is to perform a minimum of 10 replicates over a period of at least one week and run in parallel with the controls currently in use. The Lab tolerance limits must be within the manufacturer's stated limits.

1) All results are entered in Cerner using DB QC Maintenance where a mean and 1 SD are calculated and the ± 2SD limits are determined. After the mean is established the Lead CLS or Technical Specialist monitors the means on a weekly basis for the next several weeks and adjusts the ranges as necessary so there is a minimum of 20 quality control runs.

ii. Note for the hematology analyzers:

1) Since new control lots are used monthly, the lab mean is established using a minimum of 10 replicates over a period of one week and historical tolerance limits are used which have been calculated from a minimum of 10 IQAP reports. These are monitored monthly from the IQAP reports and LJ charts.

2) The Lab limits are verified to be within the BCI assay ranges. Since the reticulocyte controls are also changed on a monthly basis and not run as frequently as the 6C controls, the BCI assay ranges are used and the IQAP reports reviewed monthly.

iii. The body fluid controls are only run when a patient specimen is received and the same lot is run over several months so the BCI assay ranges are used and IQAP reports are reviewed at the completion of the lot number.

f. Quality Control (QC) Records:

i. All QC records are maintained for a minimum of six years. This includes QC Summary printouts, instrument printouts and tapes, calibration records, reagent records, proficiency test results and evaluations, method comparisons, calibration verification and linearity records, and new procedure staff review signoff forms. ~~See the Table: Laboratory Record Retention.~~ QC charts and records which are in Cerner are available for an indefinite time.

ii. **Refer to the Laboratory Record and Specimen Retention Table.**

g. Patient Result Corrective Action Based on Quality Control Data:

i. The quality assurance procedure used in the Hematology Department to review, retest and correct patient values which may have been resulted from the last time acceptable QC was documented up to the time of the QC failure (this time period is sometimes referred to as the "Analytic Run") is called "PATIENT RESULT CORRECTIVE ACTION".

ii. When a test/method has been determined to be out of control (OOC), corrective action must be taken such as replacing the reagent, recalibrating, changes or alignments, other maintenance or retesting the control. In most circumstances it is not certain at what time the system was no longer producing reliable results. At this point the test/method is marked OOC and no further patient results are reported from this test/method until corrective action is taken and the test/method is documented to be in control. All patient results reported from the effected

test/method back to the last time the test was documented to be in control are reviewed and possibly retested and corrected based on certain review criteria. The steps involved are:

1) Determine the last QC run.
   a) The last QC run can be determined from the Table of Control Frequencies, from the Cerner application QC Inquiry or from the test worksheet or instrument printout.
2) Obtain a list of patients reported since the last QC run.
3) Select the patient samples to be tested. Repeat the test on an instrument or method that is documented to in control and determine if a corrected report is to be made.
   a) The retest value is checked against the original value and a corrected report is made if the difference in values is more than +/- 3.5 times the 1SD value for the control used in the effected test / method combination for the nearest level of control to the effected test. The 1SD values for test / control combination are obtained from the QC Inquiry or the Hematology instrument.
4) Communicate by phone the corrected results and document the phone call.
5) Refer to the **Analytic Error Detection, Specimen Rejection, and Correction of Errors Procedure for additional information.**~~Laboratory Gen Lab QA procedure: Procedure for Detecting and Correcting Erroneous Laboratory Results~~

4. Quality Assurance Activities in the Hematology Department:
   a. The Quality Assurance Program for the Hematology section may be broken down to active process performed on an individual test, shift, daily, monthly, quarterly, semi-annually and annual basis. In addition, other activities may be included as needs arise or performance dictates. All activities are directed toward providing the physician a reliable (accurate, precise, clinically meaningful) result.
   b. Quality Control Inquiry/Quality Control Review:
      i. Daily ~~the~~ activity report is printed for both the **CMAX 1**~~Stago A~~ and **CMAX 2**~~Stago B~~. All the QC results are reviewed from the previous day.
         1) Control results, method and test combination, which have failed one or more of the Westgard rules defined for the test/method are reviewed by the Technical Specialist or the Lead Clinical Lab Scientist (CLS).
         2) This review consists of entering QA Inquiry for the method, test and control combination listed on the QC report and reviewing corrective action that was taken for the out of control result.
         3) All subsequent control runs will be reviewed to ensure the appropriate corrective action was taken for the control to be within acceptable limits.
         4) Each control that is reviewed is marked as "Reviewed" in the LIS. If necessary, the Levy-Jennings charts are reviewed for further corrective action.
      ii. The rest of the quality control that is entered into Cerner such as the urine and **S**~~s~~edimat 15 quality control is also checked to ensure that the daily qc was run and any corrective action was documented. If corrective action was taken it will be marked "Reviewed" by the Technical Specialist **and/**or Lead CLS.
      iii. The manual worksheets are also reviewed and checked to ensure the controls were entered into Cerner and the patient results were also entered correctly.
      iv. Exceptions to the above QC Inquiry in the LIS are the Beckman Coulter DXH 1600 and IRIS iQ200. The quality control will not be entered into the LIS. All corrective action will be documented onboard the DXH 1600 and on the QC printouts for the IRIS iQ200, The QC will be reviewed daily Monday through Friday by either the **Hematology Technical Specialist**~~Operations Manager~~

and/or Lead CLS to ensure all corrective action is performed and documented by the Clinical Lab Scientists. On a weekly basis the Lead CLS prints the QC report off the **i-ChemQ** velocity and reviews the results to ensure compliance.

c. Quality Review Report (QRR) from RL Solutions):
   i. TCMC uses the RL Solutions QRR system for tracking quality problems and near misses throughout the facility. The Laboratory Operations Manager receives risk alert notifications via email when there is a problem or incident involving the Laboratory that needs investigation.
   ii. Any RLs involving the Hematology Department will be tasked to the Technical Specialist for follow up. The outcome of the investigation determines what action is taken in the lab to correct the problem and is documented in RL Solutions.
   iii. The incident is reviewed at the Lab Leadership Meeting and other staff meetings as needed for educational opportunities and possible performance improvement opportunities. No copies of the RLs are maintained in the lab.

d. PI/CQI Workgroups (FINE FOCUS):
   i. A group of lab staff who have been trained in PI/CQI serve as teams for the purpose of addressing opportunities for improvement. The membership of the team is voluntary from lab staff who use it to achieve their performance appraisal goals. The Lab Dashboard serves as the main source of improvement opportunities. The model for PI used in the laboratory is FOCUS/PDCA.

e. Turn Around Time Reports (TAT):
   i. The TAT is used to assess actual turn-around times against stated goals and benchmark standards. Selected critical tests for critical care area are reviewed each month and added to the Laboratory Dashboard. For the Hematology/Urinalysis Department these tests are PT/PTT TAT for Stroke Codes and urine pregnancy tests TAT from the Emergency Department. Target TATs are identified and results are monitored for outliers. Outliers may become an opportunity for improvement for the FINE FOCUS teams (see above).

f. Daily QA Review (Daily Reports):
   i. The Daily Exception Reports are generated each day from the Daily Reports in Cerner and are reviewed by the Technical Specialist or Lead Clinical Laboratory Scientist. The report lists all patient results that have failed predefined limits for acceptability. These limits are Correction Report, Critical Results, Failed Delta Checks (the difference between the current and previous results), and Converted Result Types.
   ii. **See the Procedure section below for instructions on how to print Daily Reports.**

g. Corrected Test Report:
   i. Daily the Technical Specialist **and/**or Lead CLS will print and review the Correction Report from the previous day.
      1) **See the Procedure section below for instructions on how to print Daily Reports.**
      ~~1) Use the Daily Reports icon from 6.a. except at Report Type select Correction report.~~
   ii. Hematology ~~utilizes the procedure~~**uses the Analytic Error Detection, Specimen Rejection, and Correction of Errors Procedure** for handling corrected reports ~~in the General Lab QA Manual~~.
      1) During ~~this~~ **the** review **of the corrected report, the** Technical Specialist or Lead CLS reviews the correction ~~report to ensure compliances~~**for compliance**. Critical review of each correction is also performed to determine if there is a systematic trend or if disciplinary action needs to be taken. It is also documented on the QA review log and error log.
   iii. Any corrections of critical values to non-critical value or non-critical value to critical value or corrections of critical test results must be fully investigated and

reported to the Laboratory Director. This includes all tests listed in the ~~procedure Laboratory/General Laboratory Manual Procedure: Critical Values and Critical Tests.~~ **Critical Tests and Critical Results Reporting procedure.**

h. Monitoring Timeliness and Completeness of Critical Value Communication:

i. To check ~~to be sure~~**that** critical values have been ~~timely~~ reported **in a timely manner** and **documented** correctly ~~documented~~, the bench technologists assigned to Hematology must print a Daily Report for critical value exceptions. Check Order Result Viewer in Cerner for the communication documentation for those tests that appear on the **Critical Tests and Critical Results Quick Reference Guide at the intervals listed below.**

1) ~~*Critical Value Table* according to the schedule below:~~ Note: At the same time the Review Results report will also be called for Urinalysis to verify that urine cultures have not been missed.

2) **Hematology/Urinalysis Review:**

a) 0800-0900 (prior to morning break) (AM Tech responsible)
b) 1400-1500 (AM tech responsible)
c) 2200-2300 (PM Tech responsible)
d) 0600-0630 (Night Tech responsible)

ii. All completed Daily Reports should be initialed by the reviewing tech and placed in the Daily Report box.

iii. Critical values will also be reviewed by the Technical Specialist **and/or** ~~or~~ Lead CLS by reviewing the *Daily Exception Report* printed at 0600 each day. Each critical value will be reviewed for proper documentation including name of person to whom the call was made, their credential (RN, LVN, RCP, physician), the name of the test, the date and time of call and the Cerner ID of the person calling the critical result

i. Pending Inquiry:

i. Pending Inquiry logs list tests that have not been resulted or dispatched and not received in the Lab. Along with the pending tests, the log includes the accession number, patient location and medical record number and the priority if any.

ii. The logs are reviewed at frequent intervals throughout the day by the Hematology staff and reviewed by the staff CLSs or the phlebotomy team for unreceived specimens. Logs are reviewed between outgoing and incoming shifts for testing status, turnaround time and specimen location. These logs should be printed. This coordinated effort is done to prevent unnecessary delays in reporting or improper specimen handling.

j. Instrument Function Checks and Maintenance:

i. To maintain optimal performance of instrumentation and to reduce down time, a rigid schedule of instrument maintenance and function checks are performed by and are the responsibility of the staff CLSs using the instruments.

1) Function checks and maintenance are performed according to the individual instrument manufacturer's requirements.

2) All maintenance and checks are recorded in an instrument-specific log located at the instrument.

3) Refer to **DxH1600 QC and Maintenance Checklist** ~~fthe Hematology QC Flow Chart f~~or the daily maintenance; ~~and~~ **see Hematology and Urinalysis Quality Control Outline for** QC performed on the hematology analyzers.

4) The ~~logs and/or Hematology/Urinalysis Function Checks log sheets are monitored weekly and reviewed monthly by the Technical Specialist and/or Lead CLS.~~ **Hematology Daily Function Checks log is monitored daily.**

5) **The following maintenance logs are reviewed as follow~~weekly~~:**

a) **CellaVision DM 1200 Maintenance Log (Weekly)**

~~a~~b) Clinitek Status Maintenance Log (Daily/Weekly/Monthly)
c) Cytospin Weekly Maintenance Sheet
d) DxH 1600 QC and Maintenance Checklist (Daily/Weekly/Monthly)
e) Hema-Tek Slide Stainer Maintenance Log (Daily/Weekly)
f) iQ200 Maintenance Log (Daily/Weekly/Monthly)
g) Stago STA Compact Max Maintenance Chart (Daily/Bi-weekly)
h) VerifyNow Maintenance Log (Daily/Bi-weekly/Monthly)
i) iChem Velocity QC/Maintenance Log (Daily/Weekly/Monthly)

6) **All logs are reviewed monthly by the Hematology Technical Specialist and/or Lead ~~Hematology~~ CLS.**

ii. If any instrument function checks results are out of tolerance limits or if any problems are encountered the CLS may begin troubleshooting based on their ability to diagnose and correct problems on the particular instrument.
1) Major repair and troubleshooting documentation ~~is~~**are** included with most manufacturer instrument manuals.
2) Telephone hotline assistance is also available and is expected to be used by the CLS.

iii. Instruments that cannot be brought into acceptable tolerance may not be used for patient testing and the Technical Specialist and/or Lead CLS must be notified.
1) Documentation of all actions are recorded in the Problem / Corrective Action sections of the individual instrument maintenance logs.

k. Test-Specific Quality Control
i. Quality control materials of two or three levels are tested for each analyte performed in the Hematology Department according to a schedule of frequency determined by the instrument manufacturer, instrument performance and in no case greater than 24 hours or the day of use. Whenever possible quality control material is handled and tested in the same manner as patient samples.
ii. Quality control procedures are performed by the staff Clinical Lab Scientists who evaluate and interpret the results and act according to the ~~Laboratory/Hematology/Quality Assurance Procedure:~~ Hematology Quality Control Outline **procedure. ~~Pand~~** patient results are not released until the quality control is acceptable and documented in the LIS or the instrument.
iii. LJ Charts and outlier interpretation and corrective action documentation are kept in the LIS except for the Beckman Coulter DXH 1600 and the Iris iQ which is kept on the instrument.
1) Monday through Friday the QC is reviewed by the Technical Specialist or Lead CLS using QC Inquiry for the Stagos and on board for the DXH 1600 and Iris iQ. If an analyte fails one of the Westgard rules used for that assay, the LJ charts will be reviewed and appropriate corrective action verified.
2) Monthly, the Levey-Jennings Charts generated by the Beckman Coulter DXH 1600 are printed and reviewed by the Technical Specialist. The LJ charts generated by the STAGO instruments are reviewed monthly by the **Technical Specialist or** Lead CLS. The means and CVs of both instruments are then compared.
3) The QC on the Iris iQ is indicated as "Pass or Fail" and is reviewed daily for appropriate action if any control Fails the instrument parameters and printed weekly. ~~Refer to the Laboratory/Hematology/Quality Assurance Procedure: Hematology and Urinalysis Quality Control Outline.~~

l. Review of Hematology Department Worksheets
i. Worksheets are generated throughout the day for methods that are not interfaced to the LIS. ~~Recorded on the worksheets is the patient as well as QC values~~**Patients and QC values are recorded on the worksheets**. The

worksheets are reviewed for appropriate control runs and reagent checks. Problems revealed through review are brought to the attention of the CLS involved.

ii. The previous day's Coagulation Activity Report is also reviewed for appropriate action on abnormal results, and appropriate comments.

iii. The Stago Compact **Max** printouts are reviewed for appropriate action taken by the staff CLS when instrument flags are given and verifies appropriate repeats and dilutions. Problems revealed through the review are brought to the attention of the CLS involved and disciplinary action taken when necessary and documented on the **Daily** Quality Assurance **Review** Log. Worksheets are filed each month and maintained for at least six years.

5. **Monthly Quality Activities:**
   a. Review of Temperature Charts, Instrument Maintenance and Function Check logs by the Technical Specialist ~~or~~**and** Lead CLS**.**
   b. Review of the Levy-Jennings Charts for all control lots on the Beckman Coulter DXH 1600 by the Technical Specialist. The LJ charts generated by the STAGO instruments are reviewed monthly by **Technical Specialist or** ~~the~~ Lead ~~Coagulation~~ CLS. The QC on the Iris iQ is indicated as "Pass or Fail" and is printed and reviewed monthly for appropriate action if any control Fails the instrument parameters. The control charts are reviewed for:
      i. Shifts, trends and corrective action by technologists.
      ii. Comments and corrective action are documented on the charts.
   c. Quality Assurance Program (QAP)
      i. Accuracy and Precision Check: Review of control material Quality Assurance Data reports from Beckman Coulter (IQAP) by the **Hematology Technical Specialist**~~Operations Manager~~. Data is collected for a period of a month and submitted to Beckman Coulter. The returned reports contain analytic method specific control statistics for our laboratory's lot to date performance as well as comparative statistics for all participating laboratory's analytic method specific control results.
         1) Accuracy: Method / test accuracy is evaluated for the DXH 1600 by reviewing the IQAP report each month for monthly TCMC mean SDI (standard deviation interval) vs all laboratories analytic system SDI. Corrective action may be taken for analytes that fall outside +/- 2 SDI for either the month or lot to date data.
         2) Precision: Method / test precision is evaluated for the DXH 1600 using the Beckman Coulter IQAP report. The QAP reports are used to compare the TCMC coefficient of variation (CV) for the last month's data vs the CV of the previous month and the Pool CV. For the Diagnostica Stago Compact **Maxs**, ~~monthly~~ the QC data is reviewed **monthly** for any significant changes in the SD and CVs. Action is taken if the CVs differ by more than a factor of two and documented on the report form.

6. **Semi-Annual Quality Activities:**
   a. Method comparison studies for the Hematology, Coagulation and Urinalysis analyzers.
      i. Refer to the Comparison Studies for Hematology and Urinalysis Instruments and Methods procedure for more information.
   b. Calibration of the D**X**~~x~~H 1600 is performed at least every six months.

7. **Annual Quality Activities:**
   ~~a. Thermometer verification is performed by the staff technologists and reviewed by the Operations Manager. Refer to the PIPET / THERMOMETER Manual.~~
   ~~b.~~**a.** Hematology hazardous chemical inventory reviewed by the Hematology Technical Specialist.
   ~~c.~~**b.** Review of the Hematology Chemical Hygiene and Bloodborne Pathogen Task Assessment by the Hematology Technical Specialist.

~~d. Micropipettor calibration and accuracy / precision checks are performed by the staff CLSs and reviewed by the Technical Specialist.~~

~~e.~~**c.** Centrifuge tachometer and timer checks and electronic timers are checked annually by the Biomedical Engineering Department.

i. Note: Certified Calibrated three channel timers are used until their expiration date and then new timers are purchased. These timers do not have to be checked annually.

~~f.~~**d.** The Microfuge tachometer and timer check is performed by a staff CLS.

~~g.~~**e.** Microscope maintenance is performed annually by an outside microscope vendor.

8. **Biennial Quality Activities:**
   a. Procedure manual review and review of the QA Plan done by the Hematology Technical Specialist and Lead CLS.
9. **Summary of Other Quality Assurance Procedures:**
   a. Technical Procedures:
      i. Technical procedures written for the department or those used from manufactures must conform to the standard format established for this institution in compliance with **Clinical and Laboratory Standards Institute GP2-A4**~~NCCLS GP2-A4 Clinical Laboratory Technical Procedure Manuals~~. ~~The Hematology/Urinalysis Department guidelines are stated in the in the Laboratory/General Laboratory Manual: Procedure Manuals and Technical Policies, Procedures, and Document Control. These will be reviewed on a bi-annual basis.~~
   b. Detecting and Correcting Erroneous Lab Results:
      i. Staff technologists review all quality assurance failure flags (delta, normal and technical limit failures) before a result is reported. The specimen container is also inspected for multiple labels name match to be sure there has not been a labeling error. The specimen is examined for clots, fibrin, particulate matter and other conditions that would cause rejection. Refer to the procedures located in the Laboratory General ~~Laboratory~~ **Quality Assurance** Manual:
         1) ~~Procedure for Detecting and Correcting Erroneous Lab Results~~**Analytic Error Detection, Specimen Rejection, and Correction of Errors Procedure**
         2) Verification of Specimen ID and Review of Results **Procedure**
         3) ~~Procedure for Assuring Correct Specimen Identification and Labeling;~~ Specimen and Aliquot Labeling
         4) Specimen Handling, Transportation, Special Collection, Processing, Aliquoting and Criteria for Rejection
         5) ~~Also refer to the Laboratory/Hematology/Quality Assurance Procedure:~~ Rejection **and Handling** of Specimens.
   c. Manual Backup System for LIS Downtime:
      i. At times when the LIS is down for scheduled or unscheduled maintenance the Hematology Department utilizes a manual backup system. The system's purpose is to provide timely results to the caregiver while maintaining quality control. The system also provides for rapid recovery once the LIS is back on line. Refer to the procedures:
         1) ~~Laboratory/Hematology/Quality Assurance Procedure:~~ Laboratory Information System (LIS) Downtime Procedures for Hematology
         2) ~~Laboratory/Hematology/Urinalysis Procedure:~~ Downtime Procedures for Urinalysis
         3) ~~Laboratory/Hematology/Coagulation Procedure:~~ Downtime Coagulation Procedure.
   d. Clinical Laboratory Scientist Training Checklist
      i. All new employees of the Hematology Department are trained **by** the department Technical Specialist, Lead CLS or qualified staff CLS. The training checklist is

used to verify successful orientation to the department as well as a guide for topics to be reviewed during the training.

ii. Upon completion of the orientation and evaluation, both the employee and Technical Specialist will verify competency in all sections reviewed.

e. Method Validation (Method Performance Specification):

i. The step-by-step process for the integration of new test into the lab is **described in the Instrument and Method Validation and Verification procedure.**

10. Hematology Quality Control Summary:

a. Internal Quality Control:

i. The Hematology Department uses assayed control material for the evaluation of method performance. ~~The Laboratory/Hematology/Quality Assurance Procedure:~~ **The** Hematology and Urinalysis Quality Control Outline describes the procedure to follow for one, two and three level control systems. The procedure describes the method for documentation of QC outliers and the corrective action taken.

b. QC Material:

i. Beckman Coulter 6C tri-level control
ii. Beckman Coulter Retic-X tri-level control
iii. Beckman Coulter Latron CP-X Control
iv. Polymedco Sed-Check 2 bi-level controls (Sedimat 15 and Manual Sediplast)
v. **Remil** ~~Seradyn Access~~ Mono Test Positive and Negative Controls
vi. Diagnostica Stago Coag Normal and Abnormal Control **Pluse**
vii. Diagnostica Stago Lia Normal and Abnormal Controls
viii. Diagnostica Stago FDP **Plasma** Positive and Negative Controls
ix. Medical Analysis Systems Moni-Trol Urinalysis Abnormal and Normal Controls
x. Distilled **water** (H_2O)
xi. 5% Sodium Chloride (Na**C**~~c~~l)
xii. Streck Retic Chex bi-level control
xiii. IriSpec CA/~~ and~~ CB/**CC** Controls
xiv. Iris iQ Positive/Negative Controls and Focus
xv. Pacific Hemostasis Sickling Hemoglobin Positive and Negative Controls

c. External QC (IQAP): Precision and Accuracy Check:

i. The Hematology Department is enrolled in the following Quality Assurance Peer Group Comparative Pool: Beckman Coulter Corporation IQAP, ~~ and~~ Sedimat 15 Peer Review Report **and my Expert QC for Coagulation.**~~:~~

d. Comparability Studies of Instrumentation:

i. Note:

1) **Refer to the Comparison Studies for Hematology and Urinalysis Instruments and Methods procedure for information on how to collect and compare these results.**

ii. The Hematology Department verifies the comparability of results for those tests run on different instrumentation as follows.

1) INTER:

a) Hematology Analyzers: Beckman Coulter DXH 1600:

i) Semi-annually 20 patients are run on the DxH1 in the repeatability automated mode and then run on the DXH2 in the repeatability automated mode. NOTE: As wide a range of results for each analyte will be chosen.

ii) Results are compared to ensure acceptability of the results between the two analyzers using an unpaired t test

~~iii) See Laboratory/Hematology/Quality Assurance Procedure: Comparison Studies for Hematology/Urinalysis Instruments/Methods for further details.~~

2) Manual Differential vs Automated Differential from the DXH 1600

a) Semi-annually, the method comparison is performed using fresh human samples (EDTA whole blood) rather than stabilized commercial control material.
b) Before beginning the comparison, be sure both instruments meet quality control specifications. Ensure that variations in slide preparation are minimized by making quality smears, staining quality standards are met and a qualified technologist performs the differential count.
c) A total of 20 patients will be run on the D**X**~~x~~H 1600 and a manual differential will be performed.

3) Coagulation Analyzers: Diagnostica Stago Compact **Max**~~s~~
a) Semi-annually, 20 patients that have been run on Stago ~~A~~ Compact **Max 1** will be analyzed on the Stago ~~B~~-Compact **Max 2** for PT, PTT, d-Dimer and Fibrinogen.

4) Urinalysis Analyzers: iChem Velocity and the **Clinitek Status Plus**~~iChem 100~~
a) Semi-annually 20 patients that have been run on the iChem Velocity will be run on the **Clinitek Status Plus**~~iChem 100~~ which is the backup dipstick analyzer.

5) Refractometer: iChem Velocity **vs** ~~and~~ the **(Digital vs Manual)** Refractometer**s**
a) Semi-annually, 20 patients that have been run on the iChem Velocity will be run on the Refractometer.~~Results are recorded on the iChem Velocity vs Refractometer Correlation worksheet.~~

e. Proficiency Tests:
i. The Hematology Department is enrolled in the College of American Pathologists Proficiency Survey Program for all regulated analytes as well as those analytes for which survey material is available. The surveys are handled as though patient samples ~~according to the Laboratory/General Laboratory Manual Procedure~~**as described in the**~~:~~ Proficiency Testing Procedure.
ii. The Hematology Department is enrolled in the following surveys:
1) Comprehensive Hematology with Flow-Through Differential (FH13) – Beckman Coulter DXH 1600 and photomicrographs
2) Reticulocyte (RT1) and (RT) – Beckman Coulter DxH 1600 and Manual
~~3)~~ Erythrocyte Sedimentation Rate (ESR and ESR1) – Sedimat 15 and Manual
~~4)~~**3)** ~~Hemacytometer Fluid Count (HFC)~~
~~5)~~**4)** Clinical Microscopy (CM/DSC) - iChem Velocity, Ictotest, Urine Protein and photomicrographs.
~~6)~~**5)** Coagulation Limited (CGL) – Stago Compacts (PT/INR, PTT, Fibrinogen, d-Dimer, FDP)
~~7)~~**6)** Coagulation Extended (CGE) – Stago Compacts (Thrombin Time, PT/PTT Mixing Studies)
~~8)~~**7)** Serology Fulfillment (S) – Mono Test
~~9)~~**8)** Calibration Verification/Linearity Survey LN9 (WBC, RBC, HGB, PLT) and LN19 (Retic) – Beckman Coulter DxH 1600; LN42 D-Dimer and LN44 Fibrinogen – Stago Compact **Max**~~s~~
~~10)~~**9)** Sickling Hemoglobin Screen (SCS) – Sicklescreen
~~11)~~**10)** Automated Body Fluid (ABF2) – Beckman Coulter DxH 800
~~12)~~**11)** Hemacytometer Fluid Count (HFC) – Manual counts
~~13)~~**12)** Automated Urinalysis (UAA) – IRIS iQ
~~14)~~**13)** Special Clinical Microscopy (SCM2) – Urine Eosinophils
~~15)~~**14)** Body Fluid/Urine Crystals (CRS - BFC)
~~16)~~**15)** Urine Crystals (CRS - URC)

~~17)~~**16)** Instrumentation (I) – Refractometer
~~18)~~**17)** Platelet Induced Aggregation (PIA) – VerifyNow
~~19)~~**18)** CMQ – Clinical Microscopy Quality Cross Check – iChem Velocity and Siemens Clinitek Status **Plus**

f. Laboratory Reference Intervals:
   i. The laboratory reference range must be established or verified for each analyte and specimen source (e.g., blood, urine, cerebrospinal fluid), when appropriate. For many analytes (e.g., CSF ranges), literature references or a manufacturer's package insert information may be appropriate.
   ii. The laboratory evaluates the appropriateness of the reference intervals and takes corrective action if necessary.
   iii. The criteria for evaluation of reference intervals include:
      1) Introduction of a new analyte to the test repertoire
      2) Change of analytic methodology
      3) Change in patient population
   iv. If it is determined that the range is no longer appropriate for the patient population take corrective action.
   v. Evaluation of the reference range may be done using the NCCLS How to Define and Determine Reference Intervals in the Clinical Laboratory; Approved Guideline C28-A2 by validation of the transfer of the manufacturer's reference range.
      1) **Refer to the procedure section below for guidelines on how** ~~This guideline is how~~ the Hematology and Urinalysis reference ranges ~~were~~ **are** verified.~~Procedure:~~

11. Competency Assessment, Orientation and Performance Evaluation:
    a. **Refer to the Laboratory Training and Competency Assessment procedure.**
12. ~~HEMATOLOGY/URINALYSIS SECTION RECORD MAINTENANCE~~**Hematology Department Record Maintenance:**
    a. **Refer to the Laboratory Record and Specimen Retention procedure.**
13. Delegation of **Laboratory** Responsibility:
    a. The Laboratory Director has delegated certain responsibilities to key Laboratory Management team members.
    b. **Refer to the Laboratory Quality Management Plan and the linked Laboratory Director Letter of Delegation.**
14. **Selection of Laboratory Equipment and Supplies:**
    ~~c.~~**a. Refer to the Laboratory Quality Management Plan.**

C. **PROCEDURE:**

1. **Print Daily Reports:**
   a. Press the Daily Reports Icon and the following menu will be displayed:
      i. At the Test site box enter Hematology.
      ii. At the Date/Time Range box, enter the appropriate date range.
      iii. **Select Report Type:**
         1) Exception: ~~Then a~~**At** Report Type select Exception report and which Exception Criteria (Critical results, Failed delta checks or Converted result types) report to print.
         2) **Correction: at Report Type, select Correction report.**
2. **Verify Hematology and Urinalysis Reference Ranges:**
   a. ~~Using~~ **Use** the labs subject population by selecting 20 healthy subjects stratified into age and sex categories that cover the usual patient population serviced by the lab.
   b. Run the samples and check to be sure none are outliers.
   c. Any apparent outliers should be discarded and a new patient substituted.
   d. The manufacturer's donor range may be considered valid for application in the receiving

lab if no more than 2 of the 20 test subject values or 10% of the test results fall outside of the original reporting limits.

e. If three or more test results do fall outside the limits, another 20 reference specimens must be obtained and re-tested. Validity is confirmed using the same criteria as the preceding sample.

f. Note:

i. The exception to the above is for the pediatric population. TCMC does not have a pediatric unit so this patient population is not readily available. Rady's Children's Hospital is in the same basic geographical area and their hematology analyzer is the DXxH 1600 so TCMC adoptsed their reference range for the pediatric population less than 17 years of age.

D. **FORM(S):** N/A

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

1. Laboratory Organizational Chart
2. **Laboratory Record and Specimen Retention Table**
3. **Analytic Error Detection, Specimen Rejection, and Correction of Errors Procedure**
4. **Critical Tests and Critical Results Reporting**
5. **Comparison Studies for Hematology and Urinalysis Instruments and Methods**
6. **Proficiency Testing Procedure**
7. **Laboratory Training and Competency Assessment**
8. **Laboratory Record and Specimen Retention**
9. **Laboratory Quality Management Plan**
10. **Daily Quality Assurance Review**

F. **EXTERNAL LINK(S):** N/A

G. **REFERENCES:**

1. California Association of Hospital and Health Systems. *Guide to Record Retention*. 2000.
2. College of American Pathologists. Inspection and Accreditation Checklist, Section 1 General Laboratory. September 2007.
3. **Clinical and Laboratory Standards Institute GP2-A4, 4th Edition. January 2013.**
3. NCCLS. How to define and determine reference intervals in the clinical laboratory; approved guideline C28-A2. Wayne, PA: NCCLS, 2000.

1. Method Validation (Method Performance Specification
   a. The step-by-step process for the integration of new test in to the lab is as follows:
      i. Order the product.
      ii. Add the test to the CAP Activity menu for the lab. Obtain the test product insert.
      iii. Check for and enroll in proficiency testing.
      iv. Obtain control material.
      v. Create orderables in Cerner. Consult with Information Technology (IT)
      vi. Obtain CPT codes.
      vii. Submit for Charge Master Code.
      viii. Obtain linearity material.
      ix. Method Validation – Precision, Linearity, Correlation, Reference Range Validation.
      x. Submit Validation Statement to Lab Director.
   b. Method Validation: **Summary Statement Of Acceptable Performance:**
      i. The Laboratory Director must review the validation study and approve each test

for clinical use (for tests implemented after 6/15/09). The review must be documented on the validation study using the statement.

ii. This validation study has been reviewed and the performance of the method is considered acceptable for patient testing.

iii. *By :_____Date:_____Laboratory Director_____*

B.

C. **COMPETENCY ASSESSMENT, ORIENTATION AND PERFORMANCE EVALUATION**

1. Competency assessment is done to provide a system to document all staff are knowledgeable about policies and the contents of procedure manuals relevant to the scope of their activities and that Clinical Laboratory Scientists meet the competency requirements to perform moderate and/or high complexity testing as appropriate.
2. Responsibilities:
   a. The Laboratory Director is responsible for ensuring that policies and procedures are established for monitoring the competency of personnel. Responsibility for performing competency assessment is delegated to the Technical Specialist and Lead CLS.
   b. All laboratory employees are responsible for being knowledgeable of procedure manuals within their area of assignments and for demonstrating competency in those procedures. Employees must review new or revised policies or procedures applicable to their job duties that are distributed by Lab Leadership throughout the year.
3. Department Orientation:
   a. Each new employee or employees transferring into the laboratory will have an orientation to the laboratory. The orientation includes a review of their job description, hospital and laboratory organizational charts, a tour of the lab and hospital, an introduction to the staff and review of their customers, annual physical requirements, various laboratory policies and scheduling of Lab Safety Training. The Operations Manager or Technical Specialist completes the department orientation. The record of the review is maintained on the "Department Orientation Checklist" and should be completed within 1 month of the start date. The form is filed in the employee's main file.
4. Orientation and Initial Competency Evaluation:
   a. All lab staff undergoes an orientation process in each section of the laboratory where they will be assigned. During the orientation an evaluation of their competency is conducted. Upon completion of the orientation and competency both the employee and the technical specialist will verify competency in all sections reviewed. The following section, including but not limited to, will be completed on all competency checklists to verify training and competency:

TRAINING APPROVAL AND AUTHORIZATION TO PERFORM JOB DUTIES:

I_____ confirm that I have completed training on the above

Name of (Position Title)

checklist items and that I am competent to perform these waived, moderate complexity to high complexity tests. I acknowledge that I am authorized by the Medical Director or designee to independently perform these tests without direct supervision.

Signature:_____ Date:_____

Signature of (Position Title)

The CLS has completed training on the above checklist items. He/she is competent to perform specimen processing, test performance and result reporting for these CLIA categories of testing independently without direct supervision.

Signature:_____ Date:_____

(Medical Director or designee)

Annual ID Verification	Please complete the information below, using your normal handwriting, as you would while performing your routine laboratory duties.		
Signature	Print Comer Code	Initials	**My name has changed in the last 12 months: YES NO** (CIRCLE ONE)
			Previous Name:

5. Six-Month and One Year Competency Assessment:
   a. The Operations Manager in consultation with the Lead CLS will complete a Six-Month Competency Assessment within the initial six-month period and then a One Year Competency Assessment. These will be filed in the employee's main file.
6. Annual Competency and Performance Review:
   a. Annual review of the performance of employees is conducted according to the schedule determined by the Human Resources Department.
   b. Prior to the employee's annual performance appraisal a Competency Assessment, along with all other required departmental specific competencies must be completed. The Competency Assessment is reviewed with the employee during the Annual Performance Appraisal conference and areas requiring additional review are identified. The areas for improvement may then be made into performance goals to be evaluated on the following year's performance appraisal.
7. Methods of Competency Assessment:
   a. Direct observation of routine test performance, including as applicable, patient identification and preparation; specimen collection, handling, processing and testing, instrument maintenance and function checks.
   b. Monitoring the recording and reporting of test results including as applicable, reporting critical results.
   c. Review of intermediate test results or worksheets, test results, worksheet, quality control records, proficiency test results, turn around time logs, daily patient result exception reports and preventive maintenance records

d. Direct observation of performance of instrument maintenance and function checks.
e. Assessing test performance by testing previously analyzed specimens, internal blind samples, or external proficiency testing samples.
f. Assessing problem solving skills using case studies.
g. Paper and pencil tests.
h. CAP Photomicrograph Slide Tests.

8. Frequency of Competency Assessment:
   a. Competency assessment will be performed throughout the year but during the first year of the employee's duties, competency must be assessed at least every six months. Retraining and reassessment of employee competency must occur when problems are identified with employee performance.
   b. CAP slide tests will be given at least semi-annually to ensure consistency of morphologic observations of all technologists who perform blood cell microscopy and annually editing of urine samples on the Iris iQ200 to ensure consistency of morphologic observations among all personnel performing urine sediment microscopy. As the Technical Specialist perform annual review of technical procedure manuals, written competency tests will be given to the CLSs to ensure that testing personnel are knowledgeable about the contents of the procedure manuals relevant to the scope of their testing. When policies and procedures are revised, any changes are highlighted and put out for all employees to read and sign off on. In addition, when there is a change in methodology or instrumentation, extensive training and competency assessments will be conducted.

9. Documentation Competency Assessment:
   a. Many of the elements of competency assessment are performed by the Technical Specialist or Lead CLS during the daily review process. The review process uses any or all of the following; direct observation of test performance, daily review of failures to call critical values, reporting errors due to failure to follow procedure, reporting errors due to failure to follow up on QA flags (delta check, technical limit failures and verify failures), review of QA Logs, failures to run Quality Control and document corrective action of outlier, review of Outlier reports, failures to log in new lot number and calibration dates in Calibration Logs, incomplete entries in Instrument Function Check and Maintenance Logs, completed result worksheets, unacceptable test performance as detected by direct observation, unacceptable proficiency survey results and with investigation, and other quality assurance activities previously listed.

10. Remediation (Competency Re-assessment):
    a. After completion of annual procedure review with time allowed for additional training and question review, if personnel fail the competency test the following remedial action will occur: Also refer to
    b. Verbal warning and immediate retraining with possible work restriction as directed by the Manager until employee can demonstrate competency by direct observation documented on the "Competency Re-assessment Tool.
    c. Reassess competency in three months. A failure may result in further disciplinary action up to and including termination.

11. Annual Competency Assessment Record Keeping:
    a. Each evaluation period, every employee will have an annual competency file. Within the file is the "Annual Department Specific Employee Competency Verification Record". Competency assessments are recorded on this document by each of the staff. Whenever a competency assessment is initiated by Lab Management, the assessment tool will contain a template that guides the staff member in completing the competency verification record. As indicated above, this file is reviewed at each employee's performance evaluation.
    b. Competency Log File Template:

Competency/Training	Procedures	Technical	Technology	Equipment	Skills	Methods of Validation T = Test D = Demonstration V = Verbalized	Date Of Completion	Evaluator's Initials	Criteria (Bold all that apply)
									High Risk **Problem Prone** **Essential** **New/Improved**

D. **HEMATOLOGY/URINALYSIS SECTION RECORD MAINTENANCE**

1. Laboratory records must be retained for certain periods of time as defined by the State of California, and College of American Pathologists. Records will accumulate in the lab until a time when the working records are no longer required then they will be moved to off site locations designated by the Medical Center.
2. Record Retention
   a. Laboratory records must be retained for certain periods of time as required by regulatory and accreditation requirements. The period of time meets or exceeds these requirements and is appropriate for educational or quality improvement needs. The Lab records are retained as follows:

Clinical Laboratory		
Instrument Printouts	6 years	Lab current month, then warehouse
Patient Reports	Indefinite	HIS. Indefinite (remote hosted)
Requisitions	6 years	Lab current month, then warehouse
Quality Control Records	6 years	Lab
Proficiency Test Records	6 years	Lab
Quality Improvement Records	6 years	Lab
Worksheets	6 years	Lab
Archived Procedures	6 years	Lab
Instrument Maintenance Logs	Life of instrument.	Lab
Method Performance Records	Life of Method + 2 years	Lab
Specimens		
Blood (EDTA, Serum, Plasma)	3 days (BB 14 days)	Refrigerator
Urine for UA	2 days	Refrigerator
Peripheral smears, body fluid slides	7 days	Lab
Body Fluids	3 days	Refrigerator

E. **DELEGATION OF RESPONSIBILITY:**

1. The Laboratory Director has delegated certain responsibilities to key Laboratory Management team members. The name and title of the individuals and the specific activities are listed in Table 1 below:

Table 1: Laboratory Director Delegated Responsibilities	
Activity:	**Delegated To:**
Hematology - Review of QC data, QA review, procedure manual review, proficiency testing performance, instrument maintenance records, competency review, selection of equipment and supplies.	Hematology Technical Specialist Lead Clinical Laboratory Scientist or qualified designee
Proficiency testing – Director's attestation statement signature. Review of Summary Reports.	Technical Specialist

F. **SELECTION OF LABORATORY EQUIPMENT AND SUPPLIES:**

1. The selection of laboratory instruments, equipment and supplies are under the control of the Laboratory Director. While the director has delegated the selection process to specific Laboratory management team members the technical, clinical and operational criteria of the Director must be met. The individuals designated for instrument, equipment and supply selection are listed in Table 1 above.

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

1. Annual Department Specific Employee Verification Record
2. Hematology Daily Quality Assurance Review
3. Hematology QC Flow Chart
4. HematologyChemical Hygiene and Bloodborne Pathogen Task Assessment
5. Instrument Problem/Repair Log
6. Laboratory/General Laboratory Manual Procedure: Critical Values and Critical Tests
7. Laboratory/General Laboratory Manual Procedure: Procedure for Assuring Correct Specimen Identification and Labeling;
8. Laboratory/General Laboratory Manual Procedure: Procedure for Detecting and Correcting Erroneous Lab Results
9. Laboratory/General Laboratory Manual Procedure: Specimen and Aliquot Labeling
10. Laboratory/General Laboratory Manual Procedure: Specimen Handling, Transportation, Special Collection, Processing, Aliquoting and Criteria for Rejection
11. Laboratory/General Laboratory Manual Procedure: Verification of Specimen ID and Review of Results
12. Laboratory/Hematology/Coagulation Procedure: Downtime Coagulation Procedure
13. Laboratory/Hematology/Quality Assurance Procedure: Comparison Studies for Hematology/Urinalysis Instruments/Methods
14. Laboratory/Hematology/Quality Assurance Procedure: Hematology and Urinalysis Quality Control Outline
15. Laboratory/Hematology/Quality Assurance Procedure: Laboratory Information System (LIS) Downtime Procedures for Hematology
16. Laboratory/Hematology/Quality Assurance Procedure: Rejection of Specimens
17. Laboratory/Hematology/Urinalysis Procedure: Downtime Procedures For Urinalysis Stage A vs Stage B QC Mean/CV Correlati

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 04/94

SUBJECT: Disaster and Emergency Preparedness

REVISION DATE~~(S)~~: 2/05, 6/09, 11/10, 9/12, 5/15~~;~~, 02/17 04/20

Surgical Services Department Approval:	~~02/20~~08/23
Department of Anesthesiology Approval:	n/a
Operating Room Committee Approval:	~~02/20~~02/24
Environmental Health and Safety Committee Approval:	04/24
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~03/20~~03/24
Administration Approval:	~~04/20~~04/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. **PURPOSE:**
1. To provide guidelines for Perioperative Services (including Pre-Operative Education [POE], Pre-Operative Hold [POH], Surgery and Post-Anesthesia Care Unit [PACU]) personnel in the event of a disaster.
2. To maintain adequate availability of personnel and supplies during a disaster.

B. **PROCEDURE:**
1. Due to the varying types and magnitudes of emergency events, Tri-City Healthcare District (TCHD) has adopted the command structure of Hospital Incident Command System (HICS). Once the decision has been made to activate the disaster plan, the HICS becomes the standard operating procedure. The complete plan is located in the TCHD Disaster Plan Manual located in each department.
2. French Rooms 1 and 2 are designated as the Incident Command Center (ICC).

C. **NOTIFICATION:**
1. In the event of a disaster (Code Orange or Code Yellow), departments will be notified via the overhead paging system.
2. Management staff is to be notified by their respective area lead staff via pager/phone 24 hours per day, 7 days per week.
3. Management responsibilities following the activation plan for a disaster or drill:
   a. The Surgical Services Director/Assistant Director/Supervisor/designee will:
      i. Review the HICS form, located in the disaster manual.
      ii. Assess number of patients currently in department(s).
      iii. Assess anticipated time of discharge from department(s).
      iv. Assess number of available staff.
      v. Complete HICS form and submit to the ICC.
   b. Dependent upon the type and severity of the disaster, the ICC may direct the departments to:
      i. Delay or cancel elective surgeries/procedures
      ii. Discharge patients
      iii. Call in on-call staff

iv. Initiate the disaster recall list
v. PACU may be directed to discharge all patients capable of returning to the nursing units, and clearing this department for holding area of disaster victims if necessary.
vi. Surgery staff will obtain emergency case carts and pick extra supplies for emergency procedures:
1) Extra Lap, Chest, and Extremity custom packs
2) Six (6) extra cases of laparotomy sponges (laps) and raytex
3) IV solutions and tubing
4) Blood administration sets
5) Irrigation: water and saline
6) Antibiotics
7) Morgue packs

4. Employee's Responsibilities:
a. Employees at work but away from the department are to return immediately to their home department.
b. In the event that the department is in the location of the disaster, employees will report to the Labor Pool.
c. Personnel will take direction from the Director/Assistant Director/Supervisor/designee in each area.
i. Surgery:
1) Registered Nurses will circulate/scrub with surgical procedures, picking of supplies and instruments of following cases.
2) Anesthesia technician will assist anesthesiologist with line placement and intubations as directed.
3) OR Technicians will scrub surgical cases or assist with instrument processing and duties as assigned.
4) Endoscopy Suite personnel will assist with minor surgical care and in Pre-Op holding area.
5) Perioperative Aides will assist with transporting patients from the Emergency Department and discharging cancelled elective surgical patients, as well as OR turnovers and duties as assigned.
6) OR Secretaries will answer the telephones and perform duties as assigned.
ii. PACU:
1) RN's will assist with the delayed surgery patients, assist in recovering patients in ICU if patients are sent directly to ICU (bypassing PACU), if staffing allows.
2) Acute Care Technicians (ACTs) will assist with transporting patients and patient care as directed.
3) PACU Secretary will answer telephones and perform duties as assigned.

D. **EVACUATION OF THE OPERATING ROOM:**
1. In the event the Surgical Services is directed to evacuate:
a. Evacuation routes are posted in each specific department
b. Hallways are to be cleared, moving all carts/equipment to the closest storage areas.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 04/94 **SUBJECT: Intraoperative Deaths**

REVISION DATE(~~S~~): 02/05; 06/09; 01/13, 05/20

Department Approval:	**~~02/20~~08/23**
Operating Room Committee Approval:	**~~03/20~~02/24**
Department of Anesthesiology Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/20~~03/24**
Administration Approval:	**~~05/20~~04/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/20**

A. **PURPOSE:**
1. To outline nursing and physician responsibilities in the event of an intraoperative death.

B. **POLICY:**
1. Nursing Responsibilities
   a. Notify a member of the Surgical Services leadership team (i.e., Director, Assistant Director, or Supervisor) and Nursing Administration (i.e., Administrative Supervisor) of patient death in the Operating Room (OR).
   b. Document the death in the patient's Electronic Health Record (EHR), including details of events preceding the death.
   c. Obtain a post-mortem kit and follow manufacturer's instructions for use (IFU).
   d. Complete a Quality Review Report (QRR) via the RL system.
   e. Notify the Coroner of all deaths occurring in the OR.
   f. If the Coroner accepts the case, leave all invasive devices and lines intact, including, but not limited to, intravenous/vascular catheters, bladder catheters, drains, and endotracheal tube.
   g. If necessary and under the approved direction of the Coroner, the body may be moved to an appropriate location for holding or viewing.
   h. If the Coroner declines the case, the Surgeon determines the disposition of the body (i.e. autopsy, mortuary). Contact a Perioperative Aide to transport the body to the morgue.
   i. The Coroner or Mortuary must sign for body's release, when occurring directly from the OR.
   j. Complete the Expiration Record in the patient's EHR
   k. After the Surgeon and Anesthesiologist have completed their documentation, send the paper chart to the Administrative Supervisor.
   l. Refer to Patient Care Services Release of Deceased Policy for additional details on patient expiration.
2. Physician Responsibilities
   a. The physician pronounces the death.
   b. Physician may need to inform the Coroner of circumstances surrounding the death; if the Coroner declines/releases the case, the physician determines the disposition of the body (i.e. autopsy, mortuary).
   c. Physician informs the family/significant other(s) of patient's outcome.
   d. The physician shall communicate the patient's expiration to the admitting physician or other providers as appropriate.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 04/94

SUBJECT: Scheduling Surgical Procedures

REVISION DATE: 09/99, 04/01, 01/02, 06/03, 02/05, 02/08, 06/09, 11/10, 10/12, 12/12, 01/13, 03/14, 02/17, 08/19, 05/20, 04/22

Surgical Services Department Approval:	~~02/22~~02/24
Department of Anesthesiology Approval:	n/a
Operating Room Committee Approval:	~~02/22~~03/24
Pharmacy &Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~03/22~~03/24
Administration Approval:	~~04/22~~04/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/22

A. **PURPOSE:**
1. To provide scheduling guidelines for surgery, endoscopy, ~~elective cesarean sections (in OB-OR)~~ and procedures requiring an anesthesia provider.

B. **DEFINITIONS:**
1. Add-On Cases: Additions to the surgery schedule after the "final schedule" has been published. The "final schedule" is published by 4:00pm for the next day.
2. Elective Case: Surgery can be scheduled at the time best suited for the surgeon and the patient.
3. Urgent Case: Surgical intervention is needed within 4-6 hours of presentation. Urgent procedures are placed in an available time on the OR schedule.
4. Emergent Case: Surgical intervention is needed within one hour of presentation and may require that another scheduled or add-on case is bumped.
5. Emergency: Surgical intervention is needed immediately upon presentation to preserve life or limb. Emergency procedures are performed in the first available operating room and may require that another scheduled or add-on case is bumped.

C. **SCHEDULING ELECTIVE CASES:**
1. All elective surgical and endoscopic procedures will be scheduled through the Surgery scheduling office.
2. There are 12 rooms in the Tri-City Medical Center (TCMC) OR suite which are utilized as follows:
   a. Ten (10) operating rooms (OR 1-10) can accommodate any type of case.
   b. OR ~~5~~6 is reserved for cardiac cases.
   c. OR 11 is the Cystoscopy Room and is considered a wound class II room. Only certain procedures may be performed in this room due to the open drain:
      i. Circumcision
      ii. Endourology procedures
      iii. Percutaneous Suprapubic Cystotomy
      iv. Vasectomy
      v. Orchiectomy

d. OR **8** ~~12~~ is the GI Endoscopy Room

3. Expected available surgery rooms Monday-Thursday (may fluctuate based on staffing, surgical volume and surgical acuity):
   - **a.** 0715-15~~7~~00 hours: **5~~8~~** rooms
   - ~~**a.**~~**b.** **1500-1700 hours: 3 rooms**
   - ~~**b.**~~**c.** 1700-1900 hours: **24** rooms
   - ~~**c.**~~**d.** 1900-23~~1~~00 hours: **1~~3~~** rooms
   - ~~**d.e.** 2100-2300 hours: 2 rooms~~

~~4. Expected available surgery rooms on Friday (may fluctuate based on staffing, surgical volume and surgical acuity):~~
   - ~~a. 0715-1700 hours: 7 rooms~~
   - ~~b. 1700-1900 hours: 4 rooms~~
   - ~~c. 1900-2100 hours: 3 rooms~~
   - ~~d. 2100-2300 hours: 2 rooms~~

~~**5.**~~**4.** Elective cases shall be scheduled by the surgery scheduling office between the hours of 0800 and 1630, Monday through Friday, at 760-940-7382. After 1430, cases scheduled for the following day are scheduled by staff at the Surgery desk (760-940-5400).
   a. Elective cases are performed Monday through Friday from 0715 (0815 on Thursday) to 2300 hours. Elective cases should not extend beyond 2300.

~~**6.**~~**5.** Start Times:
   a. The Start time of a procedure (time on the OR schedule) is the time the patient is expected to be in the OR. Start time of first cases are tracked and report to the OR committee monthly.
   b. The start time of elective or add-on case requested for 1600 or later cannot be guaranteed. In those instances, the surgeon's preferred start time will be noted, and the surgeon will be given one hour's notice of expected start time. If the surgeon cannot start at the expected time, the next surgeon to start will be offered the time.

~~**7.**~~**6.** Delays:
   a. Surgeons who notify the OR they will be late for their scheduled start time must provide an expected time of arrival. Delays of more than 30 minutes, or delays that will impact another surgeon's schedule will cause the first surgeon to be bumped back to the next available start time.
   b. Surgeons who are not in the hospital 30 minutes past the scheduled time of surgery ~~and are unable to be contacted~~ will be bumped back to the next available start time once they ~~either~~ arrive at the hospital ~~or contact the OR~~.

~~**8.**~~**7.** Cases are scheduled on a consecutive, first-come first-served basis, or in a surgeon's block time.

~~**9.**~~**8.** Procedures may be scheduled by the surgeon or the surgeon's office staff only.

~~**10.**~~**9.** The process for scheduling an elective case is as follows:
   a. The surgeon's office calls the TCMC Surgery Scheduling department to reserve a case time.
      i. The TCMC Surgery Scheduler will schedule the case, obtain a financial account number (FIN#) and book a Pre-Operative Education appointment.
      ii. The TCMC Surgery Scheduler will provide the FIN# and the date and time of the Pre-Operative Education appointment to the surgeon's office scheduler.
   b. The surgeon must enter electronic orders at least one week prior to surgery date. Faxed or paper orders will not be accepted.
      i. If the case is scheduled less than one week prior to the date of surgery, electronic orders are required by the next business day.

~~**11.**~~**10.** Patient Requirements:
   a. If a patient has a cardiac history, it is the patient's responsibility to get a cardiac clearance from their primary care provider and have it reviewed by their surgeon and faxed into the hospital prior to their Pre-Operative Education appointment. If

there is not a cardiac clearance, the patient may be rescheduled until clearance is obtained.

~~a.~~**b.** Surgery patients must be at least 18 years of age at the time of surgery, except in the case of emergency.
   i. Patients 14-17 years of age presenting with surgical emergency are to be surgically treated at TCMC. Patients shall be transferred to Rady Children's Hospital if they require post-operative hospital admission.
   ii. Any requested patient who is under 18 years of age must be reviewed/approved prior to scheduling by the Chief of Anesthesia or designee.

~~12.~~**11.** The surgeon must have the appropriate privileges granted to be allowed to schedule a procedure.
   a. Current privilege lists are maintained through the E-PRIV system, accessible through TCMC Intranet.
   b. If the physician's privilege status is still not clear, the Medical Staff Office is contacted for clarification. The Administrative Supervisor may be contacted for assistance outside of Medical Staff Office hours.
   c. It is the responsibility of the surgeon to acquire an assistant or proctor as necessary for designated procedures.

D. **PRE-OPERATIVE EDUCATION APPOINTMENT SCHEDULING GUIDELINES:**
1. Patients may be scheduled for a telephone Pre-Operative Education appointment.

E. **SCHEDULING ADD-ON URGENT, EMERGENT, OR EMERGENCY PROCEDURES:**
1. Urgent, Emergent, and Emergency cases may be performed at any time.
2. Urgent, Emergent, and Emergency cases shall be scheduled through the Main OR desk in person or via telephone (760-940-5400) **or by contacting the Administrative Supervisor on duty (760-940-7765)**.
3. Required information when scheduling an add-on case includes:
   a. Patient name, date of birth, age, and medical record number
   b. Patient phone number, Social Security number, and insurance information (excludes in-house patients)
   c. Patient current location in the hospital
   d. NPO status
   e. Pre-Op diagnosis and Procedure to be performed
   f. Physical needs/mobility limitations
   g. Surgeon and assistant (if applicable)
   h. Instrumentation/Equipment/X-ray/**Vendor** needed
   i. Relevant cardiac/medical history
   j. Time of surgeon availability
4. **Administrative Supervisor responsibilities for scheduling add-on urgent, emergent, or emergency procedures:**
   a. Take required information for scheduling a case.
   b. Required information when scheduling an add-on case includes:
      i. Patient name, date of birth, age, and medical record number
      ii. Patient phone number, Social Security number, and insurance information (excludes in-house patients)
      iii. Patient current location in the hospital
      iv. NPO status
      v. Pre-Op diagnosis and Procedure to be performed
         1) Physical needs/mobility limitations
      vi. Surgeon and assistant (if applicable)
      vii. Instrumentation/Equipment/X-ray/Vendor needed
      viii. Relevant cardiac/medical history
      ix. Time of surgeon availability

c. **Call On Call RN and scrub tech. Once the RN and scrub tech are in house, the RN will call the on call Anesthesia and PACU RN at their perspective times they are needed.**

~~k.~~**d.** **The OR desk will email the on call schedule to the Administrative Supervisor for each day by 2pm.**

F. **WEEKEND/HOLIDAY CASES:**

1. For Saturday and Sunday 0730-19~~5~~00, **12** room~~s~~ **is** ~~are~~ available for Add-on cases and 1 room is available for ~~emergency cases or~~ a heart. ~~For 1500-0730, 1 room is available for Add-on cases and 1 room is available for emergency cases or a heart~~.
2. Memorial Day, Labor Day, July 4th, Thanksgiving, Christmas, and New Year's Day have one urgent and one emergent room only. No elective surgeries are scheduled on these holidays.
3. President's Day will be treated like a regular weekend day.
4. Weekend and holiday cases are not to be scheduled more than 24 hours prior to the day of surgery.
5. Add-on cases are started in order of scheduling, providing the surgeon is available and the patient is ready for surgery.
6. If the first scheduled add-on case cannot be performed in the first available time, the next case's surgeon will be contacted and offered to start at the available time. Upon availability of the next time to start an add-on case, the surgeon for the first case will again be contact and offered the time.
   a. The first available time is **0800** ~~0730~~. If a physician requests a specific time, e.g., ~~0900~~ **1000** to start a case, then another physician is available to start at **0800** ~~0730~~, the physician requesting the ~~0900~~ start time will be contacted to move up to **0800** ~~0730~~, or will start after the preceding case is finished.
7. For ~~0730~~ **0800** cases, the patient must be ready for transfer to the Operating Room by **0715** ~~0645~~, otherwise, the next scheduled case may replace the delayed case.
8. ~~When the first Saturday/Sunday room is booked for three hours or more, the second room is opened. The surgeon following the 0730 slot in the first room will be offered the 0730 slot in the newly available room.~~
9. Robotic ~~cases are not to be scheduled on holidays. However, robotic~~ cases may be scheduled on **holidays and** weekends.
10. **There will be a scheduled lunch break for staff from 1100-1200 Saturdays and Sundays to ensure lunches are accommodated. No cases are to be booked during this time.**
~~9.~~11. **If a case goes over 1100, the staff will be granted an hour break starting at the time the patient leaves the OR room. This will ensure they are able to clean up the case prior to going to lunch, take their lunch and set up the room for the next case.**
~~10.~~12. ~~Requests may be approved on an individual basis by a member of the Surgery Nursing leadership team/designee and Operating Room Medical Director.~~

G. **ENDOSCOPY:**

1. Endoscopy services are available 24/7.
2. Endoscopy procedures are scheduled in the same manner as surgical procedures.
3. Endoscopy procedures requiring an anesthesia provider are scheduled in the appropriate block time or in an open time on the OR schedule.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
PERI-ANESTHESIA NURSING SERVICES

ISSUE DATE: 10/11 **SUBJECT:** Visitors in the Post Anesthesia Care Unit (PACU)

REVISION DATE(S):

Surgical Services Department Approval:	~~06/18~~08/23
Department of Anesthesiology Approval:	n/a
Operating Room Committee Approval:	~~01/19~~03/24
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~02/19~~03/24
Administration Approval:	~~04/19~~04/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/19

A. **PURPOSE:**

1. To provide guidelines for limited admission of family members/significant others into the Post Anesthesia Care Unit. Recovery from anesthesia is a time of transition for patients during which their vulnerability necessitates specialized nursing care and attention. Due to the nature of the unit, visitors are admitted under special circumstances only as described in this policy. The safety and privacy of all patients in the PACU will take priority at all times.

B. **PROCEDURE:**

1. During normal hours & circumstances, patients recovering from anesthesia may require a family member/significant other at the bedside for a period of time. Those circumstances are limited to:
   a. Patients with special needs, such as developmental delay, may have one family member/caregiver in the PACU as requested by the RN.
   b. At the time of discharge, same day surgery patients may have their designated responsible person with them for the discharge process.
   c. In the event of a prolonged PACU stay of 3 hours or more, a brief visit may be possible depending on patient condition and activity in the unit at that time.
2. During early morning hours when the PACU space is utilized for the pre-operative preparation of patients, one person may accompany the patient at the time the primary nurse designates appropriate. This will depend on:
   a. Type and amount of preparation required for the procedure
      i. Additional preoperative testing required
   b. Regional blocks administered by anesthesiologist
   c. Activities in the unit at that time
3. Visitors with signs of infection or illness, including but not limited to, fever, nausea, vomiting, coughing, sneezing, or sore throat will not be permitted.
4. Children under the age of 14 years old will not be permitted.
5. Exceptions will be made at the discretion of the manager/director or PACU charge RN.

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

March 28, 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 March 28, 2024.

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

Director Nina Chaya
Director George W. Coulter
Director Gigi Gleason
Director Marvin Mizell
Director Adela Sanchez
Director Tracy Younger

Absent: Director Rocky Chavez

Also present were:

Dr. Gene Ma, Chief Executive Officer
Henry Showah, M.D., Chief of Staff
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant

1. Chairperson, Director Tracy M. 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 Gleason and seconded by Director Coulter to approve the agenda as presented. The motion passed (6-0-0-1) with Director Chavez absent.

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

   Chairperson Younger made an oral announcement of the items listed on the March 28, 2024 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Reports Involving Trade Secrets.

4. Motion to go into Closed Session

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

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

6. Report on any action taken in Closed Session.

   Board Counsel Scott stated the report out from closed session will be given at the beginning of today's Regular Board meeting at 3:30 p.m.

7. Adjournment

   There being no further business, Chairperson Younger adjourned the meeting at 3:22 p.m.

_____
Tracy M. Younger
Vice Chairperson

ATTEST:

_____
Gigi Gleason
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
March 28, 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 March 28, 2024.

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

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

Absent was Director Rocky J. Chavez

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
Mark Albright, Chief Information Officer
Dr. Henry Showah, Chief of Staff
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. Pledge of Allegiance

   Director Younger led the Pledge of Allegiance.

4. Report from Closed Session

   Board Counsel Scott reported the Board heard reports related to Trade Secrets and took no action.

5. Public Comments – Announcement

   Chairperson Younger read the Public Comments section listed on the March 28, 2024 Regular Board of Directors Meeting Agenda.

6. February, 2024 Financial Statements – Janice Gurley, Chief Financial Officer

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

- Net Operating Revenue – $188,671
- Operating Expense – $220,615
- EBITDA – ($12,392)
- EROE – ($24,639)

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

- Average Daily Census – 112
- Adjusted Patient Days – 52,593
- Surgery Cases – 3,154
- ED Visits – 29,106

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

- Net Operating Revenue – $23,581
- Operating Expense – $25,075
- EBITDA – $1,376
- EROE – $633

Janice reported on the current month Key Indicators as follows:

- Average Daily Census – 119
- Adjusted Patient Days – 6,486
- Surgery Cases – 430
- ED Visits – 3,469

Lastly, Janice commented that volumes were strong in March and she is forecasting the district will break-even for the remainder of the year.

Directors made comments and asked questions that were answered by Janice, Dr. Ma and Donald Dawkins.

7. New Business –

a) Approval of the renewal of an agreement for the Medical Directorship for Opioid Stewardship Program with Ole Snyder, M.D., for a term of 12 months, beginning May 1, 2024 and ending April 30, 2025, for an annual and total cost for the term of $459,384.

It was moved by Director Gleason to approve the agreement for Medical Directorship for the Opioid Stewardship Program with Ole Snyder, M.D. for a term of 12 months, beginning May 1, 2024 and ending April 30, 2025, for an annual and total cost for the term of $459.384. Director Chaya seconded the motion.

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

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

b) Approval of an agreement with Infor (US), Inc. for software support for a term of 12 months, beginning June 1, 2024 and ending May 31, 2025, for an annual and total term cost not to exceed $18,000.

It was moved by Director Chaya to approve the agreement with Infor (US), Inc. for software support for a term of 12 months, beginning June 1, 2024 and ending May 31, 2025, for an annual and total term cost not to exceed $18,000. Director Gleason seconded the motion.

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

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

8. Old Business -

a) Affiliation Update –

Dr. Ma reassured everyone that both parties remain highly interested and motivated and are working collaboratively to come to a sustainable long-lasting agreement.

9. Chief of Staff –

Dr. Henry Showah, Chief of Staff presented the March 2024 Credentialing Actions and Reappointments Involving the Medical Staff. No concerns or "red flags" were raised by the Credentials Committee.

It was moved by Director Coulter to approve the March 2024 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on March 25, 2024. Director Gleason seconded the motion.

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

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

10. Consideration of Consent Calendar

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

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

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

11. Discussion of items pulled from Consent Calendar

    There were no items pulled from the Consent Calendar.

12. Comments by Members of the Public

    There were no comments from members of the public.

13. Comments by Chief Executive Officer

    Dr. Ma wished everyone a happy Easter!

14. Board Communications

    There were no comments from Board members.

15. Adjournment

    There being no further business, Chairperson Younger adjourned the meeting at 3:50 p.m.

Tracy M. Younger
Chairperson

ATTEST:

Gigi Gleason, Secretary

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

April 17, 2024 – 3:30 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 3:30 p.m. on April 17, 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 Marvin Mizell
Director Adela I. Sanchez
Director Tracy M. Younger

Absent were Director Gigi Gleason and Director George Coulter

Also present were:

Dr. Gene Ma, Chief Executive Officer
Donald Dawkins, Chief Nurse Executive
Jeremy Raimo, Chief Operations Officer
Janice Gurley, Chief Financial Officer
Mark Albright, Chief Information Officer
Roger Cortez, Chief Compliance Officer
Henry Showah, M.D., Chief of Staff
Nandan Prasad, M.D. Medical Director of Quality
Jennifer Paroly, President, Foundation
Eva England, Senior Director, Ancillary Services
Joanne Barnett, Senior Director, Nursing
Melissa Terah, Clinical Director of Nursing Strategy & Integration
Heidi Benson, Clinical Quality Manager
Shirley Krussel, Quality Performance Improvement Coordinator
Tara Eagle, Director of Laboratory Services
Ellen Langenfeld, Director of Pharmacy
Priscilla Reynolds, Regulatory Compliance Manager
Susan Bond, General Counsel
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant

1. Chairperson, Director Tracy M. 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 Chaya and seconded by Director Sanchez to approve the agenda as presented. The motion passed (5-0-0-2) with Directors Coulter and Gleason absent.

3. Oral Announcement of Items to be Discussed During Closed Session

Chairperson Younger made an oral announcement of the items listed on the April 17, 2024 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees, Reports Involving Trade Secrets and one matter of Potential Litigation.

4. Motion to go into Closed Session

It was moved by Director Sanchez and seconded by Director Mizell to go into Closed Session at 3:35 p.m. The motion passed (5-0-0-2) with Directors Coulter and Gleason absent.

5. At 6:10 p.m. the Board returned to Open Session with Board members Chaya, Mizell, Sanchez and Younger present. Others present included Dr. Gene Ma, Jeffrey Scott and Teri Donnellan.

6. Report on any action taken in Closed Session.

Board Counsel Scott reported the Board in Closed Session heard a Report from the Quality Assurance Committee.

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

Reports of the Hospital Medical Audit or Quality Assurance Committees and took no action.

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

Lastly, the Board discussed a Potential Litigation matter and took no action.

7. Adjournment

There being no further business, Chairperson Younger adjourned the meeting at 6:12 p.m.

_____
Tracy M. Younger
Vice Chairperson

ATTEST:

_____
Gigi Gleason
Secretary

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending March 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)	56,565.96	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)	37,020.98	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)	18,075.40	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)	11,088.63	05/14/21	10/31/31	**Seaside Medical Group** 115 N EL Camino Real, Suite A Oceanside, CA 92058	7094
Nextmed III Owner LLC 6125 Paseo Del Norte, Suite 210 Carlsbad, CA 92011 V#83774	Approx 4,553	$4.00	(a)	23,811.92	09/01/21	08/31/33	**PCP Clinic Calrsbad** 6185 Paseo Del Norte, Suite 100 Carlsbad, CA 92011	7090
500 W Vista Way, LLC & HFT Melrose P O Box 2522 La Jolla, CA 92038 V#81028	Approx 7,374	$1.67	(a)	12,812.09	07/01/21	06/30/26	**Outpatient Behavioral Health** 510 West Vista Way Vista, Ca 92083	7320
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 #V81250	Approx 7,000	$4.12	(a)	31,749.00	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				**243,250.21**				

(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 March 2024

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
8740	Charge	31424 EDU	199.99	81649	MILAN-AGLUGUB, BENILDA
8740	RN TO BSN	30124EDU	2,500.00	84388	HO PHOUNG VY
8740	PCCN	30124 EDU	150.00	84389	SMILEY GLORIECEL

**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.