TRI-CITY HEALTHCARE DISTRICT **REVISED**
AGENDA FOR A Special MEETING
October 2, 2025 – 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	Special Presentation – a) 2025 Healthcare Organizations SUD Care Honor Roll – Julie Abraham, Director of Pharmacy	10 min.	CEO
6	Executive Management Reports	5 min.	Standard
7	August 2025 Financial Statement Results	10 min.	CFO
8	New Business – a) Consideration to accept the Fiscal Year 2025 Financial Statement Audit – Kyle Rogers, Stelian Damu (Baker Tilly Advisory Group, LP) and Anh Nguyen, CFO b) Consideration to approve an agreement with BD/CareFusion for a term of 84 months for Pyxis Med Station and Pyxis Server beginning October 1, 2025 and ending September 30, 2032, a term of 60 months for Carousel beginning October 1, 2025 and ending September 30, 2030 and a term of 36 months for Pharmacy Keeper	15 min 5 min.	CFO 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 Tri-City Healthcare District regarding any item on this Agenda is available for public inspection in the Administration Departme located at the Tri-City Medical Center during normal business hours.

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

	Agenda Item	Time Allotted	Requestor
	beginning October 1, 2025 and ending September 30, 2028 for a total term aggregate cost of $5,615,688. c) Consideration to approve the execution of a Service Agreement between Tri-City Healthcare District d/b/a Tri-City Medical Center and Physicians Radiology Medical Group, Inc. for the provision of diagnostic radiology interpretive services for MRI studies, for an initial term of 12 months beginning September 26, 2025 and ending September 25, 2026 at an annual cost not to exceed $225,000. d) Consideration to award Board Sponsorship for the 2025 Gala.	5 min. 5 min	COO President/ Foundation
9	Old Business – None	--	--
10	Chief of Staff - a) Consideration of September 2025 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals, as recommended by the Medical Executive Committee on September 22, 2025.	5 min.	COS
11	Consent Calendar 1) Board Committee **a. Finance, Operations & Planning Committee Director Younger, Committee Chair** 1) Approval of the renewal of an agreement with Victor Souza, M.D., as the Medical Director/Covering Physician for the Specialty Care Clinic and Progressive Care Unit for a term of 24 months, beginning September 1, 2025 and ending August 31, 2027, not to exceed an average of 20 hours per month or 240 hours annually, at an hourly rate of $163 and an annual cost of $39,120 and a total term cost of $78,240. 2) Approval of the second amendment renewal with Medline Industries, Inc. for medical supply distribution services, for a term of 36 months, beginning November 1, 2025 and ending October 31, 2028, for a projected annual cost of $187,728, a total projected cost for the term of $563,184 and an anticipated total term savings of $159,000. 3) Approval of an agreement with Boston Scientific Corporation for a catheter-based program upgrade for a term of 36 months, beginning July 1, 2025 and ending June 30, 2028, for an annual cost of $313,440 and a total term cost of $940,320. 4) Approval of an agreement with Egnite, Inc. for a comprehensive cardiovascular focused artificial intelligence software system for a term of 36 months, beginning August 1, 2025 and ending July 31, 2028, with a first-year cost of $135,000 which includes start-up fees, and an annual cost of $110,000 for years two and three, for a total term cost of $355,000. 5) Approval of the purchase of 51 Carescape replacement	10 min.	Chair

	Agenda Item	Time Allotted	Requestor

patient monitors for Post-Anesthesia Care Unit (PACU)/Interventional Radiology (IR) from G.E. Healthcare for a total cost of $1,652,675.

6) Approval of the renewal of the Comprehensive Neurology Services Agreement with The Neurology Center for a term of 24 months, beginning October 1, 2025 and ending September 20, 2027, at a total 24-month cost not to exceed $1,115,386.

7) Approval of the continuation of a Critical Care Intensivist Program with CEP America-Intensivists PC dba Vituity, for a term of 36 months, beginning November 1, 2025 and ending October 31, 2028, at an annual cost not to exceed $1,886,656, and a total term cost not to exceed $5,659,968.

(2) **Administrative Policies & Procedures**

A. Patient Care Services
1. Abbreviations, Use of
2. Accounting of Disclosure of Patient Information (PHI) Procedure
3. Autopsy, Authorization of Policy
4. Blood Glucose Point of Care Testing Procedure
5. Point of Care (POC) New Test Method Request & Implementation Policy
6. Program Flexibility
7. Volunteers, Patient Care Services Departments Policy

B. Administrative District Operations 200s
1. Policy & Procedure Approval Process Policy 240

C. Administrative Human Resources 400s/Pay Practice
1. Alcohol & Drug Testing for Employees Policy – 429
2. Fair Treatment for Supervisory and Management Employees – 427
3. Fair Treatment for Non-Management – 428
4. Leave of Absence – 435
5. Bereavement Leave for Benefitted Employees 435.01
6. Subpoena/Jury Duty – 435.02
7. Monitoring Licenses Professional Registrations Certificates – 430
8. Paid Time Off Program – 433
9. Premium Specialty Pay – 473
10. Charge Pay – 473.01 (RETIRE)
11. Holiday and Holiday Premiums – 473.02 (RETIRE)
12. Interpreter Premium – 473.03 (RETIRE)
13. On-Call and Call Back – 473.04 (RETIRE)
14. Report in Pay – 473.06 (RETIRE)
15. Special Pay Practices – 473.08 (RETIRE)
16. Severance Plan Policy – 454

D. Employee Health & Wellness
1. Alcohol and Drug Testing Guidelines (RETIRE)
2. Immunization

E. Medical Staff
1. Educational Planning; Needs Assessment; Objectives; and Evaluation of a Continuing Medical Education (CME) Activity

	Agenda Item	Time Allotted	Requestor
	8710-600 **F. Outpatient Behavioral Health** 1. Medications **G. Outpatient Infusion Center** 1. Department-Specific Orientation (RETIRE) **H. Rehabilitation** 1. Computer Downtime/Printer Malfunction 2. Hydroworx Therapy Pool Contamination 3. Hydroworx Therapy Pool – General Operations 4. Mission Statement Goals & Objectives Policy – 100 5. Productivity Reporting System 6. Rehabilitation Dress and Appearance Policy – 1710 7. Service Locations 8. Staff Rotations – 615 Policy 9. Statement of Accountability Policy - 102 (3) **Licenses/Memberships** a) TCHD Facility License Renewal Fee - $307,256.00 b) ACHD Membership - $24,733.00 (4) Minutes a) Special Meeting – August 21, 2025 b) Special (Regular) Meeting – August 21, 2025 (5) Reports – (Discussion by exception only) a) Building Lease Report – (August, 2025) b) Reimbursement Disclosure Report - (August, 2025)		
12	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
13	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
14	Comments by Chief Executive Officer	5 min.	Standard
15	Board Communications	5 min,	Standard
16	Total Time Budgeted for Open Session	1.5 hour	
17	Adjournment		

Tri-City Medical Center

BOARD OF DIRECTORS MEETING
DATE OF MEETING: 10/02/2025
BD/Carefusion

Type of Agreement		Medical Directors		Panel	X	Other: Addendum – Carousel & Pharmacy Keeper USP Training Module
Status of Agreement		New Agreement	X	Renewal – Pyxis Server Service & Pharmacy Keeper	X	Renewal – Lower Rate – Pyxis Med-station

Vendor's Name: BD/Carefusion

Area of Service: Pharmacy

Term of Agreement: Effective Date: 10/01/2025
Pyxis Med-station: 84 Months; Expires 09/30/2032
Pyxis Server Service: 84 Months; Expires 09/30/2032
Carousel: 60 Months; Expires 09/30/2030
Pharmacy Keeper: 36 Months; Expires 09/30/2028

Maximum Totals (Month):

Item	Prior Cost/Month	Proposed Cost/Month	Total Term Cost
Pyxis Med-station	**$53,823**	**$51,999**	**$4,367,916**
Pyxis Server	**$685**	**$685**	**$57,540**
Carousel	**End of Life/Obsolete parts; unable to repair**	**$16,891**	**$1,013,460**
Pharmacy Keeper	**$4922**	**$5,906**	**$212,616**
Pharmacy Keeper – USP training module	**$0**	**$671**	**$24,156**
Credit	**$0**	**-$1666.67**	**-$60,000**
		Total Term Aggregated Cost	**$5,615,688**

Description of Services/Supplies:

- Server and operating system upgrade are included at no charge, an additional savings of $295,700 over the term.
- Avoid paying month-to-month, approximately a $40,000/month increase (Pyxis Med-station)

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

Tri-City Medical Center

Person responsible for oversight of agreement: Julie Abraham, Director of Pharmacy; Dr. Gene Ma, CEO

Motion: I move that the TCHD Board of Directors approve the agreement with BD/Care Fusion for a term of 84 months for Pyxis Med Station and Pyxis Server beginning October 1, 2025 and ending September 30, 2032 and a term of 60 months for Carousel beginning October 1, 2025 and ending September 30,2030, and a term of 36 months for Pharmacy Keeper beginning October 1, 2025 and ending September 30, 2028 for a total term aggregate cost of $5,615,688.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: October 2, 2025

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

Vendor's Name: Physicians Radiology Medical Group

Area of Service: Radiology read for OSNC

Term of Agreement: September 26, 2025 – September 25, 2026 (one year)

Maximum Totals:

Annual Total Cost
NTE $225,000

Description of Services/Supplies:

- Diagnostic radiology interpretations for outpatient OSNC (orthopedic)MRI scanner

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

Person responsible for oversight of agreement: Jeremy Raimo, COO

Motion:
To approve and authorize the execution of a Service Agreement between Tri-City Healthcare District d/b/a Tri-City Medical Center and Physicians Radiology Medical Group, Inc., for the provision of diagnostic radiology interpretive services for MRI studies, for an initial term of 12 months commencing on September 26, 2025 and ending September 25, 2026 at an annual cost not to exceed $225,000.

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT
September 10, 2025

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:

Practitioner Name	Specialty	Staff Status	Initial Appointment Term	Comments
AGHDASI, Bayan MD	Orthopedic Surgery	Provisional	10/02/2025 - 10/02/2027	
GILLES, Louis DPM	Podiatry	Provisional	10/02/2025 - 10/02/2027	
PATEL, Tejal MD	Teleradiology	Provisional	10/02/2025 - 10/02/2027	
RIAZ, Muhammad MD	Family Medicine	Provisional	10/02/2025 - 10/02/2027	
SIOW, Matthew MD	Orthopedic Surgery	Provisional	10/02/2025 - 10/02/2027	
TO, Andrew DPM	Podiatry	Provisional	10/02/2025 - 10/02/2027	
WILSON-FLEWELLING, Scott MD	Teleradiology	Provisional	10/02/2025 - 10/02/2027	
ZHU, Ruo MD	Internal Medicine	Provisional	10/02/2025 - 10/02/2027	

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 2 of 3
September 10, 2025

Modification of Staff Status

The following practitioners have requested privilege status change as noted below.
Effective **October 2, 2025.**

Practitioner Name	Department/Specialty	Change in Staff Status
BASERI, Babak MD	Medicine/Oncology	Provider changing status from Refer and Follow to Active Affiliate.
SCHWERKOSKE, John MD	Medicine/Oncology	Provider changing status from Refer and Follow to Active Affiliate.
LEE, Anna E. MD	Pediatrics	Provider changing status from Active to Refer and Follow

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
September 10, 2025

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)
CHUNG, David MD	Medicine/Internal Medicine	• Admit patients, Internal Medicine • Consultation, Internal Medicine, including via Telemedicine (F) • History and physical examination, Internal Medicine, including via Telemedicine (F)
FAHY, John MD	Anesthesiology	• Consultation including via telemedicine (F) • Evaluate and treat patients with anesthesia related problems. • Perform history and physical examination, including via telemedicine (F) • General Anesthesiology • Invasive Monitoring (Includes: Arterial line, Central line, Midline and Pulmonary Artery catheters • Cardiac Anesthesiology • Transesophageal Echocardiography (TEE) • Coronary sinus catheter placement.
SHARMA, Abhinav, MD	Medicine/Cardiology	• Admission of Patient to Inpatient Services • Performance of History & Physical Examination, including Telemedicine. • Performance of a Cardiac Consultation, including via telemedicine • Supervision of an approved category of Allied Health Practitioner • Transesophageal echocardiography • EKG • Thoracic Echo

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
SEPTEMBER 2025

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 Medicine:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
ALKHADDO, Jamil B. MD	Endocrinology, Diabetes & Meta	Active Affiliate	9/25/2025-9/25/2027	Creds Comm. Approved 6 months ext. to complete pending proctoring moving him from Provisional to Active Affiliate.
FARNSWORTH, William B, MD	Neurology	Active	9/25/2025-9/25/2027	
KABRA, Ashish, MD	Cardiology	Active	9/25/2025-9/25/2027	
KERN, Hannah S., MD	Infectious Diseases	Active	9/25/2025-9/25/2027	Change of status from Provisional to Active.
RIZVI, Nadia, MD	Internal Medicine	Active	9/25/2025-9/25/2027	
SADOFF, Mark N, MD	Neurology	Active	9/25/2025-9/25/2027	
SIDDIQUI, Fareeha, MD	Oncology	Refer and Follow	9/25/2025-9/25/2027	Change of status from Active to Refer and Follow.

Department of Pediatrics:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
CALHOUN, Chanelle R. MD	Pediatrics	Refer and Follow	9/25/2025-9/25/2027	
YUNG, Siyi Z. MD	Pediatrics	Refer and Follow	9/25/2025-9/25/2027	

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
SEPTEMBER 2025

Attachment B

Department of Surgery:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
AMORY, David W, MD	Orthopedic Surgery	Active	9/25/2025-9/25/2027	
KIRBY, Hannah, MD	Orthopedic Surgery	Active	9/25/2025-9/25/2027	.

Resignations *Medical Staff*:

Practitioner Name	Department/Specialty	Reason for Resignation
HOANG, Ngoc MD	Emergency Medicine	Resignation documentation received. Resigned effective 5/23/2025
WALLACE, Stephanie PAC	OB/GYN	Resignation documentation received. Resigned effective 8/5/2025
FAKHRO, Sameeh MD	Medicine (hospitalist)	Resignation documentation received. Resigned effective 5/31/2025
SAUNDERS, Phillip DO	Medicine (Oncology)	Resignation documentation received. Resigned effective 12/31/2024
SHAIKH, Anwer A. MD	Medicine (Oncology)	Resignation documentation received. Resigned effective 8/8/2025
LACROIX, Diane C. NP	Emergency Medicine	Resignation documentation received. Resigned effective 9/30/2025
DANG, Paul T. MD	Medicine (hospitalist)	Resignation documentation received. Resigned effective 4/10/2025
DAY, Richard B. MD	Medicine (hospitalist)	Resignation documentation received. Resigned effective 9/1/2025
EVTIMOV, Stoimen S. MD	Medicine (hospitalist)	Resignation documentation received. Resigned effective 9/1/2025
NERIO, Namiko DO	Medicine (hospitalist)	Resignation documentation received. Resigned effective 9/1/2025
PULIDO, Richard N. MD	Medicine (hospitalist)	Resignation documentation received. Resigned effective 9/1/2025
NGUYEN, Andrew MD	Neurosurgery	Resignation documentation received.
GUERIN, Chris, MD	Endocrinology, Diabetes & Meta	Resignation documentation via email. Resigned effective 09/30/2025.
STEIN, Alexander, MD	Dermatology	Resigned effective 9/30/2025. Fail to submit reappointment application.

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
INTERDISCIPLINARY PRACTICE COMMITTEE INITIALS REPORT
September 18, 2025

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 Professional:

Practitioner Name	Specialty	Staff Status	Initial Appointment Term	Comments
COOPER, Craig CRNA	Nurse Anesthetist	Allied Health Professional	10/2/2025 – 10/2/2027	
FOLSOM, Madison PA	PA – Oncology	Allied Health Professional	10/2/2025 – 10/2/2027	
WHARRAM, Jennifer PA	PA – Oncology	Allied Health Professional	10/2/2025 – 10/2/2027	

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – 1 of 1
September 18, 2025

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.

Medical Staff

Department of Emergency Medicine:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
ALDINOV, Kyra, PAC	Emergency Medicine	Allied Health Professional	9/25/2025-9/25/2027	

Department of Surgery:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
RYAN, Johnson, PAC	Surgery	Allied Health Professional	9/25/2025-9/25/2027	
ALLEN, Danielle M., AuD	Audiology	Allied Health Professional	9/25/2025-9/25/2027	

Resignations *Medical Staff and AHP*:

Practitioner Name	Department/Specialty	Reason for Resignation
HUFFMAN, Gregory, PAC	Medicine/ Physician Assistant	Resigned effective 9/30/2025. Will not proceed with reappointment.

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
Finance, Operations and Planning Committee Minutes
September 24, 2025

Members Present	Director Tracy Younger, Director Nina Chaya (via teleconference), Dr. Henry Showah, Dr. Mohammad Jamshidi-Nezhad
Non-Voting Members Present:	Dr. Gene Ma (via teleconference), Jeremy Raimo, COO, Donald Dawkins, CNE, Roger Cortez, CCO, Anh Nguyen, CFO, Susan Bond, General Counsel
Others Present:	Eva England, VP Ancillary Services, Chuck Sawyers, Manager, Supply Chain, Jennifer Paroly, Jane Dunmeyer, Teri Donnellan
Members Absent:	Director Adela Sanchez, Dr. Robert Lee, Mark Albright, CIO

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Tracy Younger called the meeting to order at 3:01 pm.		Chair
2. Approval of Agenda		**MOTION** **It was moved by Dr. Jamshidi-Nezhad, seconded by Dr. Showah, and it was unanimously approved to accept the agenda of September 24, 2025.**	Chair
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Younger read the paragraph regarding comments from members of the public.	No comments	Chair
4. Ratification of minutes of August 19, 2025	Minutes were ratified.	Minutes were ratified. **MOTION** **It was moved by Dr. Showah, seconded by Dr. Jamshidi-Nezhad, and it was unanimously passed, with Director Sanchez and Dr. Lee absent,**	Chair

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		that the minutes of August 18, 2025, are to be approved without any requested modifications.	
5. Old Business	None		
6. New Business	None		
7. Consideration of Consent Calendar:		**MOTION** **It was moved Dr. Showah and seconded by Dr. Jamshidi-Nezhad and unanimously passed with Director Sanchez and Dr. Lee absent, to approve the Consent Calendar** **Members:** **AYES: Younger, Chaya, Jamshidi-Nezhad, Showah** **NOES: None** **ABSTAIN: None** **ABSENT: Sanchez**	Chair
a) Physician Agreement for Specialty Care Clinic & Progressive Care Unit • Dr. Victor Souza		**Approved via Consent Calendar**	Eva England
b) Medline Industries Supply Distribution – 2nd Amendment Renewal Proposal • Medline Industries, Inc.		**Approved via Consent Calendar**	Dr. Gene Ma
c) Catheter Based Agreement Amendment • Boston Scientific Corporation (BSC)		**Approved via Consent Calendar**	Dr. Gene Ma

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
d) Cardiovascular Focused Artificial Intelligence (A.I.) Software Systems Agreement • Egnite, Inc.		**Approved via Consent Calendar**	Donald Dawkins
e) G.E. Healthcare Agreement • Healthcare		**Approved via Consent Calendar**	Eva England
f) Physician Agreement for Comprehensive Neurology Services • The Neurology Center		**Approved via Consent Calendar**	Eva England
g) Physician Agreement for ICU On-Call Coverage – Intensivist Services • CEP America – Intensists PC, dba Vituity		**Approved via Consent Calendar**	Eva England
8. Financials	Anh Nguyen presented the financials ending August 31, 2025 (dollars in thousands) **TCHD – Financial Summary** **Fiscal Year to Date** Operating Revenue $ 56,310 Operating Expense $ 58,471 EBITDA $ 3,075 EROE $ 214 **TCMC – Key Indicators** **Fiscal Year to Date** Avg. Daily Census 117 Adjusted Patient Days 13,299 Avg Acute Length of Stay 4.90		Anh Nguyen

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	Surgery Cases 863 ED Visits 7,951 **Graphs:** • TCHD-EBITDA and EROE • TCMC-Average Daily Census, Total Hospital - Excluding Newborns • TCMC-Acute Average Length of Stay • TCMC-Paid Full Time Equivalents-13 Month Trend		
a. Dashboard	No discussion	Information Only	Anh Nguyen
7. Comments by Committee Members	None	None	Chair
8. Date of next meeting	October 15, 2025		Chair
10. Adjournment	Meeting adjourned 3:39 p.m.	It was moved by Dr. Showah and seconded by Dr. Jamshidi-Nezhad and unanimously passed to adjourn the meeting at 3:39 p.m.	Chair

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 24, 2025
PHYSICIAN AGREEMENT FOR SPECIALTY CARE CLINIC & PROGRESSIVE CARE UNIT

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

Physician's Name: Victor Souza, M.D.

Area of Service: Specialty Care Clinic and Progressive Care Unit

Term of Agreement: 24 months, Beginning, September 1, 2025 – Ending, August 31, 2027

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	24 Month (Term) Cost
$163	20	240	$3,260	$39,120	**$78,240**

Position Responsibilities:

- Participates in daily UR on the inpatient unit with the CDCR patients as needed.
- Participates in risk management investigation and evaluation of events.
- Establishes and reviews policies and procedures for medical care.
- Participates in quarterly or more frequent meetings with CDCR and Sheriff Departments.
- Communicates as needed with attending and referring physicians; provides oversight of chart audits, and peer review and delinquencies in documentation.
- Assists in introducing new services/programs requested by the vendors.

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: Joshua Smiley, BSN, RN, Clinical Nurse Manager-Specialty Care Clinic & Progressive Care Unit / Donald Dawkins, Chief Nursing Executive

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors approve the renewal of an agreement with Dr. Victor Souza as the Medical Director/Covering Physician for the Specialty Care Clinic and Progressive Care Unit for a term of 24 months beginning September 1, 2025 and ending August 31, 2027. Agreements not to exceed an average of 20 hours per month or 240 hours annually, at an hourly rate of $163, for an annual cost of $39,120 and a total term cost of $78,240.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 24, 2025
MEDLINE INDUSTRIES SUPPLY DISTRIBUTION – 2nd AMENDMENT RENEWAL PROPOSAL

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

Vendor's Name: Medline Industries, Inc

Area of Service: Supply Chain Management

Term of Agreement: 36 months, Beginning, November 1, 2025 – Ending, October 31, 2028

Maximum Totals:

Current Monthly Cost*	Current Annual Cost	Current Total Term Cost	
$20,060	$240,720	$722,160	
Amended Renewal Monthly Cost*	**Amended Renewal Annual Cost**	**Amended Renewal Total Term Cost**	**Amended Renewal Projected Term Savings**
$15,644	$187,728	$563,184	**$159,000**

*Costs calculated from historical purchase volume and may vary

Description of Services/Supplies:

- Projected savings for the 3-year term is estimated to be $159K ($53K/year) over current rates

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

Person responsible for oversight of agreement: Chuck Sawyers, Supply Chain Manager / Anh Nguyen, CFO

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the second amendment renewal with Medline Industries Inc. for medical supply distribution services for a term of 36 months, beginning November 1, 2025 and ending October 31, 2028 for a projected annual cost of $187,728, a total projected cost for the term of $563,184, and an anticipated total term savings of $159,000.

Tri-City Medical Center

FINANCE, OPERATION & PLANNING COMMITTEE
DATE OF MEETING: September 24, 2025
CATHETER-BASED AGREEMENT AMENDMENT

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

Vendor's Name: Boston Scientific Corporation (BSC)

Area of Service: Cardiac Cath lab

Term of Agreement: 36 months, Beginning, July 1, 2025 – June 30, 2028

Maximum Totals:

	Year 1 Annual Cost (NTE)	Year 2 Annual Cost (NTE)	Year 3 Annual Cost (NTE)	Total Term Cost (NTE)
TOTALS	$313,440	$313,440	$313,440	**$940,320**

Description of Services/Supplies:

- Upgrade catheter-based program to current Intravascular Ultrasound (IVUS) and Fractional Flow Reserve (FFR) units, which are no longer serviced.

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

Person responsible for oversight of agreement: Tara Eagle, Assistant Director-Lab Services / Eva England, Vice President-Ancillary Services

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Boston Scientific Corporation for a catheter-based program upgrade for a term of 36 months, beginning July 1, 2025 and ending June 30, 2028 for an annual cost of $313,440 and a total term cost of $940,320.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 24, 2025
CARDIOVASCULAR FOCUSED ARTIFICIAL INTELLIGIENCE (A.I.) SOFTWARE SYSTEM AGREEMENT

Type of Agreement		Medical Director		Panel	X	Other- A.I. Cardio-vascular Software
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Vendor's Name: Egnite, Inc.

Area of Service: Cardiac Cath Lab

Term of Agreement: 36 months, Beginning, August 1, 2025 – Ending, July 31, 2028

Maximum Totals:

	Year 1 Cost - Includes Start up Fees (not to exceed)	Year 2 Cost (not to exceed)	Year 3 Cost (not to exceed)	Total Term Cost (not to exceed)
TOTALS	$135,000	$110,000	$110,000	**$355,000**

Description of Services/Supplies:

- Comprehensive, cardiovascular-focused artificial intelligence (AI) platform
- Evaluation of potential aortic stenosis patients within our current McKesson system
- Decrease delay in care for potential Transaortic Valve Replacement (TAVR) patients, to align with American Heart Association best practice

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

Person responsible for oversight of agreement: Eva England, VP-Ancillary Services / Dr. Gene Ma, Chief Executive Officer

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Egnite, Inc. for a comprehensive cardiovascular focused artificial intelligence software system for a term of 36 months, beginning August 1, 2025 and ending July 31, 2028. The first-year cost will be $135,000 which includes start-up fees, and an annual cost of $110,000 for years two and three, for a total term cost of $355,000.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 24, 2025
G.E. HEALTHCARE AGREEMENT

Type of Agreement		Medical Directors		Panel	X	Other: Capital Lease ($1 Buyout)
Status of Agreement		New Agreement		Renewal – Same Rates		Renewal – Lower Rate

Vendor's Name: G.E. Healthcare

Area of Service: Surgery

Term of Capital Lease Agreement: 60 Months

Maximum Totals:

Total Cost
$1,652,675

Description of Services/Supplies:

- Replacement of 51 patient monitors for Post-Anesthesia Care Unit (PACU) / Interventional Radiology (IR)
- Current equipment is 20 years old, has reached "end of life" and can no longer be supported or repaired.
- Currently multiple monitors are non-repairable.
- The G.E. Carescape Canvas monitoring platform is designed for high-acuity environments with advanced anesthesia capabilities

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

Person responsible for oversight of agreement: Chuck Sawyers, Manager-Supply Chain / Anh Nguyen, Chief Financial Officer

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the purchase of 51 Carescape replacement patient monitors for Post-Anesthesia Care Unit (PACU) / Interventional Radiology (IR) from G.E. Healthcare for a total cost of $1,652,675.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 24, 2025
PHYSICIAN AGREEMENT for COMPREHENSIVE NEUROLOGY SERVICES

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

Physician's Name: The Neurology Center

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

Term of Agreement: 24 months, Beginning October 1, 2025– Ending September 30, 2027

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

Service	Rate Year	Hours per Month (NTE)	Hours per Year (NTE)	Annual Cost (NTE)	24 Month Term Cost (NTE)
ED Neurology Call Coverage	Yr. 1: $850/24 hr. Yr. 2: $880/24 hr.	N/A	N/A	Yr. 1: $310,250 Yr. 2: $321,200	$631,450
Stroke Medical Director	Yr. 1: $220/hr. Yr. 2: $227/hr.	12	144	Yr. 1: $31,680 Yr. 2: $32,688	$64,368
Neurology Medical Director	Yr. 1: $220/hr. Yr. 2: $227/hr.	8	96	Yr. 1: $21,120 Yr. 2: $21,792	$42,912
Epilepsy Monitoring/Director	Yr. 1: $220/hr. Yr. 2: $227/hr.	4	48	Yr. 1: $10,560 Yr. 2: $10,896	$21,456
ARU Medical Director	Yr. 1: $185/hr.	80	960	Yr. 1: $177,600	$355,200

	Yr. 2: $185/hr.			Yr. 2: $177,600	
			Yr. 1: **$551,210** **Yr. 2:** **$564,176**	**$1,115,386**	

Position Responsibilities:

- The Neurology Center to provide comprehensive coverage and directorship services for all areas of service requiring clinical neurological care and oversight.
- Provide 24/7 patient coverage for all Neurological specialty services in accordance with Medical Staff Policy #8710-520 (Emergency Room Call: Duties of the On-Call Physician)
- Complete related medical records in accordance with all Medical Staff, accreditation, and regulatory requirements.

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

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

Motion:

I move that Finance Operations and Planning Committee recommend that the TCHD Board of Directors authorize the renewal of the comprehensive neurology services agreement with The Neurology Center for a term of 24 months beginning October 1, 2025 and ending September 20, 2027, at a total 24 month term cost not to exceed $1,115,386.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 24, 2025
PHYSICIAN AGREEMENT for ICU ON-CALL COVERAGE - INTENSIVIST SERVICES

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

Vendor's Name: CEP America – Intensivists PC, dba Vituity

Area of Service: ICU: Critical Care Intensivist Program

Term of Agreement: 36 months, Beginning, November 1, 2025 – Ending, October 31, 2028

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

Annual Program Total Cost (NTE)	Annual Performance Achievement Compensation	Total Term Cost (NTE)
$1,886,656	$0.00	$5,659,968

Description of Services/Supplies:

- Continuation of a Critical Care Program providing 24/7 Physician Intensivist, in critical care medicine, who are dedicated to the care of ICU patients
- Provide 24/7 physician coverage for all Critical care specialty services in accordance with Medical Staff Policy #8710-520 (Emergency Room Call: Duties of the On-Call Physician)
- Collaborate with hospital to design a quality program designed to improve outcomes utilizing key performance indicators
- Designate a Medical Director for the Critical Care Intensivist program to oversee program growth and opportunities

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

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

Motion: I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the continuation of a Critical Care Intensivist Program with CEP America- Intensivists PC, dba Vituity, for a term of 36 months, beginning November 1, 2025 and ending, October 31, 2028, at an annual cost not to exceed $1,886,656 and a total term cost not to exceed $5,659,968.

Tri-City Medical Center

ADMINISTRATION CONSENT AGENDA
September 23, 2025

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services		
1. Abbreviations, Use of	3 year review	Forward to BOD for Approval
2. Accounting of Disclosure of Patient Information (PHI) Procedure	3 year review	Forward to BOD for Approval
3. Autopsy, Authorization of Policy	3 year review, practice change	Forward to BOD for Approval
4. Blood Glucose Point of Care Testing Procedure	2 year review, practice change	Forward to BOD for Approval
5. Point of Care (POC) New Test Method Request and Implementation Policy	3 year review, practice change	Forward to BOD for Approval
6. Program Flexibility	3 year review, practice change	Forward to BOD for Approval
7. Volunteers, Patient Care Services Departments Policy	3 year review, practice change	Forward to BOD for Approval
Administrative District Operations 200s		
1. Policy and Procedure Approval Process Policy 240	3 year review, practice change	Forward to BOD for Approval
Administrative Human Resources 400s/Pay Practice		
1. Alcohol and Drug Testing for Employees Policy - 429	3 year review, practice change	Forward to BOD for Approval
2. Fair Treatment for Supervisory and Management Employees - 427	3 year review, practice change	Forward to BOD for Approval
3. Fair Treatment For Non Management - 428	RETIRE	Forward to BOD for Approval
4. Leave of Absence - 435	3 year review, practice change	Forward to BOD for Approval
5. Bereavement Leave for Benefited Employees 435.01	3 year review, practice change	Forward to BOD for Approval
6. Subpoena/Jury Duty - 435.02	3 year review, practice change	Forward to BOD for Approval
7. Monitoring Licenses Professional Registrations Certificates - 430	3 year review, practice change	Forward to BOD for Approval
8. Paid Time-Off Program - 433	Practice change	Forward to BOD for Approval
9. Premium Specialty Pay - 473	3 year review, practice change	Forward to BOD for Approval
10. Charge Pay - 473.01	RETIRE	Forward to BOD for Approval
11. Holiday and Holiday Premiums - 473.02	RETIRE	Forward to BOD for Approval
12. Interpreter Premium - 473.03	RETIRE	Forward to BOD for Approval

Tri-City Medical Center

ADMINISTRATION CONSENT AGENDA
September 23, 2025

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
13. On-Call and Call-Back - 473.04	RETIRE	Forward to BOD for Approval
14. Special Pay Practices - 473.08	RETIRE	Forward to BOD for Approval
15. Severance Plan Policy 454	3 year review, practice change	Forward to BOD for Approval
Employee Health & Wellness		
1. Alcohol and Drug Testing Guidelines	RETIRE	Forward to BOD for Approval
2. Immunization	3 year review, practice change	Forward to BOD for Approval
Medical Staff		
1. Educational Planning; Needs Assessment; Objectives; and Evaluation of a Continuing Medical Education (CME) Activity 8710 - 600	Practice change	Forward to BOD for Approval
Outpatient Behavioral Health		
1. Medications	Practice change	Forward to BOD for Approval
Outpatient Infusion Center		
1. Department-Specific Orientation	RETIRE	Forward to BOD for Approval
Rehabilitation		
1. Computer Downtime/ Printer Malfunction	3 year review, practice change	Forward to BOD for Approval
2. Hydroworx Therapy Pool Contamination	3 year review	Forward to BOD for Approval
3. Hydroworx Therapy Pool - General Operations	3 year review	Forward to BOD for Approval
4. Mission Statement Goals and Objectives Policy - 100	3 year review	Forward to BOD for Approval
5. Productivity Reporting System	3 year review	Forward to BOD for Approval
6. Rehabilitation Dress and Appearance Policy - 1710	3 year review	Forward to BOD for Approval
7. Service Locations	3 year review, practice change	Forward to BOD for Approval
8. Staff Rotations - 615 Policy	3 year review, practice change	Forward to BOD for Approval
9. Statement of Accountability Policy - 102	3 year review, practice change	Forward to BOD for Approval

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 03/97 **SUBJECT: Abbreviations, Use of**

REVISION DATE: 05/02, 12/02, 05/03, 12/03, 03/04, 04/06, 08/06, 07/09, 06/15, 04/18, 02/22

Department Approval:	~~10/21~~04/25
Clinical Policies & Procedures Committee Approval:	~~11/21~~05/25
Nursing Leadership Approval:	~~12/21~~08/25
Pharmacy and Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~01/22~~09/25
Administrative Approval:	~~02/22~~09/25
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/22

A. **PURPOSE:**

1. To provide optimal safety for patients and clear understanding of written medical communication by eliminating the use of potentially dangerous abbreviations and dose designations.

B. **POLICY:**

1. Tri-City Medical Center (TCMC) has adopted the Neil-Davis Medical Abbreviations.
   a. In addition, Pharmacy has adopted the Institute for Safe Medication Practices (ISMP)'s Error-Prone Abbreviations, Symbols, and Dose Designations for medication orders.
2. Abbreviations identified as "Do Not Use Abbreviations" by the Joint Commission are prohibited for use in all orders and medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed orders.
3. Medication orders
   a. If an unapproved abbreviation is used on a medication order or other written communication for patient care, the ordering physician shall be contacted by the nurse or pharmacist for clarification. The clarified order shall be documented in the medical record.
   b. Medication orders containing unapproved abbreviations shall not be dispensed by pharmacy or administered by the nurse until clarified and the medication order re-entered.
4. Changes to abbreviation references will be approved by the Pharmacy and Therapeutics Committee (P&T), the Medical Executive Committee and the Board of Directors.

C. **RELATED DOCUMENTS**:

1. **Institute for Safe Medication Practices (ISMP). ISMP List of Error-Prone Abbreviations, Symbols, and Dose Designations. ISMP; 2024.**~~Institute for Safe Medication Practices (ISMP). (2021) List of Error-Prone Abbreviations~~
2. The Joint Commission Official ""Do Not Use" List (2020)

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

1. Neil-Davis Medical Abbreviation - http://www.medabbrev.com/

E. **REFERENCES:**

1. The Joint Commission. (August, 2020). *Fact sheet. Offical "do no use" list.* Retrieved fromwww.jointcommission.org

ISMP
Institute for Safe Medication Practices
An ECRI Affiliate

ISMP List of Error-Prone Abbreviations, Symbols, and Dose Designations

Abbreviations, symbols, and certain dose designations are a convenience; a time saver; a means of fitting a word, phrase, or dose into a restricted space; and a way to avoid misspellings. However, they are sometimes misunderstood, misread, or misinterpreted, occasionally resulting in patient harm. Their use can also waste time tracking down their meaning, sometimes delaying patient care.

The abbreviations, symbols, and dose designations in the **Table** below were reported to ISMP through the ***ISMP National Medication Errors Reporting Program*** *(ISMP MERP)* and have been misinterpreted and involved in harmful or potentially harmful medication errors. They should **NOT** be used when communicating medical information verbally, electronically, and/or in handwritten applications. This includes internal communications; verbal, handwritten, or electronic prescriptions; handwritten and computer-generated medication labels; drug storage bin labels; medication administration records; and screens associated with pharmacy and prescriber computer order entry systems, automated dispensing cabinets, smart infusion pumps, and other medication-related technologies.

In the **Table**, error-prone abbreviations, symbols, and dose designations that are included on The Joint Commission's **"Do Not Use"** list (Information Management standard IM.02.02.01) are identified with a double asterisk (**) and must be included on an organization's **"Do Not Use"** list. Error-prone abbreviations, symbols, and dose designations that are relevant mostly in handwritten communications of medication information are highlighted with a dagger (†).

Table. Error-Prone Abbreviations, Symbols, and Dose Designations

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
Abbreviations for Doses/Measurement Units			
cc†	Cubic centimeters	Mistaken as u (units)	Use mL
IU**	International unit(s)	Mistaken as IV (intravenous) or the number 10	Use unit(s) (International units can be expressed as units alone)
l **ml**	Liter Milliliter	Lowercase letter l mistaken as the number 1	Use L (UPPERCASE) for liter Use mL (lowercase m, UPPERCASE L) for milliliter
MM or **M** **M** or **K**	Million Thousand	Mistaken as thousand Mistaken as million M has been used to abbreviate both million (begins with the letter m) and thousand (M is the Roman numeral for thousand)	Use million Use thousand

** On The Joint Commission's "Do Not Use" list
† Relevant mostly in handwritten medication information

List — continued on page 2 >

ISMP List of Error-Prone Abbreviations, Symbols, and Dose Designations

List — continued from page 1

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
Ng or **ng**	Nanogram	Mistaken as mg Mistaken as nasogastric	Use nanogram
U or **u****	Unit(s)	Mistaken as zero or the number 4, causing a 10-fold overdose or greater (e.g., 4U seen as 40 or 4u seen as 44) Mistaken as cc, leading to administration in volume instead of units (e.g., 4u seen as 4cc)	Use unit(s)
µg	Microgram	Mistaken as mg	Use mcg
Abbreviations for Route of Administration			
AD, AS, AU	Right ear, left ear, each ear	Mistaken as OD, OS, OU (right eye, left eye, each eye)	Use right ear, left ear, or each ear
IN	Intranasal	Mistaken as IM or IV	Use intranasal
IT	Intrathecal	Mistaken as intratracheal, intratumor, intratympanic, or inhalation therapy	Use intrathecal
OD, OS, OU	Right eye, left eye, each eye	Mistaken as AD, AS, AU (right ear, left ear, each ear)	Use right eye, left eye, or each eye
Per os	By mouth, orally	The os mistaken as left eye (OS, oculus sinister)	Use PO, by mouth, or orally
SC, SQ, sq, or **sub q**†	Subcutaneous(ly)	SC and sc mistaken as SL or sl (sublingual) SQ mistaken as "5 every" The "q" in sub q has been mistaken as "every"	Use SUBQ (all UPPERCASE letters, without spaces or periods between letters), or subcutaneous(ly)
Abbreviations for Frequency/Instructions for Use			
o.d. or **OD**	Once daily	Mistaken as right eye (OD, oculus dexter), leading to oral liquid medications administered in the eye	Use daily
Q.D., QD, q.d., or **qd****†	Every day	Mistaken as q.i.d., especially if the period after the q or the tail of a handwritten q is misunderstood as the letter i	Use daily
Qhs†	Nightly at bedtime	Mistaken as qhr (every hour)	Use QHS or qhs for bedtime
Qn†	Nightly or at bedtime	Mistaken as qh (every hour)	Use QHS or qhs for bedtime

** On The Joint Commission's "Do Not Use" list
† Relevant mostly in handwritten medication information

List — continued on page 3 >

ISMP List of Error-Prone Abbreviations, Symbols, and Dose Designations

List — continued from page 2

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
Q.O.D., QOD, q.o.d., or **qod****†**	Every other day	Mistaken as qd (daily) or qid (four times daily), especially if the "o" is poorly written	Use every other day
q1d	Daily	Mistaken as qid (four times daily)	Use daily
q6PM, etc.	Every evening at 6 PM	Mistaken as every 6 hours	Use daily at 6 PM or 6 PM daily
SSRI **SSI**	Sliding scale regular insulin Sliding scale insulin	Mistaken as selective-serotonin reuptake inhibitor Mistaken as Strong Solution of Iodine (Lugol's)	Use sliding scale (insulin)
TIW or **tiw** **BIW** or **biw**	3 times a week 2 times a week	Mistaken as 3 times a day or twice in a week Mistaken as 2 times a day	Use 3 times weekly Use 2 times weekly
UD	As directed (ut dictum)	Mistaken as unit dose (e.g., an order for "dil**TIAZ**em infusion UD" mistakenly administered as a unit [bolus] dose)	Use as directed
Miscellaneous Abbreviations Associated with Medication Use			
BBA **BGB**	Baby boy A (twin) Baby girl B (twin)	B in BBA mistaken as twin B rather than gender (boy) B at end of BGB mistaken as gender (boy) not twin B	When assigning identifiers to newborns, use the mother's last name, the baby's gender (boy or girl), and a distinguishing identifier for all multiples (e.g., Smith boy A, Smith girl B)
D/C	Discharge or discontinue	Premature discontinuation of medications if D/C (intended to mean discharge) on a medication list has been misinterpreted as discontinued	Use discharge and discontinue or stop
IJ	Injection	Mistaken as IV or intrajugular	Use injection
OJ	Orange juice	Mistaken as OD or OS (right or left eye); drugs meant to be diluted in orange juice may be given in the eye	Use orange juice
Period following abbreviations (e.g., mg., mL.)†	mg or mL	Unnecessary period mistaken as the number 1, especially if written poorly	Use mg, mL, etc., without a terminal period

** On The Joint Commission's "Do Not Use" list
† Relevant mostly in handwritten medication information

List — continued on page 4 >

ISMP List of Error-Prone Abbreviations, Symbols, and Dose Designations

List — continued from page 3

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
Drug Name Abbreviations			
To prevent confusion, avoid abbreviating drug names entirely. Exceptions may be made for multi-ingredient drug formulations, including vitamins, when there are electronic drug name field space constraints; however, drug name abbreviations should NEVER be used for any medications on the ***ISMP List of High-Alert Medications*** (in Acute Care Settings [www.ismp.org/node/103], Community/Ambulatory Settings [www.ismp.org/node/129], and Long-Term Care Settings [www.ismp.org/node/130]). Examples of drug name abbreviations involved in serious medication errors include:			
Antiretroviral medications (e.g., DOR, TAF, TDF)	DOR: doravirine TAF: tenofovir alafenamide TDF: tenofovir disoproxil fumarate	DOR: Dovato (dolutegravir and lami**VUD**ine) TAF: tenofovir disoproxil fumarate TDF: tenofovir alafenamide	Use complete drug name
APAP	acetaminophen	Not recognized as acetaminophen	Use complete drug name
AT II and AT III	AT II: angiotensin II (Giapreza) AT III: antithrombin III (Thrombate III)	AT II (angiotensin II) mistaken as AT III (antithrombin III) AT III (antithrombin III) mistaken as AT II (angiotensin II)	Use complete drug names
AZT	zidovudine (Retrovir)	Mistaken as azithromycin, aza**THIO**prine, or aztreonam	Use complete drug name
CPZ	Compazine (prochlorperazine)	Mistaken as chlorpro**MAZINE**	Use complete drug name
DTO	diluted tincture of opium, or deodorized tincture of opium (Paregoric)	Mistaken as tincture of opium	Use complete drug name
HCT	hydrocortisone	Mistaken as hydro**CHLORO**thiazide	Use complete drug name
HCTZ	hydro**CHLORO**thiazide	Mistaken as hydrocortisone (seen as HCT250 mg)	Use complete drug name
MgSO4**	magnesium sulfate	Mistaken as morphine sulfate	Use complete drug name
MS, MSO4**	morphine sulfate	Mistaken as magnesium sulfate	Use complete drug name
MTX	methotrexate	Mistaken as mito**XANTRONE**	Use complete drug name
Na at the beginning of a drug name (e.g., Na bicarbonate)	Sodium bicarbonate	No bicarbonate	Use complete drug name
NoAC	novel/new oral anticoagulant	Mistaken as no anticoagulant	Use complete drug name
OXY	oxytocin	Mistaken as oxy**CODONE**, Oxy**CONTIN**	Use complete drug name

** On The Joint Commission's "Do Not Use" list
† Relevant mostly in handwritten medication information

List — continued on page 5 >

ISMP List of Error-Prone Abbreviations, Symbols, and Dose Designations

List — continued from page 4

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
PCA	procainamide	Mistaken as patient-controlled analgesia	Use complete drug name
PIT	Pitocin (oxytocin)	Mistaken as Pitressin, a discontinued brand of vasopressin still referred to as PIT	Use complete drug name
PNV	prenatal vitamins	Mistaken as penicillin VK	Use complete drug name
PTU	propylthiouracil	Mistaken as Purinethol (mercaptopurine)	Use complete drug name
T3	Tylenol with codeine No. 3	Mistaken as liothyronine, which is sometimes referred to as T3	Use complete drug name
TAC or **tac**	triamcinolone, tacrolimus	Mistaken as tacrolimus Mistaken as triamcinolone Mistaken as tetracaine, Adrenalin, and cocaine; or as Taxotere, Adriamycin, and cyclo**PHOS**phamide	Use complete drug names Avoid drug regimen or protocol acronyms that may have a dual meaning or may be confused with other common acronyms, even if defined in an order set
TNK	TNKase	Mistaken as TPA	Use complete drug name
TPA or **tPA**	tissue plasminogen activator, Activase (alteplase)	Mistaken as TNK (TNKase, tenecteplase), TXA (tranexamic acid), or less often as another tissue plasminogen activator, Retavase (retaplase)	Use complete drug names
TXA	tranexamic acid	Mistaken as TPA (tissue plasminogen activator)	Use complete drug name
ZnSO4	zinc sulfate	Mistaken as morphine sulfate	Use complete drug name
Stemmed/Coined Drug Names			
Nitro drip	nitroglycerin infusion	Mistaken as nitroprusside infusion	Use complete drug name
IV vanc	Intravenous vancomycin	Mistaken as Invanz	Use complete drug name
Levo	levofloxacin	Mistaken as Levophed (norepinephrine)	Use complete drug name
Neo	Neo-Synephrine, a well-known but discontinued brand of phenylephrine	Mistaken as neostigmine	Use complete drug name

** On The Joint Commission's "Do Not Use" list
† Relevant mostly in handwritten medication information

List — continued on page 6 >

ISMP List of Error-Prone Abbreviations, Symbols, and Dose Designations

List — continued from page 5

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
Coined names for compounded products (e.g., magic mouthwash, banana bag, GI cocktail, half and half, pink lady)	Specific ingredients compounded together	Mistaken ingredients	Use complete drug/product names for all ingredients Coined names for compounded products should only be used if the contents are standardized and readily available for reference to prescribers, pharmacists, and nurses
Number embedded in drug name (not part of the official name) (e.g., 5-fluorouracil, 6-mercaptopurine)	fluorouracil, mercaptopurine	Embedded number mistaken as the dose or number of tablets/capsules to be administered	Use complete drug name, without an embedded number if the number is not part of the official drug name
Dose Designations and Other Information			
1/2 tablet	Half tablet	1 or 2 tablets	Use text (half tablet); avoid using fractions or decimals (i.e., 0.5 tablet, 1.5 tablets)
Doses expressed as Roman numerals (e.g., V)	5	Mistaken as the designated letter (e.g., the letter V) or the wrong numeral (e.g., 10 instead of 5)	Use only Arabic numerals (e.g., 1, 2, 3) to express doses
Lack of a leading zero before a decimal point (e.g., .5 mg)**	0.5 mg	Mistaken as 5 mg if the decimal point is not seen	Use a leading zero before a decimal point when the dose is less than one measurement unit
Trailing zero after a decimal point (e.g., 1.0 mg)**	1 mg	Mistaken as 10 mg if the decimal point is not seen	Do not use trailing zeros for doses expressed in whole numbers
Ratio expression of a strength of a single-entity injectable drug product (e.g., EPINEPHrine 1:1,000; 1:10,000; 1:100,000)	1:1,000: contains 1 mg/mL 1:10,000: contains 0.1 mg/mL 1:100,000: contains 0.01 mg/mL	Mistaken as the wrong strength	Express the strength in terms of quantity per total volume (e.g., **EPINEPH**rine 1 mg per 10 mL) Exception: combination local anesthetics (e.g., lidocaine 1% and **EPINEPH**rine 1:100,000)
Drug name and dose run together (especially problematic for drug names that end in "l" [e.g., propranolol20 mg; TEGretol300 mg])	propranolol 20 mg **TEG**retol 300 mg	**Propranolol20 mg** mistaken as propranolol 120 mg **TEGretol300 mg** mistaken as **TEG**retol 1300 mg	Place adequate space between the drug name, dose, and unit of measure

** On The Joint Commission's "Do Not Use" list
† Relevant mostly in handwritten medication information

List — continued on page 7 >

ISMP List of Error-Prone Abbreviations, Symbols, and Dose Designations

List — continued from page 6

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
Numerical dose and unit of measure run together (e.g., 10mg, 10Units)	10 mg 10 units	The m in mg, or U in Units, has been mistaken as one or two zeros when flush against the dose (e.g., 10mg, 10Units), risking a 10- to 100-fold overdose	Place adequate space between the dose and unit of measure
Large doses without properly placed commas (e.g., 100000 units; 1000000 units)	100,000 units 1,000,000 units	100000 has been mistaken as 10,000 or 1,000,000 1000000 has been mistaken as 100,000	Use commas for dosing units at or above 1,000, or use words such as 100 thousand or 1 million to improve readability **Note:** Use commas to separate digits only in the United States; commas are used in place of decimal points in some other countries
Symbols			
ʒ or ♍ †	Dram Minim	Symbol for dram mistaken as the number 3 Symbol for minim mistaken as mL	Use the metric system
x1	Administer once	Administer for 1 day	Use explicit words (e.g., for 1 dose)
> and <	More than and less than	Mistaken as opposite of intended Mistakenly used the incorrect symbol < mistaken as the number 4 when handwritten (e.g., <10 misread as 40)	Use "more than" or "less than"
↑ and ↓†	Increase and decrease	Mistaken as opposite of intended Mistakenly used the incorrect symbol ↑ mistaken as the letter T, leading to misinterpretation as the beginning of a drug name or the numbers 4 or 7	Use increase and decrease

** On The Joint Commission's "Do Not Use" list
† Relevant mostly in handwritten medication information

List — continued on page 8 >

ISMP List of Error-Prone Abbreviations, Symbols, and Dose Designations

List — continued from page 7

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
/ (slash mark)†	Separates two doses	Mistaken as the number 1 (e.g., 25 units/10 units misread as 25 units and 110 units)	Use and rather than a slash mark to separate doses
@†	At	Mistaken as the number 2	Use at
&†	And	Mistaken as the number 2	Use and
+†	Plus or and	Mistaken as the number 4	Use plus, and, or in addition to
° †	Hour	Mistaken as a zero (e.g., q2° seen as q20)	Use hr, h, or hour
Φ or ⌀†	Zero, null sign	Mistaken as the numbers 4, 6, 8, and 9	Use 0 or zero, or describe intent using whole words
#	Pound(s)	Mistaken as a number sign	Use the metric system (kg or g) rather than pounds Use lb if referring to pounds
Apothecary or Household Abbreviations			
Explicit apothecary or household measurements may **ONLY** be safely used to express the directions for mixing dry ingredients to prepare topical products (e.g., dissolve 2 capfuls of granules per gallon of warm water to prepare a magnesium sulfate soaking aid). Otherwise, metric system measurements should be used.			
gr	Grain(s)	Mistaken as gram	Use the metric system (e.g., mcg, g)
dr	Dram(s)	Mistaken as doctor	Use the metric system (e.g., mL)
min	Minim(s)	Mistaken as minutes	Use the metric system (e.g., mL)
oz	Ounce(s)	Mistaken as zero or 02	Use the metric system (e.g., mL)
tsp	Teaspoon(s)	Mistaken as tablespoon(s)	Use the metric system (e.g., mL)
tbsp or **Tbsp**	Tablespoon(s)	Mistaken as teaspoon(s)	Use the metric system (e.g., mL)

** On The Joint Commission's "Do Not Use" list
† Relevant mostly in handwritten medication information

While the abbreviations, symbols, and dose designations in the **Table** should **NOT** be used, not allowing the use of **ANY** abbreviations is exceedingly unlikely. When organizational approved abbreviations are used, the person who uses the abbreviation must understand the risk of misinterpretation. If an uncommon or ambiguous abbreviation is used, it may not be understood correctly, and it should be defined by the writer/sender. Where uncertainty exists, clarification with the one who used the abbreviation is required.

*Report medication errors to the **ISMP National Medication Errors Reporting Program** (ISMP MERP) at: www.ismp.org/MERP.*

ISMP List of Error-Prone Abbreviations, Symbols, and Dose Designations

The abbreviations, symbols, and dose designations in the **Table** below were reported to ISMP through the ISMP National Medication Errors Reporting Program (ISMP MERP) and have been misinterpreted and involved in harmful or potentially harmful medication errors. These abbreviations, symbols, and dose designations should **NEVER** be used when communicating medical information verbally, electronically, and/or in handwritten applications. This includes internal communications; verbal, handwritten, or electronic prescriptions; hand-written and computer-generated medication labels; drug storage bin labels; medication administration records; and screens associated with pharmacy and prescriber computer order entry systems, automated dispensing cabinets, smart infusion pumps, and other medication-related technologies.

In the **Table**, error-prone abbreviations, symbols, and dose designations that are included on The Joint Commission's "**Do Not Use**" list (Information Management standard IM.02.02.01) are identified with a double asterisk (**) and must be included on an organization's "**Do Not Use**" list. Error-prone abbreviations, symbols, and dose designations that are relevant mostly in hand-written communications of medication information are highlighted with a dagger (†).

Table. Error-Prone Abbreviations, Symbols, and Dose Designations

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
Abbreviations for Doses/Measurement Units			
cc	Cubic centimeters	Mistaken as u (units)	Use mL
IU**	International unit(s)	Mistaken as IV (intravenous) or the number 10	Use unit(s) (International units can be expressed as units alone)
l **ml**	Liter Milliliter	Lowercase letter l mistaken as the number 1	Use L (UPPERCASE) for liter Use mL (lowercase m, UPPERCASE L) for milliliter
MM or M **M or K**	Million Thousand	Mistaken as thousand Mistaken as million M has been used to abbreviate both million and thousand (M is the Roman numeral for thousand)	Use million Use thousand
Ng or ng	Nanogram	Mistaken as mg Mistaken as nasogastric	Use nanogram or nanog
U or u**	Unit(s)	Mistaken as zero or the number 4, causing a 10-fold overdose or greater (e.g., 4U seen as 40 or 4u seen as 44) Mistaken as cc, leading to administering volume instead of units (e.g., 4u seen as 4cc)	Use unit(s)
µg	Microgram	Mistaken as mg	Use mcg
Abbreviations for Route of Administration			
AD, AS, AU	Right ear, left ear, each ear	Mistaken as OD, OS, OU (right eye, left eye, each eye)	Use right ear, left ear, or each ear
IN	Intranasal	Mistaken as IM or IV	Use NAS (all UPPERCASE letters) or intranasal

** On The Joint Commission's **"Do Not Use"** list
† Relevant mostly in handwritten medication information

List continued on page 2

List — continued from page 1

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
IT	Intrathecal	Mistaken as intratracheal, intratumor, intratympanic, or inhalation therapy	Use intrathecal
OD, OS, OU	Right eye, left eye, each eye	Mistaken as AD, AS, AU (right ear, left ear, each ear)	Use right eye, left eye, or each eye
Per os	By mouth, orally	The os was mistaken as left eye (OS, oculus sinister)	Use PO, by mouth, or orally
SC, SQ, sq, or sub q	Subcutaneous(ly)	SC and sc mistaken as SL or sl (sublingual) SQ mistaken as "5 every" The q in sub q has been mistaken as "every"	Use SUBQ (all UPPERCASE letters, without spaces or periods between letters) or subcutaneous(ly)
Abbreviations for Frequency/Instructions for Use			
HS **hs**	Half-strength At bedtime, hours of sleep	Mistaken as bedtime Mistaken as half-strength	Use half-strength Use HS (all UPPERCASE letters) for bedtime
o.d. or OD	Once daily	Mistaken as right eye (OD, oculus dexter), leading to oral liquid medications administered in the eye	Use daily
Q.D., QD, q.d., or qd**	Every day	Mistaken as q.i.d., especially if the period after the q or the tail of a handwritten q is misunderstood as the letter i	Use daily
Qhs	Nightly at bedtime	Mistaken as qhr (every hour)	Use nightly or HS for bedtime
Qn	Nightly or at bedtime	Mistaken as qh (every hour)	Use nightly or HS for bedtime
Q.O.D., QOD, q.o.d., or qod**	Every other day	Mistaken as qd (daily) or qid (four times daily), especially if the "o" is poorly written	Use every other day
q1d	Daily	Mistaken as qid (four times daily)	Use daily
q6PM, etc.	Every evening at 6 PM	Mistaken as every 6 hours	Use daily at 6 PM or 6 PM daily
SSRI **SSI**	Sliding scale regular insulin Sliding scale insulin	Mistaken as selective-serotonin reuptake inhibitor Mistaken as Strong Solution of Iodine (Lugol's)	Use sliding scale (insulin)
TIW or tiw **BIW or biw**	3 times a week 2 times a week	Mistaken as 3 times a day or twice in a week Mistaken as 2 times a day	Use 3 times weekly Use 2 times weekly
UD	As directed (ut dictum)	Mistaken as unit dose (e.g., an order for "dil**TIAZ**em infusion UD" was mistakenly administered as a unit [bolus] dose)	Use as directed

** On The Joint Commission's **"Do Not Use"** list
† Relevant mostly in handwritten medication information

List — continued on page 3

List — continued from page 2

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
Miscellaneous Abbreviations Associated with Medication Use			
BBA **BGB**	Baby boy A (twin) Baby girl B (twin)	B in BBA mistaken as twin B rather than gender (boy) B at end of BGB mistaken as gender (boy) not twin B	When assigning identifiers to newborns, use the mother's last name, the baby's gender (boy or girl), and a distinguishing identifier for all multiples (e.g., Smith girl A, Smith girl B)
D/C	Discharge or discontinue	Premature discontinuation of medications when D/C (intended to mean discharge) on a medication list was misinterpreted as discontinued	Use discharge and discontinue or stop
IJ	Injection	Mistaken as IV or intrajugular	Use injection
OJ	Orange juice	Mistaken as OD or OS (right or left eye); drugs meant to be diluted in orange juice may be given in the eye	Use orange juice
Period following abbreviations (e.g., mg., mL.)†	mg or mL	Unnecessary period mistaken as the number 1, especially if written poorly	Use mg, mL, etc., without a terminal period
Drug Name Abbreviations			
To prevent confusion, avoid abbreviating drug names entirely. Exceptions may be made for multi-ingredient drug formulations, including vitamins, when there are electronic drug name field space constraints; however, drug name abbreviations should NEVER be used for any medications on the *ISMP List of High-Alert Medications* (in Acute Care Settings [www.ismp.org/node/103], Community/Ambulatory Settings [www.ismp.org/node/129], and Long-Term Care Settings [www.ismp.org/node/130]). Examples of drug name abbreviations involved in serious medication errors include:			
Antiretroviral medications (e.g., DOR, TAF, TDF)	DOR: doravirine TAF: tenofovir alafenamide TDF: tenofovir disoproxil fumarate	DOR: Dovato (dolutegravir and lami**VUD**ine) TAF: tenofovir disoproxil fumarate TDF: tenofovir alafenamide	Use complete drug names
APAP	acetaminophen	Not recognized as acetaminophen	Use complete drug name
ARA-A	vidarabine	Mistaken as cytarabine ("ARA C")	Use complete drug name
AT II and AT III	AT II: angiotensin II (Giapreza) AT III: antithrombin III (Thrombate III)	AT II (angiotensin II) mistaken as AT III (antithrombin III) AT III (antithrombin III) mistaken as AT II (angiotensin II)	Use complete drug names
AZT	zidovudine (Retrovir)	Mistaken as azithromycin, aza**THIO**prine, or aztreonam	Use complete drug name
CPZ	Compazine (prochlorperazine)	Mistaken as chlorpro**MAZINE**	Use complete drug name
DTO	diluted tincture of opium or deodorized tincture of opium (Paregoric)	Mistaken as tincture of opium	Use complete drug name

** On The Joint Commission's "**Do Not Use**" list
† Relevant mostly in handwritten medication information

List — continued on page 4 ▶

List — continued from page 3

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
HCT	hydrocortisone	Mistaken as hydro**CHLORO**thiazide	Use complete drug name
HCTZ	hydro**CHLORO**thiazide	Mistaken as hydrocortisone (e.g., seen as HCT250 mg)	Use complete drug name
MgSO4**	magnesium sulfate	Mistaken as morphine sulfate	Use complete drug name
MS, MSO4**	morphine sulfate	Mistaken as magnesium sulfate	Use complete drug name
MTX	methotrexate	Mistaken as mito**XANTRONE**	Use complete drug name
Na at the beginning of a drug name (e.g., Na bicarbonate)	Sodium bicarbonate	Mistaken as no bicarbonate	Use complete drug name
NoAC	novel/new oral anticoagulant	Mistaken as no anticoagulant	Use complete drug name
OXY	oxytocin	Mistaken as oxy**CODONE**, Oxy**CONTIN**	Use complete drug name
PCA	procainamide	Mistaken as patient-controlled analgesia	Use complete drug name
PIT	Pitocin (oxytocin)	Mistaken as Pitressin, a discontinued brand of vasopressin still referred to as PIT	Use complete drug name
PNV	prenatal vitamins	Mistaken as penicillin VK	Use complete drug name
PTU	propylthiouracil	Mistaken as Purinethol (mercaptopurine)	Use complete drug name
T3	Tylenol with codeine No. 3	Mistaken as liothyronine, which is sometimes referred to as T3	Use complete drug name
TAC or tac	triamcinolone or tacrolimus	Mistaken as tetracaine, Adrenalin, and cocaine; or as Taxotere, Adriamycin, and cyclophosphamide	Use complete drug names Avoid drug regimen or protocol acronyms that may have a dual meaning or may be confused with other common acronyms, even if defined in an order set
TNK	TNKase	Mistaken as TPA	Use complete drug name
TPA or tPA	tissue plasminogen activator, Activase (alteplase)	Mistaken as TNK (TNKase, tenecteplase), TXA (tranexamic acid), or less often as another tissue plasminogen activator, Retavase (retaplase)	Use complete drug names
TXA	tranexamic acid	Mistaken as TPA (tissue plasminogen activator)	Use complete drug name
ZnSO4	zinc sulfate	Mistaken as morphine sulfate	Use complete drug name
Stemmed/Coined Drug Names			
Nitro drip	nitroglycerin infusion	Mistaken as nitroprusside infusion	Use complete drug name
IV vanc	Intravenous vancomycin	Mistaken as Invanz	Use complete drug name
Levo	levofloxacin	Mistaken as Levophed (norepinephrine)	Use complete drug name

** On The Joint Commission's **"Do Not Use"** list
† Relevant mostly in handwritten medication information

List — continued on page 5

List — continued from page 4

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
Neo	Neo-Synephrine, a well-known but discontinued brand of phenylephrine	Mistaken as neostigmine	Use complete drug name
Coined names for compounded products (e.g., magic mouthwash, banana bag, GI cocktail, half and half, pink lady)	Specific ingredients compounded together	Mistaken ingredients	Use complete drug/product names for all ingredients Coined names for compounded products should only be used if the contents are standardized and readily available for reference to prescribers, pharmacists, and nurses
Number embedded in drug name (not part of the official name) (e.g., 5-fluorouracil, 6-mercaptopurine)	fluorouracil mercaptopurine	Embedded number mistaken as the dose or number of tablets/capsules to be administered	Use complete drug names, without an embedded number if the number is not part of the official drug name
Dose Designations and Other Information			
1/2 tablet	Half tablet	1 or 2 tablets	Use text (half tablet) or reduced font size fractions (½ tablet)
Doses expressed as Roman numerals (e.g., V)	5	Mistaken as the designated letter (e.g., the letter V) or the wrong numeral (e.g., 10 instead of 5)	Use only Arabic numerals (e.g., 1, 2, 3) to express doses
Lack of a leading zero before a decimal point (e.g., .5 mg)**	0.5 mg	Mistaken as 5 mg if the decimal point is not seen	Use a leading zero before a decimal point when the dose is less than one measurement unit
Trailing zero after a decimal point (e.g., 1.0 mg)**	1 mg	Mistaken as 10 mg if the decimal point is not seen	Do not use trailing zeros for doses expressed in whole numbers
Ratio expression of a strength of a single-entity injectable drug product (e.g., EPINEPHrine 1:1,000; 1:10,000; 1:100,000)	1:1,000: contains 1 mg/mL 1:10,000: contains 0.1 mg/mL 1:100,000: contains 0.01 mg/mL	Mistaken as the wrong strength	Express the strength in terms of quantity per total volume (e.g., **EPINEPH**rine 1 mg per 10 mL) **Exception:** combination local anesthetics (e.g., lidocaine 1% and **EPINEPH**rine 1:100,000)
Drug name and dose run together (problematic for drug names that end in the letter l [e.g., propranolol20 mg; TEGretol300 mg])	propranolol 20 mg **TEG**retol 300 mg	Mistaken as propranolol 120 mg Mistaken as **TEG**retol 1300 mg	Place adequate space between the drug name, dose, and unit of measure
Numerical dose and unit of measure run together (e.g., 10mg, 10Units)	10 mg 10 mL	The m in mg, or U in Units, has been mistaken as one or two zeros when flush against the dose (e.g., 10mg, 10Units), risking a 10- to 100-fold overdose	Place adequate space between the dose and unit of measure

** On The Joint Commission's "**Do Not Use**" list
† Relevant mostly in handwritten medication information

List — continued on page 6

List — continued from page 5

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
Large doses without properly placed commas (e.g., 100000 units; 1000000 units)	100,000 units 1,000,000 units	100000 has been mistaken as 10,000 or 1,000,000 1000000 has been mistaken as 100,000	Use commas for dosing units at or above 1,000 or use words such as 100 thousand or 1 million to improve readability **Note:** Use commas to separate digits only in the US; commas are used in place of decimal points in some other countries
Symbols			
3 or ♏	Dram Minim	Symbol for dram mistaken as the number 3 Symbol for minim mistaken as mL	Use the metric system
x1	Administer once	Administer for 1 day	Use explicit words (e.g., for 1 dose)
> and <	More than and less than	Mistaken as opposite of intended Mistakenly have used the incorrect symbol < mistaken as the number 4 when handwritten (e.g., <10 misread as 40)	Use more than or less than
† and ↓†	Increase and decrease	Mistaken as opposite of intended Mistakenly have used the incorrect symbol † mistaken as the letter T, leading to misinterpretation as the start of a drug name, or mistaken as the numbers 4 or 7	Use increase and decrease
/ (slash mark)†	Separates two doses or indicates per	Mistaken as the number 1 (e.g., 25 units/10 units misread as 25 units and 110 units)	Use per rather than a slash mark to separate doses
@†	At	Mistaken as the number 2	Use at
&†	And	Mistaken as the number 2	Use and
++	Plus or and	Mistaken as the number 4	Use plus, and, or in addition to
º	Hour	Mistaken as a zero (e.g., q2º seen as q20)	Use hr, h, or hour
Φ or ø†	Zero, null sign	Mistaken as the numbers 4, 6, 8, and 9	Use 0 or zero, or describe intent using whole words
#	Pound(s)	Mistaken as a number sign	Use the metric system (kg or g) rather than pounds Use lb if referring to pounds

** On The Joint Commission's "**Do Not Use**" list
† Relevant mostly in handwritten medication information

List — continued on page 7

List — continued from page 6

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
Apothecary or Household Abbreviations			
Explicit apothecary or household measurements may **ONLY** be safely used to express the directions for mixing dry ingredients to prepare topical products (e.g., dissolve 2 capfuls of granules per gallon of warm water to prepare a magnesium sulfate soaking aid). Otherwise, metric system measurements should be used.			
gr	Grain(s)	Mistaken as gram	Use the metric system (e.g., mcg, g)
dr	Dram(s)	Mistaken as doctor	Use the metric system (e.g., mL)
min	Minim(s)	Mistaken as minutes	Use the metric system (e.g., mL)
oz	Ounce(s)	Mistaken as zero or 0_2	Use the metric system (e.g., mL)
tsp	Teaspoon(s)	Mistaken as tablespoon(s)	Use the metric system (e.g., mL)
tbsp or Tbsp	Tablespoon(s)	Mistaken as teaspoon(s)	Use the metric system (e.g., mL)
Common Abbreviations with Contradictory Meanings	**Contradictory Meanings**		**Correction**
For additional information and tables from Neil Davis (MedAbbrev.com) containing additional examples of abbreviations with contradictory or ambiguous meanings, please visit: www.ismp.org/ext/638.			
B	Breast, brain, or bladder		Use breast, brain, or bladder
C	Cerebral, coronary, or carotid		Use cerebral, coronary, or carotid
D or d	Day or dose (e.g., parameter based dosing formulas using D or d [mg/kg/d] could be interpreted as either day or dose [mg/kg/day or mg/kg/dose]; or x3d could be interpreted as either 3 days or 3 doses)		Use day or dose
H	Hand or hip		Use hand or hip
I	Impaired or improvement		Use impaired or improvement
L	Liver or lung		Use liver or lung
N	No or normal		Use no or normal
P	Pancreas, prostate, preeclampsia, or psychosis		Use pancreas, prostate, preeclampsia, or psychosis
S	Special or standard		Use special or standard
SS or ss	Single strength, sliding scale (insulin), signs and symptoms, or ½ (apothecary) SS has also been mistaken as the number 55		Use single strength, sliding scale, signs and symptoms, or one half or ½

** On The Joint Commission's "**Do Not Use**" list
† Relevant mostly in handwritten medication information

While the abbreviations, symbols, and dose designations in the **Table** should **NEVER** be used, not allowing the use of **ANY** abbreviations is exceedingly unlikely. Therefore, the person who uses an organization approved abbreviation must take responsibility for making sure that it is properly interpreted. If an uncommon or ambiguous abbreviation is used, and it should be defined by the writer or sender. Where uncertainty exists, clarification with the person who used the abbreviation is required.

The Joint Commission

Official "Do Not Use" List

The Joint Commission
FACT SHEET

- This list is part of the Information Management standards
- Does not apply to preprogrammed health information technology systems (i.e. electronic medical records or CPOE systems), but remains under consideration for the future

Organizations contemplating introduction or upgrade of such systems should strive to eliminate the use of dangerous abbreviations, acronyms, symbols and dose designations from the software.

Official "Do Not Use" List[1]

Do Not Use	Potential Problem	Use Instead
U, u (unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily)	Mistaken for each other	Write "daily"
Q.O.D., QOD, q.o.d, qod (every other day)	Period after the Q mistaken for "I" and the "O" mistaken for "I	Write "every other day"
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS	Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate" Write "magnesium sulfate"
MSO_4 and $MgSO_4$	Confused for one another	

[1]Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

***Exception:** A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Development of the "Do Not Use" List
In 2001, The Joint Commission issued a *Sentinel Event Alert* on the subject of medical abbreviations. A year later, its Board of Commissioners approved a National Patient Safety Goal requiring accredited organizations to develop and implement a list of abbreviations not to use. In 2004, The Joint Commission created its "Do Not Use" List to meet that goal. In 2010, NPSG.02.02.01 was integrated into the Information Management standards as elements of performance 2 and 3 under IM.02.02.01.

For more information

- Complete the Standards Online Question Submission Form.
- Contact the Standards Interpretation Group at 630-792-5900.

8/20

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**ACCOUNTING OF DISCLOSURE OF PATIENT INFORMATION (PHI)**
Purpose:	To outline the procedure for capturing information on disclosures of patient information which Tri-City Medical Center (TCMC) is required to account and track
Supportive Data:	Reporting reference included on reverse side of form.
Equipment:	Form – TCMC Accounting of Disclosures Form

A. **PROCEDURE:**

1. Clinical Departments and Nursing Units:
   - a. Complete and forward the attached form for each disclosure referenced, to the Privacy Officer.
   - b. Record the patient identifying information (patient name, medical record number, account number).
   - c. Record specific information relating to the recipient of the disclosed information.
     - i. Name of Requestor (person's name)
     - ii. Name of Entity (facility name)
     - iii. Current Address (location of the entity)
   - d. Record the purpose of the disclosure by marking off the appropriate box on the form. Check only one box per disclosure.
   - e. Record the reason for the disclosure by marking off the appropriate box.
     - i. State or Federal law or regulation
     - ii. Court order (attach accompanying supporting documentation)
     - iii. Other – specify reason for the disclosure
   - f. Record a description of the information disclosed (i.e., lab results, Form #1234)
   - g. Record the treatment date for the information disclosed.
   - h. Identify the originating location of the information disclosed (i.e., medical record for lab results).
   - i. Record the method of disclosure by marking off the box that describes how the information was disclosed. Multiple answers to this question may apply and can be recorded on the single form.
   - j. Print the name, department, and date of disclosure.
   - k. Forward the completed sheet to the Privacy Officer for data entry into the Release of Information database.
2. Privacy Office/Release of Information
   - a. Stamp the Accounting of Disclosures form upon receipt.
   - b. Log into the electronic health record (EHR).
   - c. Identify the patient based upon the identifying information provided on the disclosure form.
   - d. Insert/Add the disclosure utilizing the following information:
     - i. Name of Entity (Organization)
     - ii. Purpose of Disclosure (response that begins with prefix PRI)
     - iii. Reason for Disclosure
     - iv. Description of Information disclosed
     - v. Method of Disclosure
     - vi. Name of Person who disclosed (record in comments field)
   - e. Date and initial entry of the information into the tracking system
   - f. Scan completed document to the patient's medical record.

B. **FORMS:**

1. Accounting of Disclosures Form Sample
2. Disclosure Tracking References Form Sample

Patient Care Services Content Expert	Clinical Policies & Procedures	Nursing Leadership	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
7/03; 3/06; 3/09, 4/16, 04/25	7/11; 5/16, 10/21, 05/25	8/11; 5/16, 11/21, 08/25	n/a	n/a	n/a	11/21, 09/25	9/11; 6/16, n/a	9/11, 6/16, 12/21

TCMC - Accounting of Disclosures Form

Complete and submit to Medical Records/Health Information (Attn: Privacy Officer)
NOT PART OF THE PERMANENT RECORD

Disclosures to be entered in the Accounting:

Patient's Name: _____
Last First MI

Patient MRUN: _____ Acct #: _____

Disclosure made to:

Name of Requestor: _____ Name of Entity: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____ Phone #: _____

Purpose of Disclosure (check only one)

- ☐ Animal Bites
- ☐ Assault & Battery to on-duty Health Care Personnel
- ☐ Assault Victims – Domestic Violence
- ☐ Child Abuse (suspected)
- ☐ Chromosomal Defects in Fetus or Infant
- ☐ Drug Use (illegal)
- ☐ Elder and Dependent Abuse
- ☐ Firearms reporting
- ☐ Infectious Diseases (reportable)
- ☐ Lapses of Consciousness/Seizures
- ☐ Locating suspects, fugitives, and witnesses
- ☐ Mental Health Holds beyond 24 hours
- ☐ Missing Patient
- ☐ Multiple bee stings
- ☐ Neural Tube Defects in a Fetus
- ☐ Newborn Screening Test Re[illegible](PK[illegible]
- ☐ Occupational Injuries/Il[illegible]ses (if not t[illegible]ayment)
- ☐ Patient Death (not LifeS[illegible]ne Homes/Directors - standard releases)
- ☐ Patient Injury/Death due to faulty e[illegible]pment
- ☐ Patient Transfer Violation
- ☐ Pesticide Poisoning
- ☐ PKU Specimen not obtained
- ☐ Research if done without authorization
- ☐ Reye Syndrome
- ☐ Threat to Kill
- ☐ Unusual occurrences that threaten the welfare of the patient, staff or visitors
- ☐ Vendors/Contractors (if not for Treatment, Payment, Operations)
- ☐ Other (specify)

Why Disclosure Made: (check only one)

☐ State or Federal law or regulation ☐ Court Order ☐ Other _____

Brief Description of Information Disclosed:

This record was for treatment date: _____

This information is in a: ☐ Medical Record ☐ Billing Record ☐ Other (specify) _____

Method of Disclosure: ☐ Phone Call/Verbal ☐ Form Submission/Fax ☐ Other (specify) _____

Person Disclosing Records: (please print)

_____ **Last Name**

First Name **Department** **Date**

	Disclosure Tracking References			
	Disclosure Type	Disclosed by	Disclosed To	Method of Disclosure
1	Animal Bites	Emergency Department Business Office	Humane Society	Phone Call
2	Assault & Battery to on-duty Health Care Personnel	Security Department - Director	Law Enforcement, Employee Health, Risk Management	Phone call
3	Assault Victims - Domestic Violence	Emergency Department Business Office Registrars, Social Services, Security, Risk Management	Law Enforcement	Phone Call with written report follow-up
4	Cancer Reporting-Neoplasms	Oncology Data Registry	Dept of Health Services Cancer Protection Service	Data Abstract/Cnet
5	Certificate of Birth	Birth Certificate Clerk	San Diego County Registrar	Birth Certificate/AVSS
6	Child Abuse (suspected)	Social Services, Health Practitioner, Child Care Custodian	Child Protective Services, Local Law Enforcement	Phone Call with written report follow-up
7	Chromosomal Defects in Fetus or Infant	Lab performing the analysis or physician making diagnosis	Dept of Health Services	
8	Drug Use (Illegal)	Security Department	Oceanside Police	Phone Call with written report follow-up
9	Elder and Dependent Adult Abuse	Social Services, Health Practitioner, Care Custodian	County Adult Protective Services	Phone Call with written report follow-up
10	Firearms Reporting	BHU Nurse Designee	Dept of Justice	Firearms Report
11	Infectious Diseases (Reportable)	Physician, Nursing Staff, Emergency Department, Infection Control, Laboratory	Public Health Dept	Phone Call with written report follow-up
12	Lapses of Consciousness/Seizures	Central source of Medical Staff Support Services	Department of Motor Vehicles	Form (PM110) completed and faxed
13	Locating suspects, fugitives, and witnesses	Privacy Officer, Risk Management	Law Enforcement	Verbal with written report follow-up
14	Mental Health Holds beyond 24 hours	Director of Emergency Services	Dept of Health Services	Phone Call with written report follow-up
15	Missing Patient	Security Department	Law Enforcement	Phone Call with written report follow-up
16	Multiple bee stings	ED Nursing Staff Designee	Public Health Services	Phone Call with written report follow-up
17	Neural Tube Defects in a Fetus	MRD/HIM Director	Dept of Health Services - Alpha-Feto Protein Screening Program	Written report
18	Newborn Screening Test Refusal (PKU)	Maternal/Child Health Representative	Department of Health Services - Genetic Disease Branch	Written report (#NBS-PR)
19	Occupational Injuries/Illnesses (if not for payment)	Physician	Employer & Employee, Insurer	Written report
20	OSHPD (Office of State Healthwide Planning & Development)	MRD/HIM - semi-annual	OSHPD	Data Abstract/Electronic
21	Outbreaks or undue prevalence of infectious or parasitic disorder	Infection Control	Dept of Health Services	Form (PM110) completed and faxed
22	Patient Deaths	Health Care Practitioner, Physician	LifeSharing (organ donation), Medical Examiner, Funeral Homes/Directors, Dept of Health Services as required	Phone immediately
23	Patient Deaths due to unusual circumstances	Health Care Practitioner, Risk Manager	Law Enforcement, Medical Examiner, Dept of Health Services. HCHA (if relate	Phone Call with written report follow-up
24	Patient Injury/Death due to faulty equipment	Health Practitioner, Risk Manager	Federal Drug Admn - Medical Device & Lab product problem reporting program	Phone Call with written report follow-up
25	Patient Transfer Violation	Risk Manager	Dept of Health Services, HCFA	Phone Call with written report follow-up
26	Pesticide Poisoning	Emergency Department Nurse	Dept of Agriculture Health Officer	Phone Call
27	PKU Specimen not Obtained	Maternal/Child Health Representative	Dept of Health Services - Genetic Screening Branch	Form (BS-No-90)
28	Research if done without authorization	IRB Coordinator	Regulatory Agencies	Written
29	Reye's Syndrome	ED Dept, Central Source - Medical Staff Support Services	Dept of Health Services	Form (CBC Reye Syndrome) completed and submitted
30	Subpoenas, court orders, discovery request of other lawful process (unless authorization is provided)	MRD/HIM Release of Information Desk	Entities as outlined in the subpoena/court order.	Copy service copies as designated or copy mailed/delivered to court.
31	Threat to Kill	Psychotherapist, Behavioral Health Manager, Security, Risk Manager	Law Enforcement, Intended Victim	Phone immediately with written report follow-up
32	Unusual occurrences that threaten the welfare of the patient, staff or visitors	Health Care Practitioner, Risk Manager	Dept of Health Services, Law Enforcement	Phone Call with written report follow-up

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 02/03 **SUBJECT:** Autopsy, Authorization of

REVISION DATE~~(S)~~: 01/04, 12/05, 05/11, 02/15, 08/20

Patient Care Services Content Expert:	~~05/2008~~/24
Clinical Policies & Procedures Committee Approval:	~~05/2005~~/25
Nursing Leadership Approval:	~~06/2008~~/25
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~06/2009~~/25
Administration Approval:	~~07/2009~~/25
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/20

A. **PURPOSE:**
1. To outline the responsibilities for obtaining the legal signature of the next of kin or other to allow an autopsy to be performed.

B. **POLICY:**
1. A family member~~,~~ **or** physician~~, or the Medical Examiner~~ may request an autopsy.
   - **a.** If the agent and/or family requests an autopsy, ensure the family understands the financial obligation.
   - ~~a.~~**b. In the event an autopsy is requested, the Pathology Department will provide the family with contact information for an outside service that provides autopsies. Tri-City Medical Center does not cover the fee for such services.**

C. **PROCEDURE:**
1. It is the responsibility of the Registered Nurse (RN) assigned to care for the patient, **Patient Liaison** or Administrative Supervisor to obtain signature for an autopsy.
2. The following individuals may authorize an autopsy:
   - a. Agent appointed in patient's power of attorney for health care
   - b. Spouse/Registered domestic partner
   - c. Children of patient over age 18 or parent
   - d. Patient's sibling
   - e. Any other kin or person who has acquired the right to control the disposition of the remains
   - ~~f. A public administrator~~
   - ~~g.~~f. A coroner or any other duly authorized public officer (i.e., the state Curator of the Unclaimed Dead)
     - i. Their signature shall authorize the performance of a postmortem examination upon the decedent.
3. List any restrictions on the "Autopsy, Authorization of" form
   - a. If there are no restrictions, please write, "No Restrictions" in the same area on the form.
4. Place completed "Autopsy, Authorization of" form with completed "Release of Deceased" form and deliver both to Administrative Supervisor.

D. **FORM(S):**
1. Authorization for Autopsy 7520-1001- Sample

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

SAMPLE

AUTHORIZATION FOR AUTOPSY

Patient's Name: _____

Date: _____

Time: _____

1. I am one of the following persons authorized by law to direct disposition of the remains of the above-named patient.

   ❑ Patient ❑ Parent

   ❑ Spouse ❑ Brother/Sister

   ❑ Registered domestic partner

   ❑ Child (over the age of 18) ❑ Agent appointed in patient's Power of Attorney for health care (copy of Power of Attorney must be attached.)

   ❑ Other: _____

2. I hereby authorize the performance of a post-mortem examination upon the above-named patient.

3. In the hope that the above-authorized examination may benefit others by protecting or preserving their lives and well-being, the undersigned also authorizes the examining physician and surgeon to remove such specimens, tissues, and/or organs, and to retain, preserve, and/or contribute the same for such diagnostic, therapeutic, or other scientific purposes as he/she shall deem proper.

4. This authorization shall be subject to the following restrictions: _____
   _____
   _____
   _____

5. I understand that the examining physician and other physicians are not employees or agents of the hospital. They are independent contractors.

Signature: _____

Witness: _____

Witness: _____

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

Affix Patient Label

AUTHORIZATION FOR AUTOPSY

7520-1001
(Rev 5/05)

White - Medical Recs Yellow - Admin Coord. Pink - Labs

Tri-City Medical Center	Patient Care Service
PROCEDURE:	**BLOOD GLUCOSE POINT OF CARE TESTING**
Purpose:	To accurately determine blood glucose levels at the patient's bedside.
Supportive Data:	The blood glucose meter is used to monitor the blood glucose in patients who have been diagnosed by conventional means. The meter is not to be used for screening or diagnosis of diabetes. Personnel trained and assessed through the Point of Care program may perform this procedure. Testing is under the supervision of the Laboratory Point of Care Coordinator and under the jurisdiction of the Laboratory Medical Director.
Equipment:	Alcohol Swab Docking Station Gauze Gloves Luer lock needleless blood sampling access device Needleless cannula Blood Glucose Meter Single-use Lancet StatStrip cleaning strips StatStrip control solutions level 1 low (green bottle) & level 3 high (red bottle) StatStrip test strips

A. **DEFINITION(S):**

1. Critically ill adult: any patient receiving intensive medical intervention/therapy with decreased peripheral blood flow, as evidenced by one or more of the following:
   a. Severe hypotension requiring the administration of two or more intravenous vasopressors;
   b. Any patient with a core body temperature equal or less than (≤) 35°C;
   c. Any patient with Emergency Severity Index (ESI) of one.
2. Critically ill neonate: ~~all~~ neonates in the **Emergency Department with an Emergency Severity Index (ESI) of I or II**~~Neonatal Intensive Care Unit (NICU)~~ are defined as critically ill.

B. **PREPARE THE METER:**

1. Touch the screen to activate the meter.
   a. Note: the meter is designed such that the operator uses their finger when dealing with the touch screen. Any sharp or abrasive material may damage the meter.
   b. Blue bar with screen title at the top of the meter will prompt next step.
2. From the Welcome screen, Press OK/Login to begin.
   a. For troubleshooting hints see the blood glucose meter Troubleshooting Guide on the Tri-City Healthcare District (TCHD) Intranet under Departments>Clinical>Clinical Products.
3. Perform Quality Control (QC) if indicated by meter. Meter is configured to require a QC both high and low every 24 hours. Meter will lock out at 24 hours and screen will display QC Lockout L1/L3 QC required if QC not performed. See QC and Calibration section for instructions on completing the QC.
4. At the Enter Operator ID Screen, scan or manually enter your Operator Identification (ID). ID must be 5 digits long; use zeroes to precede a 3- or 4-digit Employee ID Number (EID). Press Ok/Accept.
5. At Patient Test screen press accept or select QC.
6. At the Enter Strip Lot screen, scan the strip lot from the bottle **and ensure it** matches the number displayed on the screen.

Patient Care Service Content Expert	Clinical Policies & Procedures	Nursinge Leadership ~~Executive Council~~	Department of Pathology	Pharmacy and Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/13, 08/16, 08/19, 03/20, **05/21, 10/24**	06/13, 08/16, 11/16, 09/19, 03/20, 08/21, **05/25**	06/13, 01/17, 09/19, 03/20, 10/21, **08/25**	04/18, 10/19, 04/20, **01/22, 09/25**	09/13, n/a	10/13, 04/18, 11/19, 05/20, 02/22, **09/25**	11/19, 06/20, 03/22, **09/25**	11/13, 05/18, n/a	12/13, 05/18, 12/19, 06/20, 03/22

7. At the Enter Patient ID screen, scan the -FIN barcode from the Patient's armband or manually enter Patient 7 digit Financial Identification Number (FIN#), Press Accept.
   a. Non-Registered Patients in emergent situations.
      i. Emergent patients should be issued a John/Jane Doe packet. Scan the FIN barcode symbol from the packet.
      ii. If packet not available, enter an invalid Patient ID to get to the downtime override key (use the following 7 digit FIN# 1 2 3 4 5 6 7)
      iii. Fill out the Point of Care Testing Correction Form
      iv. Available on TCMC Intranet, click on Forms Icon>~~Electronic~~ Forms>Patient Care Services Forms
8. At the Confirm Patient ID screen
   a. Valid Patient ID: Verify the FIN# (Account Number) and Patient Name are correct. Press Ok/Accept.
   b. Invalid Patient ID: The Admission/Discharge/Transfer (ADT) feature was unable to pull Patient Name. This will occur if the meter has not been recently downloaded and does not have current ADT information, if the scanned encounter has been discharged, or if the patient is not yet registered and a John/Jane Doe ID was scanned.
      i. Verify the Patient ID. If the correct number was scanned, and the encounter is current press Ok/Accept to Override. The Patient ID will be recognized by the data manager, the error resolved, and the result will chart.
      ii. If the encounter is not current, obtain an armband for the current encounter and continue testing. If staff press OK/Accept and Override a discharged encounter, the result will not chart. Staff must fill out the Point of Care Testing Correction Form and send it to the lab for error resolution.
      iii. If the patient a John/Jane Doe and is not yet registered, press OK/Accept to Override. When the patient is registered, complete the Point of Care Testing Correction Form.
9. At Select Sample Type screen, select the appropriate sample type as Capillary, Venous, Arterial or Neonatal Heel Stick, then press Accept.
10. At the Insert Strip screen, insert a test strip into the strip port ~~at the top of the meter~~. The print should face up and the gold contacts enter the meter.

C. **PATIENT PREPARATION:**
1. Critically ill adult:
   a. Only arterial or venous whole blood may be used. Do not use serum, plasma, or capillary blood.
      i. To obtain whole blood from an arterial catheter, follow procedure for blood sample collection in Online Clinical Skills Arterial Catheter: Blood Sampling.
      ii. To obtain whole blood from a central venous access device, follow procedure for blood sample collection in Patient Care Services (PCS) Procedure: Central Venous Access Devices, Adults.
      iii. To obtain whole blood by venipuncture, follow procedure for blood sample collection in PCS Venipuncture for Specimen Collection.
         1) Only fresh whole blood or whole blood collected in lithium heparin collection device should be used for arterial and venous specimens. Test within 30 minutes when not sampling directly from a lancing device
         2) Fluoride, EDTA, Sodium and Ammonium blood collection devices should not be used.
      iv. To obtain whole blood from a midline catheter, follow procedure for blood sample collection in PCS Midline Catheter, Adults.
2. Critically ill neonates:
   a. Collect neonatal ~~arterial or neonatal heel~~ stick samples. The system has not been evaluated for use with neonate venous blood,

b. The system is not intended for use with neonate Cord blood samples.

3. Non-critically ill adult
   a. Capillary, Arterial, or Venous whole blood may be used. Do not use serum or plasma.
   b. Only fresh whole blood or whole blood collected in lithium heparin collection devices should be used for arterial and venous specimens. Test within 30 minutes when not sampling directly from a lancing device.
   c. Sample size is 1.2 uL.
4. Obtain single-use lancet
5. Select puncture site – see Patient Care Service (PCS) Collection of Blood Specimen by Skin Puncture.
   a. Adult/child - finger puncture
   b. Newborn – heel stick
6. Use the lancet to puncture the appropriate site - see PCS Collection of Blood Specimen by Skin Puncture.

D. **SPECIMEN COLLECTION AND PATIENT TEST :**

1. At the Apply Sample screen, obtain blood sample and touch the test strip to ~~the~~ a drop of blood. Hold the test strip to the blood until the meter begins the 6 second countdown.
   a. If the strip is not filled completely in the first attempt, you must repeat the test with a new puncture and a new test strip.
      i. Repeated squeezing of the puncture site may dilute the specimen with tissue fluid
   b. Criteria for rejection: If you receive a strip error for insufficient sample application or any other error code, you must repeat the test with a new finger puncture and a new test strip.
      i. Repeated squeezing of the puncture site may dilute the specimen with tissue fluid
   c. When collecting the sample: keep the meter level, or pointed slightly down while wet test strip is in the meter. Do not tilt the meter up while there is any chance that blood can drip down into the meter. If liquid gets into meter, **send meter to the Laboratory**~~use the cleaning strips to wick the extra fluid as soon as possible~~.
   d. Results will display in 6 seconds.
2. At the Patient Test screen
   a. Review results:
      i. Results may be read directly from the meter.
      ii. Results in the normal range display in Blue.
      iii. Results outside the normal range display in Red.
      iv. ↑ One arrow up indicates the result is high, but not critical.
      v. ↑↑ Double up arrows indicate the result is critical high.
         1) Follow PCS Critical Results and Critical Tests/Diagnostic procedure.
      vi. ↓ One arrow down indicates the result is low, but not critical.
      vii. ↓↓ Double down arrows indicate the result is critical low.
         1) Follow PCS Standardized Procedure Hypoglycemia Management in the Adult Patient
         ~~2) Follow PCS Standardized Procedure Newborn Hypoglycemia During Transition to Extrauterine Life~~
         ~~3)~~**2)** Follow PCS Critical Results and Critical Tests/Diagnostic procedure.
      viii. LO indicates the result is below the readable range of the meter, or <10.
         1) <10 meter reads LO. Repeat test. Continue with treatment and retest according to standardized procedure for hypoglycemia
      ix. HI indicates the result is above the readable range of the meter, or >600.
         1) Results >600 mg/dL. Repeat test. Obtain an order for a STAT lab glucose for a valid result for treatment (Confirmatory Testing).

2) Results that do not correlate with prior treatment. Repeat test. Obtain an order for a STAT lab glucose to verify result.

b. Accept or Reject:
   i. You must ACCEPT the result at the meter for it to be automatically charted.
   ii. If you select neither and the meter turns off, the result will sit in a queue in the lab awaiting resolution.
   iii. Fill out and submit the Point of Care Testing Correction Form to the LAB.

3. Remove strip by pressing down on ejector button on rear of device ~~or~~ remove strip manually. Ensure safe disposal into biohazard container.
4. Clean and disinfect the meter after each patient. See cleaning under Maintenance section.
5. Log off meter by selecting logout on Patient Test Screen or dock the meter when you are finished testing. Store the meter in the docking cradle and not in the tote. Battery must charge and data must transmit.
   a. The Left light is Green when the meter is connected to the network.
   b. The Center light is Green when data is transmitting
   c. The Right light is Green when the battery is fully charged and Amber when the battery is charging.
   d. Auto log off will occur after 6 ½ minutes of inactivity.

E. **DOCUMENTING RESULTS:**

1. Patients must be identified with the Financial/ Account Number (FIN). Only results identified with the FIN will be charted in CERNER. The FIN number should be scanned from the barcode on the ARMBAND. Barcodes with MRN information or AZTEC must not be scanned or the results will not transmit to Cerner.
2. Dock the meter in the cradle. Results and comments will automatically post to the chart.
3. If the result does not immediately chart,
   a. Verify the meter is properly docked and connected, with green arrow indicating data transfer complete.
   b. The INTERFACE may be temporarily down; the results will transmit and post when the interface is again functional.
4. Result was not ACCEPTED in the meter. Complete the Point of Care Testing Correction Form and send to the lab. The lab will resolve the error and process the result to the chart.
   a. Patient ID was not recognized. (John/Jane Doe). Use downtime procedure. Select Override button on the meter, continue testing, accept the result and dock the meter. Manually enter the result on the patient's chart for immediate documentation. Complete the Point of Care Testing Correction Form and send the lab. The lab will resolve the error and process the result to the chart at a later time whenever possible.

F. **MAINTENANCE:**

1. Charging the Meter:
   a. When the battery Low symbol displays on the screen, place the meter into the docking station. If you have a spare battery that is fully charged, you can change the battery.
   b. The meter should always be left in the docking station when not in use.
2. Cleaning and Disinfecting the Meter Procedure:
   a. Cleaning is not the same as disinfecting. Disinfecting means to kill or prevent the growth of disease carrying microorganisms.
   b. Prepare the meter for cleaning and disinfecting:
      i. Remove the test strip
      ii. Lay the meter on a flat surface prior to cleaning and disinfecting.
3. Clean and disinfect after each patient use per manufacturer's guidelines:
   a. See Nova Biomedical Glucose Meter instructions for use
   b. ~~See Chlorox Germicidal Wipes instructions for use~~
   c. If unable to clean the strip port, send the meter to the lab for a replacement.

4. Changing the Battery:
   a. If the meter needs a reset or is left out of the docking station for more than 8 hours or 40 tests, the battery will need to be recharged. If the meter is needed for immediate use, change the battery.
   b. Touch the screen or the Sleep Mode Button to wake the meter up. This will allow the operator approximately 2 minutes to change the battery and not lose date/time settings.
   c. If it takes longer than 2 minutes to change the battery. Dock the meter to reset the date and time.
   d. Push in on the cover latch to release the cover. Take the battery cover off the back of the meter.
   e. Remove the battery. ~~Remove the photo below it is unnecessary.~~
   f. Replace with a fully charged battery. (The battery is keyed to allow only insertion from bottom first then push in the top.)
   g. Replace the battery cover.
   h. Place the drained battery into the docking station to recharge. Be sure the light to the left comes on signifying the correct positioning of the battery.
5. Supplies and Storage :
   a. Blood Glucose Meter (Operates 15 to 40° C; 59 to 104°F)
   b. Glucose Test Strips (Store in original bottle 15 to 30°C)
      i. When opened, mark each bottle with the expiration date 180 days or manufacture expiration date, whichever comes first.
      ii. Once opened, both Stat Strip bottles in the single package must be labeled because there is no safety seal on the individual bottle.
      iii. Stable when stored as indicated for 180 days or until the printed expiration date (whichever comes first).
   c. Glucose Control Solutions, level 1 low and level 3 high (Store 15 to 30°C)
      i. When opened, mark the bottle with the expiration date 90 days or manufacture expiration date, whichever comes first.
      ii. Once opened, stable for 90 days or until the printed expiration date (whichever comes first).
   d. Do not use strips or controls past their expiration date.
   e. Remove the test strip from the vial only when ready to test and recap vial.

G. **QUALITY CONTROL AND CALIBRATION:**

1. Quality Controls (QC) are used to confirm that the meter and test strips are working correctly.
2. Control Frequency:
   a. Meter is configured to require a QC with both Level 1 low and Level 3 High every 24 hours. Meter will lock out at 24 hours and screen will display QC Lockout.
   b. Perform a QC if a patient test has been repeated and the blood glucose results are still lower or higher than expected
   c. Perform a QC any time you have a concern about the function of the meter, i.e it is dropped or problems are identified (storage, operator, instrument)
   ~~d. Performing a QC with both Level 1 low and Level 3 high solution is required for Alere / Freedom to recognize new operators in the system. This shall be done upon initial and annual competency.~~
3. Perform QC with both Level 1 low and Level 3 high QC solutions to unlock meter: If one QC level fails, repeat the test only for the level that failed.
4. Procedure:
   a. From the Welcome Screen press Login.
   b. Manually Enter or Scan your Operator ID and press OK/Accept
   c. From the Patient Test Screen, press QC.
   d. At the Enter Strip Lot screen, scan the strip lot from the bottles. Verify the strip lot number matches the number displayed on the screen.

e. At the Enter QC Lot screen, scan the QC lot
f. At the Insert Strip screen, insert the test strip into the meter.
g. Mix the control well by rolling the vial, do not shake.
h. At the Apply Sample screen, touch the tip of the test strip to the drop of control and the strip will fill by capillary action. Keep contact with the drop of control until the meter beeps, indicating sufficient sample was obtained.
    i. The test strip must fill completely on the first attempt. If insufficient sample is obtained, repeat with a new test strip.
    ii. Hold the meter level or downward while testing. This prevents any excess liquid from seeping down the strip and into the meter, causing damage.
    iii. If liquid gets into meter, dry strip port.
        1) If unable to remove liquid or the liquid dries and cannot be removed send the meter to the Lab.
i. The QC Result screen will show with a PASS or FAIL Press Ok/Accept.
j. If QC fails select comment and, perform corrective action:
    i. Verify the correct level of control was scanned and tested.
    ii. Verify the test strips and control solutions are not expired. If expired, open new strips or controls.
    iii. Mix the control thoroughly. Repeat the test with a new strip. If the second test fails, contact the lab.
k. Log off meter when you are finished testing. Auto log off will occur after inactivity.
l. The meter does not require calibration.

H. **PRINCIPLE/CLINICAL SIGNIFICANCE:**

1. This test is Clinical Laboratory Improvement Amendment (CLIA) WAIVED for capillary, venous, and arterial whole blood and neonatal heel stick whole blood.
2. Glucose is measured amperometrically, using an enzyme based test strip.
3. The meter is plasma calibrated to allow easy comparison of results with laboratory methods.
4. The measurement of glucose is used in the monitoring of carbohydrate metabolism disturbances including diabetes mellitus, and idiopathic hypoglycemia, and of pancreatic islet cell carcinoma.
5. Testing by this method is not for diagnosis of or screening for diabetes.
6. Limitations
    a. Capillary blood glucose testing is not appropriate for persons with decreased peripheral blood flow, as it may not reflect the true physiological state. Venous and arterial whole blood is the only sample that shall be used for any patient receiving intensive medical/interventional therapy with decreased peripheral blood flow, as evidenced by one or more of the following:
        i. Severe hypotension requiring the administration of two or more intravenous vasopressors
        ii. Any patient with a core body temperature equal or less than (≤) 35°C
        iii. Any patient with ESI of one
    b. When performing frequent testing in a patient, try to use the same blood source as consistently as possible.
        i. Rationale: Venous and capillary blood may differ in glucose concentration by as much as 70 mg/dL, depending on the time of blood collection after food intake. Draw lab serum glucose for the most accurate glucose value.
7. A test within 20% of laboratory results is considered accurate.
8. Interfering Substances
    a. The ~~B~~blood glucose meter ~~Glucose meter~~ exhibits no interference from the following substances at known therapeutic levels:
        i. Acetaminophen~~,~~
        ii. Ascorbic acid~~,~~

iii. Dopamine~~,~~
iv. Ephedra~~,~~
v. D+ Galactose~~,~~
vi. Ibuprofen, L-Dopa~~,~~
vii. Methyl-Dopa~~,~~
viii. Salicylate~~,~~
ix. Tetracycline~~,~~
x. Tolazamide~~, and~~
~~a.~~xi. Tobutamide.

b. The ~~B~~blood glucose meter ~~Glucose meter~~ exhibits no interference from the following substances at or above the upper clinical normal range concentrations:
i. Bilirubin~~,~~
ii. Cholesterol~~,~~
iii. Creatinine~~,~~
iv. Triglycerides~~, and~~
~~b.~~v. Uric Acid.

c. The ~~B~~blood glucose meter ~~Blood glucose meter~~Glucose meter ~~meter~~ exhibits no interference from the following substances at the normal therapeutic levels found in renal dialysis:
i. D(+) Maltose monohydrate~~,~~
ii. D(+) Maltotetraose~~, and~~
~~c.~~iii. D(+) Maltotetriose.

d. The blood glucose meter~~Blood glucose meter meter~~ exhibits no interference in blood specimens with hematocrits from 20% to 65% or with varying oxygen content.

I. REFERENCE INTERVALS:

1. Meter range 10-600 mg/dL
   a. <10 meter reads LO. Continue with treatment and retest according to standardized procedure for hypoglycemia.
   b. >600 meter reads HI. Order lab glucose to obtain a valid number for treatment.
2. Reference Range (all in mg/dL)

		NORMAL	CRITICAL LOW	CRITICAL HIGH
a.	Adults	70 – 110	≤ 40	≥ 450
b.	Neonates	45 – 120	≤ 30	none established

3. Critical Results must have follow up documentation of physician notification and any interventions.
4. Any result that is questionable or does not correlate with patient symptoms or treatment history should be repeated with a new finger puncture to rule out operator, strip, or meter error. If repeat meter value does not 'make sense', order a lab glucose.

J. REFERENCE(S):

1. Nova Biomedical. Blood glucose meter Glucose Test Strips Package Insert. Ref 42214. **2024-02**~~2016-03~~.
2. Nova Biomedical. Blood glucose meter Glucose Control Solution Package Insert. Ref 41741 & 41743. **2022-01**~~2017-03~~.
3. Nova Biomedical. CIB **06-24SS**~~04-11SS Rev. B~~. Cleaning and Disinfection Procedure. 2015-06.
4. Nova Biomedical. Blood glucose meter Glucose Hospital Meter IFU 1.86 Ref.55848F 2019-01

K. FORM(S):

1. Point of Care Testing Correction Form
~~1. Stat Strip Glucose POC Competency~~

L. RELATED DOCUMENT(S):

~~Clorox Healthcare Germicidal Wipes Instructions for Use~~

1. Online Clinical Skills Arterial Catheter: Blood Sampling
2. PCS Procedure: Central Venous Access Devices, Adults
3. PCS Procedure: Collection of Blood Specimen by Skin Puncture
4. PCS Procedure: Critical Results ~~and Critical Tests/~~**of Tests and** Diagnostic **P**~~p~~rocedures
5. PCS Procedure: Extended Dwell/Midline Catheter, Adults
6. PCS Standardized Procedure Hypoglycemia Management in the Adult Patient
7. PCS Standardized Procedure Newborn Hypoglycemia During Transition to Extrauterine Life
8. PCS Procedure: Venipuncture for Specimen Collection
9. **Point of Care Quality Assurance Procedure**
10. **Stat Strip Glucose Monitoring System Quick Operating Guide**
~~8.~~**11.** **Stat Strip Glucose Monitoring System Quick QC Guide**
~~9. Point of Care Correction Form~~
~~10.~~**12.** StatStrip Troubleshooting Guide
~~11. Nova Biomedical Glucose Meter Instructions for Use~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 12/11

SUBJECT: **Point of Care (POC) New Test/Method Request and Implementation**

REVISION DATE~~(S)~~: 04/16, 02/19, 12/21

Patient Care Services Content Expert Approval:	**~~10/20~~12/24**
Clinical Policies & Procedures Committee Approval:	**~~12/20~~05/25**
Nursing Leadership Approval:	**~~08/21~~08/25**
Department of Pathology Approval:	**~~10/21~~09/25**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~11/21~~09/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/21**

A. **PURPOSE:**

1. To ensure that:
   a. POC testing meets the needs of the patients served, is performed correctly by non-laboratory staff, and is cost effective.
   b. POC testing is approved by the appropriate committees at a hospital level before implementation.
2. Devices, tests, and analytes available as POC testing are continually improving and expanding. However, POC testing is not appropriate for use in all situations. New test and method requests must be evaluated before implementation.

B. **POLICY:**

1. POC testing is under the direction, authority, jurisdiction and responsibility of the Laboratory Medical Director.
2. **The Laboratory Medical Director ensures that the performance specifications for new tests, instruments, and methods introduced to the laboratory have been properly validated or verified prior to being used for patient testing**
3. Any patient testing, including testing that is performed outside of the clinical laboratory by non-laboratory personnel, must conform to state and federal regulations. **Purchasing**~~The Product Standards Committee (PSC)~~ reviews all requests for new testing. Once approved by **Purchasing**~~the PSC~~, the Laboratory will establish standards for POC testing, evaluate POC devices or tests before implementation, and monitor all POC testing sites for compliance.
4. Requestors must complete and submit the form "Request for Approval of New POC Test/Method" to POC Coordinator (POCC) and/or Lab Leadership Team.
   a. The front of the form explains the extent and use of desired testing, and must be filled out in full by the requesting department.
   b. The back of the form evaluates the financial impact of testing. This can be completed with assistance from the POCC, but the requesting department must be fully aware of all costs involved.
5. Requestors must then submit to **Purchasing**~~the~~/Clinical Value Analysis Team ~~according to current PSC policies~~. **Purchasing** ~~PSC~~ reviews all requests for new POC testing taking into consideration the following aspects:
   a. Medical need for decreased turn-around time
   b. Procedure complexity

c. Regulatory compliance
d. Ongoing competency
e. Cost

6. Following approval for consideration, the POCC and Lab Leadership Team assigns oversight to the appropriate personnel who will:
   a. Assess available technology for the requested test by contacting vendors.
   b. Evaluate and make recommendations to the Laboratory Leadership and Medical Director.
   c. Perform test method validation according to regulatory requirements and obtain approval by the Laboratory Medical Director.
   d. Create written policies/ procedures that are clear to users and meet all regulatory requirements.
   e. Establish quality control policy to be followed by testing personnel with regular review of data by responsible staff.
   f. Enroll in appropriate proficiency testing or establish alternative proficiency testing if needed.
   g. Ensure testing personnel are trained and demonstrate competency prior to performing patient testing.
   h. Request Lab Information System or Information System input, if needed.
   i. Communicate to physicians new test availability.
   j. The Laboratory Medical Director and POCC review and approve all data for test implementation prior to patient testing. The Lab Medical Director is involved in the selection of all equipment and supplies, in accordance with College of American Pathology (CAP) regulations.
7. CAP requirements for POC testing including but not limited to the following general items.
   a. Proficiency testing is performed at intervals determined by the subscribed survey, in a timely manner, as similar to patient testing as possible, by personnel who perform patient tests, and rotated among all testing personnel.
   b. Testing Personnel must adhere to manufacturer instructions and written procedure.
   c. Results are reported in the medical record. Critical Results are handled appropriately.
   d. Reagents are stored properly. New lots and shipments are evaluated appropriately before use.
   e. Equipment maintenance is performed and documented to meet manufacturer requirements.
   f. Personnel must be trained and competency assessed according to the Patient Care Services Procedure: Point of Care Testing Competency Assessment
   g. Quality Controls are performed and documented at required intervals.
8. Managers overseeing departments performing POC testing must complete the Request for Approval of New Point of Care Test/Method

C. **FORM(S):**
1. Request for Approval of New Point of Care Test/Method
2. Request for Clinical Product Review

D. **RELATED DOCUMENT(S):**
1. Patient Care Services Procedure: Point of Care Testing Competency Assessment

E. **REFERENCE(S):**
1. College of American Pathologists. (~~2019~~**20243**). Point of Care Testing Checklist. Northfield, IL.
2. College of American Pathologists. (~~2019~~**20243**). **Director Assessment Checklist**. Northfield, IL.
~~3. College of American Pathology. CAP Accreditation Program. Point of Care Testing Checklist Tri-City Medical Center, CAP Number: 2317601. Version: 08.22.2018.~~
~~4. College of American Pathology. CAP Accreditation Program. Team Leader Assessment of Director and Quality Checklist Tri-City Medical Center, CAP Number: 2317601. Version: 08.22.2018.~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**07/17**	**SUBJECT:**	**Program Flexibility**
REVISION DATE:	**07/17, 12/21**		

Patient Care Services Content Expert Approval:	**~~03/21~~04/25**
Clinical Policies and Procedures Approval:	**~~10/21~~05/25**
Nursing Leadership Approval:	**~~11/21~~08/25**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~11/21~~09/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/21**

A. **POLICY:**

1. Tri-City Healthcare District (TCHD) will maintain continuous compliance with the **licensing rules and regulations and supplemental service requirements** ~~special permit requirements~~ for program flexibility **as outlined in California Code of Regulation, Title 22 §70307(a)-(b) and Health and Safety Code (HSC) Division 2 Licensing Provisions, Chapter 2 Health Facilities 1276 & 1276.05.**
2. **Program flexibility e.g., program flex, request shall be submitted to the California Department of Public Health (CDPH) or the Department of Health Care Access and Information (HACi) using the prescribe manner e.g., electronic system, email, verbal.**
3. **Program flex requests may not be implemented without approval from CDPH or HACi or both. Exception; incidents that constitute an emergency as outlined in regulation**
   a. **Notify the appropriate department leader and the Regulatory Department for emergency requests.**
   ~~b. If TCHD is unable to maintain continuous compliance with all required standards, TCHD will request an exception i.e., program flexibility from the California Department of Public Health (CDPH) pursuant to Title 22 section 70363 and Health and Safety Code (HSC) section 1276.~~
4. **All program flex requests submitted to the Regulatory Department must include the following:**
   a. **Duration of Request (start and end date)**
   b. **Program flexibility type (emergency or other)**
   c. **Justification for the request**
   d. **Description of the request**
   e. **Adequate Staff, Equipment and Space, if applicable to patient care**
   f. **Alternative concepts that are intended to meet regulatory requirements e.g., methods, procedures, techniques, equipment, personnel qualifications, bulk purchasing, conducting a pilot and maintaining patient, staff, and visitors' safety**
   g. **Additional information e.g., specific or detailed explanation or supportive information**

~~2. Program flexibility requests shall be submitted to the California Department of Public Health using the appropriate Program Flexibility form (CDPH 5000 or CDPH 5000A).~~

~~3. All program flexibility requests must contain the following supportive evidence :~~
~~a. The regulation for which the facility requests flexibility~~

~~b. An explanation of the alternatives e.g., concepts, methods, procedures, techniques, equipment, personnel qualifications, bulk purchasing, terms the program flexibility will be initiated etc.,~~

~~c. Evidence demonstrating how the alternative concepts, methods, procedures, techniques, etc., meet the intent of the regulation~~

~~d. A licensee, administrator, or authorized facility representative signature on all forms and/or requests~~

5. All approved program flexibility granted by CDPH **or HACi** will ~~specify~~ **have** an expiration date and **identified** ~~are subject to~~ specific terms and conditions **outlined in the written approval** .

B. **REFERENCE(S)**:

1. **California Code of Regulation, Title 22 §70307(a)-(b)**
~~4.~~2. **Health and Safety Code (HSC) Division 2 Licensing Provisions, Chapter 2 Health Facilities 1276 & 1276.05**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**12/01**	**SUBJECT:**	**Volunteers, Patient Care Services Departments**
REVISION DATE:	**03/03, 06/03, 08/05, 01/09, 12/15 12/18**		

Patient Care Services Content Expert Approval:	**~~09/18~~02/25**
Clinical Policies & Procedures Committee Approval:	**~~10/18~~05/25**
Nursing Executive Council Approval:	**~~11/18~~08/25**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~12/18~~09/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/18**

A. **POLICY**:

1. Volunteers at Tri-City Medical Center **(TCMC)** are available to assist patients, families, and healthcare providers in the Patient Care Services Units/Departments.
   - **a.** Volunteers may not:
     - **i.** ~~-e~~Enter isolation rooms~~.~~
     - **~~a.~~ii.** **Address any medical questions with patients, visitors, or healthcare providers**
   - **b.** **Volunteers must:**
     - **i.** **Follow Health Insurance Portability and Accountability Act (HIPAA) guidelines**
2. Services that may be provided by Patient Care Services volunteers may include but are not limited to the following:
   - **a.** Intensive Care Unit (ICU):
     - **i.** Assist, screen, and comfort visitors
     - **ii.** ~~.~~Watch for the arrival~~,~~ or transfer ~~out,~~ of patients
     - **iii.** ~~-and a~~Assist in record keeping of these arrivals and transfers
     - **~~a.~~iv.** ~~.~~Escort visitors to the patient's room according to the guidelines of the ICU.
   - b. Courtesy Shuttle: Drive a covered vehicle around the hospital campus to assist people who want a ride to or from their car or the bus stop.
   - **c.** Surgery Check-in ~~Customer Relations~~:
     - **i.** Assist **within** ~~in~~ checking in patients for surgery; do not address any medical questions.
     - **ii.** Escort patients to preop hold area, ask families to wait in the main hospital lobby
     - **~~c.~~iii.** ~~.~~Facilitate communication between preop hold, **Post Anesthesia Care Unit** ~~recovery room (~~PACU~~)~~, operating rooms, and surgeons.
   - **d.** Surgery:
     - **i.** Escort patients and families
     - **ii.** ~~,s~~Store personal effects, prepare gurneys, stock blanket warmers
     - **iii.** ~~,p~~Prepare preop kits, clean equipment as directed
     - **iv.** ~~,o~~Order linen and supplies
     - **v.** ~~,~~**Transport** discharged patients in wheelchairs
     - **vi.** ~~,p~~Pick up/deliver paperwork, serve food/drinks
     - **~~d.~~vii.** ~~, and a~~Assemble blank patient packets.

e. Emergency Department:
   i. Act as liaison between visitors, patients, and the medical staff.
   ii. Offer non-medical assistance to the medical staff.
   iii. ~~, a~~Assist ~~the~~ medical secretaries and clerical staff in registration area
   iv. ~~, c~~**Clean and c**hange gurneys
   v. ~~, keep~~**Monitor** supplies on hand
   vi. ~~, make quantities of coffee, a~~Assemble medical and surgical packets
   vii. ~~, a~~Assist in taking patients to their rooms
   viii. **Additional tasks not involving patient care such as making coffee**
   ~~e.~~ix. ~~, and stand by for any errands~~.
f. Employee Health **Services**~~Office~~:
   i. Fill out and file receipts
   ii. ~~, l~~Log over-the-counter medications to employees and volunteers
   iii. ~~, s~~Stock supply cabinets
   ~~f.~~iv. ~~, and o~~Open and check in the new merchandise~~.~~
g. Escort Service:
   i. Escort patients to the proper departments
   ~~g.~~ii. ~~, Interact with patients in the waiting room and when assisting to appropriate areas of the hospital and~~ **Transport** discharges patients when requested~~.~~
h. Gift Shop:
   ~~h.~~i. Assist all customers in the sale of gift shop items.
i. Imaging: Liaison between staff, families, and patients.
   ~~Receive patients as they arrive for procedures~~
   i. ~~, e~~Escort patients to the dressing room
   ii. **Observe**~~, see to~~ patient's comfort while they are waiting or recovering from imaging procedures
   ~~i.~~iii. ~~, a~~Assist ~~with paperwork for the~~ radiology staff **as directed with** ~~and follow department and Health Insurance Portability and Accountability Act (HIPAA) guidelines for~~ checking-out films~~.~~
j. Laboratory:
   i. Assist nursing units with a pick-up and delivery service
   ii. ~~and m~~Make rounds as requested **to nursing units and departments**~~.~~
   iii. ~~-~~Dispense specimens from the lab triage tubs
   ~~j.~~iv. ~~-~~Assist ~~with paperwork at~~ the laboratory front office and the triage unit **document management**~~.~~
~~k. Women and Newborn Services: Hand out juice or food trays, fill water pitchers, strip or make beds, watch/rock newborns, run errands, make up home packets when patients discharged, and push mothers and babies in a wheelchair to front door.~~
k. Pulmonary Rehabilitation:
   i. Assemble:
      1) ~~n~~New patient orientation packets
      2) ~~; assemble~~ Asthma and Chronic Obstructive Pulmonary Disease (COPD) education packets; assemble new patient class notebooks.
   ~~l.~~ii. **Assist** ~~Help~~ with answering phones and simple clerical duties~~.~~
l. Information Desk:
   i. Relay hospital information to the public in accordance with HIPAA guidelines **to visitors or vendors**
   ii. ~~, a~~Assist security in providing visitors badges
   iii. ~~, give~~ **Provide** directions to visitors
   iv. ~~, r~~Receive patient mail, ~~and~~ assign room numbers **and**, deliver mail to patients
   ~~m.~~v. ~~, r~~Receive and deliver floral arrangements~~, and answer questions.~~
m. Registration:
   i. Serve as liaison with the Admitting Office
   ii. ~~, a~~Assist incoming patients with completion of information form
   ~~n.~~iii. ~~, and i~~Interact with patients relaying concerns when necessary~~.~~

n. Rehabilitation Services:
- **i.** Office clerical **tasks which include: Prepare** ~~making up~~ charts and/or patient packets, **and** filing
- **ii.** ~~,~~ **r**Restock~~eing~~ linens
- **iii.** ~~,~~ **t**Transport **patients**~~,~~ ~~using a copier,~~
- ~~e.~~**iv.** **Contact** ~~make phone calls to~~ patients **as directed** and process surveys~~.~~

o. Women's' Diagnostic Center:
- ~~p.~~**i.** Clerical services, **tasks include pepare** ~~to make~~ and distribute packets to patients. ~~Mail computer generated positive letters to patients~~.

p. Cardiac Rehabilitation:
- ~~q.~~**i.** Provide both clerical and operational support as directed by staff

q. Acute Care Services & Telemetry: ~~-~~**Assist with the following as instructed by nursing**
- **i.** ~~Assist with d~~**D**elivery of **meal** trays ~~as instructed by nursing staff,~~
- ~~-v~~**V**isit with patients
- **iii.** ~~, assist with t~~**T**ransporting discharged patients
- **iv.** ~~and t~~Transporting specimens to the lab
- ~~r.~~**v.** ~~-~~Answer **telephones**~~the phone~~ and call lights during nursing rounds~~.~~

r. Greeter Service: ~~-~~Welcomes patients and their families who enter the hospital.
- **i.** ~~Greeters d~~**D**irect individuals to registration
- **ii.** **Obtain wheel chairs**
- ~~s.~~**iii.** ~~and other service areas of the hospital. Help with obtaining wheelchairs when necessary.~~

s. Advocacy Service:
- **i.** Visit patients on day one or two.
- **ii.** **Provide copy** ~~Give them a copy of~~ "A Patient & Family Guide" **if not already provided**.
- **iii.** ~~-~~Encourage participation in any surveys received on discharge
- **iv.** ~~.—~~Arrange **visits** for Social Service, ~~visits, t~~Therapy dog, ~~visits,~~ or **for the c**Chaplain visits
- **v.** ~~.—~~Distribute activity packets, library books, or magazines
- ~~t.~~**vi.** ~~.—L~~isten to and provide comfort to patients.

~~3. Workshop members make toys for children admitted to the hospital, tray favors for holidays, stuffed toys for Emergency Department, red stocking for babies born in December and lovey dolls for the Neonatal Intensive Care Unit infants.~~

~~a.~~**3.** ~~Volunteers may be assigned tasks by the Assistant Nurse Managers/designee.~~

4. Off Campus volunteer support
- ~~a. Tri-City Wellness Center Carlsbad Physical Therapy and Cardiac Rehabilitation: Assist in clerical duties as directed by staff.~~
- ~~b. Outpatient Rehab, Oceanside~~
- ~~c.~~**a.** Outpatient Behavioral Health, Vista

Tri-City Healthcare District
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATIONS

ISSUE DATE: 01/07 **SUBJECT:** Policy and Procedure Approval Process

REVISION DATE: 07/09, 07/12, 08/15, 09/17 **POLICY NUMBER:** 8610-240

~~Department Approval~~**Administrative Content Expert Approval:**	~~07/17~~05/25
Administrative Policies & Procedures Committee Approval:	~~07/17~~09/25
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	09/25
Professional Affairs Committee Approval:	~~09/17~~n/a
Board of Directors Approval:	09/17

A. **PURPOSE:**

1. To define Tri-City Healthcare District's (TCHD) process for the approval of policies **and procedures**.

B. **DEFINITION(S):**

1. Policy **and** ~~/~~Procedure: **A**~~a~~ formal, approved, written description of how a governance, management, or clinical care process is defined, organized, or carried out. **Documents that may support the policy/procedure; including but not limited to practices, pre-printed orders, and chart forms; are not defined for the purposes of this policy**

a. Policy: A high-level guideline or set of rules that outlines the overall direction of why a process or action must be governed, organized or managed. A policy covers broad principles or complex standards requiring Board/Administrative approval and may have significant legal, regulatory, or financial implications.

b. Procedure: A detailed, step-by-step set of instructions on how to carry out a specific task or actions in line with or without a policy.

~~1. A policy covers broad principles or complex standards requiring Board/Administrative approval and may have significant legal, regulatory, or financial implications.~~

~~a. Documents that may support the policy/procedure; including but not limited to practices, pre-printed orders, and chart forms; are not defined for the purposes of this policy~~.

C. **POLICY:**

~~2.~~**1.** The electronic policy management system will be used for all policies and procedures.

~~3.~~**2.** Policies **and**~~/~~ procedures are:

a. To be reviewed **and** ~~/~~revised per regulatory requirements, research, or organizational processes and submitted through the approval process.
   i. See Policies and Procedures Review Grid.

b. Developed in collaboration with the medical staff, if relevant to medical staff activities and/or direct patient care.

c. Developed in collaboration with nursing ~~leadership if~~**leadership, if** relevant to direct patient care.

d. Consistent with professional references, applicable regulations, legal requirements, accreditation standards, **evidenced-based practices and standards,** and the mission and philosophy of the organization.

~~4.~~**3.** Creating and revising documents:

a. The editable version (i.e., Word document) will be stored in the electronic policy management system.
b. Revisions to the documents will be tracked as changes while going through the approval process.
c. Any changes to content, deletions, and/or combining of policies/procedures will require the full approval process.
~~c.~~**d. The content expert is responsible for updating references.**

~~5.~~**4.** Approval:
a. Policies **and/** Procedures are submitted to the Board of Directors (BOD) or Administration for final approval.
i. All policies are submitted to the Board of Directors for final approval.
ii. Procedures are submitted to the BOD or Administration for final approval based on regulatory requirements.
1) Nursing procedure must be approved by the BOD per **California Code of Regulations (CCR)**Title 22
iii. Pre-approved by Board Committees prior to submission to the Board **as applicable.**:
~~1) The Human Resource Committee (HRC) approves all administrative policies that relate to human resource issues.~~
~~2)~~**1)** The Finance, Operations, and Planning Committee (FO&P) approves all administrative policies that relate to finance issues.
~~3) The Audit, Compliance and Ethics Committee (ACE) approves all administrative policies that relate to compliance and privacy issues.~~
~~4) The Governance/Legislative Committee approves all policies that relate to the Board of Directors issues, Medical Staff By-Laws and Medical Staff Rules and Regulations.~~
~~5) The Professional Affairs Committee (PAC) approves all others.~~
iv. Reviewed by Administration if not pre-approved by Board Committee.
b. Issue Date should be the first final approval date by BOD or Administration.
c. Revision dates should reflect final approval dates each time the policy/procedure is approved by the Board/Administration.
d. The ~~Department Manual Coordinating Committee~~ **designee** will coordinate approval at Medical Staff Department/Division/Committees, Medical Executive Committee (MEC), Board Committees and the BOD.
e. Staff shall be notified of any new policies/procedures or significant revisions. Education shall be provided as appropriate.
f. **The designee will maintain A**an **electronic** ~~hard~~-copy of all current policies/procedures ~~must be available in the department for downtime~~.

~~C.~~D. PROCESS FOR ADMINISTRATIVE MANUAL(S) APPROVAL:

1. Approval Process
a. Content Expert
b. Administrative Policies and Procedures Committee (APP)
c. Pharmacy and Therapeutics Committee (P&T), if contains medication, medication administration or if standardized procedure
d. MEC, if relevant to medical staff activities and/or direct patient care
e. Appropriate Board Committee
f. BOD

~~D.~~E. PROCESS FOR PATIENT CARE SERVICES (PCS) MANUAL APPROVAL:

1. Approval Process
a. Content Expert
b. Clinical Policies and Procedures Committee (CPP)
c. Nursi**nge Leadership** ~~Executive Committee (NEC)~~

d. Medical Staff/Department Division, if relevant to medical staff activities or direct patient care
e. P&T, if contains medication, medication administration or if standardized procedure
f. Interdisciplinary Practice Committee (IDPC), if a standardized procedure
g. MEC, if relevant to medical staff activities and/or direct patient care
~~h. PAC~~
~~i.~~**h.** BOD

~~E.~~**F. PROCESS FOR DEPARTMENT SPECIFIC MANUAL~~MANAUL~~ APPROVAL:**

1. Approval Process
   a. Content Expert
   b. Department Manager and/or Director
   ~~c. Medical Director for clinical areas with a Medical Director when appropriate~~
   ~~d.~~**c.** Medical Staff/Department Division, if relevant to medical staff activities or direct patient care
   ~~e.~~**d.** MEC, if relevant to medical staff activities and/or direct patient care
   ~~f. PAC~~
   ~~g.~~**e.** BOD
2. Each Department is responsible for maintaining their own department specific manual.
   a. Makes revisions in the electronic policy management system to policies/procedures using tracked changes.
   ~~b. Obtain Medical Director's approval if applicable for policies/procedures related to Medical Staff activities or direct patient care.~~

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

1. Policies and Procedures Review Grid

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

1. ~~California Department of Public Health~~**California Code of Regulations (CCR). Title 22. §70213. Nursing Service Policies and Procedures.** ~~Title 22 California Code of Regulations~~
2. The Joint Commission **(TJC). (2025, January). Environment of Care Manual**~~Standards~~
3. California Children's Services Standards
~~3.~~**4. California Code of Regulations (CCR). Title 7. §5199. Aerosol Transmission Disease**
~~4.~~**5.** College of American Pathologists **(CAP)**

Policies and Procedures Review Grid

Policies and Procedures Category	Policy/Procedure Name	Review Period	Regulation Requirement
Nursing Policies	All	3 Years	**California Code of Regulations (CCR)** Title 22
Standardized Procedures	All	2 Years	California Board of Registered Nurses
Neonatal Unit Policies	All	2 Years	California Children Services (CCS)
Laboratory Policies	All	2 Years	College of American Pathologists (CAP)
Interpretation Policies	Patient Care Services: Interpretation and Translation Services Policy	Annual	**The** Joint Commission (**TJC**)
Environment of Care **(EOC)** Plans	~~Engineering: Utility Management Plan~~ ~~Environment of Care: Hazardous Material and Waste Management and Communication Plan~~ ~~Environment of Care: Life Safety Management Plan~~ ~~Environment of Care: Safety Plan~~ ~~Environment of Care: Security Management Plan~~ **EOC** • **Safety and Security** • **Hazardous Materials and Waste** • **Fire Safety** • **Medical Equipment** • **Utilities** • **Physical Environment Requirements** **Emergency Management (EM)** • **Emergency Operation Plans** **Life Safety** • **Interim Life Safety Measures (ILSM)**	Annual	**Code of Federal Regulation (C.F.R. Title 42.** **The** Joint Commission (**TJC**) **National Fire Protection Association Life Safety Code**
Pharmacy: Sterile Pharmaceuticals and Hazardous Drugs	Pharmacy: Automatic Therapeutic Interchange Pharmacy: Black Box Warnings, Drugs with Policy	Annual	~~TCHD Pharmacy and Therapeutics Committee~~
	Pharmacy: Sterile Products Preparation	Annual	United States Pharmacopeia (USP) <797>,<800>
Infection Control	Infection Control: Aerosol Transmissible Diseases and Tuberculosis Control Plan IC 11 Infection Control: Bloodborne Pathogen Exposure Control Plan Infection Control: Risk Assessment and Surveillance Plan	Annual	**CCR Title 7 §5199..** **The** Joint Commission (**TJC**) **Code of Federal Regulation (C.F.R. Title 42** **Centers for Disease Control and Prevention (CDC)**

Tri-City Medical Center
Oceanside, California

Administrative ~~Policy~~
Human Resources

ISSUE DATE: 05/86 **SUBJECT:** Alcohol and Drug ~~Testing~~ policy~~for Employees~~

REVISION DATE: 02/11, 04/12, 04/15,10/17 **POLICY NUMBER:** 8610- 429

Administrative Content Expert~~Department~~ Approval:	~~09/17~~09/24
Administrative Policies & Procedures Committee Approval:	~~10/17~~09/24~~09~~/25
Pharmacy & Therapeutics Committee:	n/a
Medical Executive Committee:	n/a
Administration Approval:	09/25
~~**Human Resources Committee Approval:**~~	~~09/17~~
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	~~10/17~~

A. **PURPOSE:**

1. It is the goal of Tri-City Healthcare District (TCHD) to create a healthy and safe work environment ~~in order to deliver the best and most cost efficient service~~. It is the responsibility of TCHD employees to cooperate in efforts to protect the life, personal safety, and property of co-workers, patients, and members of the public. Substance abuse has been found to be a contributing factor to absenteeism, substandard performance, increased potential for accidents, poor morale, and impaired public relations. ~~It is t~~The goal of this policy **is** to prevent substance abuse in the workplace. Employees must take all reasonable steps to abide by and cooperate in the implementation and enforcement of this policy.

~~1. Tri-City Hospital District (TCHD) has an obligation to its officers, employees, patients, and members of the public to take reasonable steps to provide an alcohol and drug free workplace and to provide services to the public in a safe manner. These guidelines are to be used by Directors and Managers for testing employees where they have a reasonable suspicion that the employee may be under the influence of alcohol and/or drugs.~~

B. **DEFINITIONS**

1. **Alcohol – The intoxicating agent in beverage alcohol, ethyl alcohol or other low molecular weight alcohols, including methyl or isopropyl alcohol.~~any beverage that has an alcohol (ethyl alcohol or ethanol) content in excess of three percent (3%) by volume.~~**
2. **TCHD – P~~p~~remises ~~all buildings, parking lots, service yards, patios, lunch rooms, break areas, rest rooms, loading docks,~~ or TCHD-owned vehicles, work sites or any other sites where employees perform services for TCHD, regardless of the location or TCHD ownership or control of the property.**
3. **Drug – A~~a~~ny chemical substance (other than alcohol) capable of altering the coordination, reflexes, moods, perception, pain level, attention span, or judgment of the individual consuming it, which is recognized as a drug in the United States Pharmacopoeia, the National Formulary, the Homeopathic Pharmacopoeia, or other drug compendia, or supplements to any of those compendia. This includes, without limitation, narcotics, hallucinogens, depressants, stimulants, or other controlled substances, including prescription drugs.**
4. **Workforce Member – Employees, Medical Staff, Allied Health Professionals (AHP), volunteers, trainees, Business Visitors, Covered Contractors and other persons whose conduct, in the performance of work for Tri-city Healthcare District (TCHD), is under the**

direct control of TCHD whether or not they are paid by TCHD.~~Employee – any individual employed by TCHD except elected officials~~. ~~Employee includes all individuals on TCHD on a voluntary basis and contracted labor.~~.

5. **Illegal Drug – Aany drug which is illegal under federal, state, or local law to use, sell, transfer, possess, manufacture or consume.**
6. **Legal drug – Aany drug or medication lawfully prescribed for use by the employee by a licensed medical practitioner, or an obtainable over-the-counter drug.**
7. **Under the influence – Bbehavior modified by alcohol or drugs, resulting in substandard or modified job performance; diminished motor reflexes;~~,~~ impairment of coordination, speech, or mental concentration; or conduct that poses a safety hazard to the employee, co-workers or others.**
8. **Possession - Whenre an employee has the substance on their~~his or her~~ person or ~~otherwise in~~ an area under their ~~employee's~~ control.**
9. **Reasonable suspicion - ~~includes a suspicion~~ Bbased on current first-hand observations concerning the appearance, behavior, speech, or body odors. Independently observed & documented behavior from two members of leadership or Administrative Supervisor(s), if after hours. ~~on specific personal observations such as an employee's manner, disposition, appearance, behavior, speech, breath, muscular movements, information provided to management by another employee, law enforcement official, security service, or other persons believed to be reliable; or a suspicion that is based on other surrounding circumstances.~~**

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

1. Alcohol and/or drug abuse ~~on the job~~ will not be tolerated. ~~for any employee.~~
2. Alcohol **and/**or drug use off the job that negatively affects an **individuals'~~employee's~~** performance or negatively impacts TCHD~~, its employees, staff, patients or its mission, in any way,~~ will not be tolerated.
3. Violation of this p~~P~~olicy may result in disciplinary action, up to and including termination of employment **and/or services provided by Workforce Members**. Discipline may be imposed regardless of whether an **Workforce Member** ~~employee~~ is charged with and/or convicted of a crime relating to any violation of this policy.
4. **Conduct violating this policy includes, but is not limited to:**
   a. **Reporting for work or being at work under the influence of alcohol or drugs;**
   b. **The illegal use, possession, transfer, purchase or illegal sale, or the attempted illegal use, possession, transfer, purchase or illegal sale of drugs during work hours or while on TCHD premises;**
   c. **The use or attempted use of alcohol in any manner during work hours or while on TCHD premises;**
   d. **Using TCHD property or premises to manufacture alcohol or drugs;**
   e. **Criminal conviction for the use, possession, transportation, transfer, purchase, theft or sale of illegal drugs whether or not on TCHD premises;**
   f. **Failure to report in writing any conviction within five (5) days of such conviction;**
   g. **Refusal to submit to a drug or alcohol test when requested to do so by a manager or Human Resources department head or their designee;**
   h. **Failure to provide, within 24 hours of a positive drug test, bona fide verification of a current valid prescription in the employee's name for any potentially impairing legal drug identified in the drug test.**
5. This p~~P~~olicy sets forth the procedures to be followed **whenwhere there is** reasonable suspicion ~~exists~~ that an **individual~~employee~~** may be under the influence of drugs or alcohol,~~.~~ **impairing their ability to perform job functions or reducing their ability to perform their job safely.**
   a. **TCHD Employees: See Alcohol and/or Drug Testing Management Guidelines**
   b. **Medical Staff, Allied Health Professionals (AHP), volunteers, trainees, Business Visitors, Covered Contractors and other persons whose conduct, in the**

performance of work for TCHD, is under the direct control of TCHD whether or not they are paid by TCHD, will be released and their employer notified.

6. Violations of this policy that may constitute criminal conduct will be reported to the appropriate law enforcement agency and State licensing agencies and the California Department of Public Health Services, as required by law.

~~4.~~7. **To the extent that any applicable collective bargaining agreement, consistent with applicable law, conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement shall prevail.**

~~Reasonable Suspicion means a belief based upon objective facts sufficient to lead a reasonably prudent person to suspect that an employee is under the influence of drugs or alcohol so that the employee's ability to perform the functions of the job is impaired or so that the employee's ability to perform his/her job safely is reduced. For example, any of the following, alone or in combination, may constitute reasonable suspicion:~~
~~Changes to employee's manner or disposition;~~
~~Changes to employee's appearance, including, but not limited to glassy eyes, eye dilation, shaking, or erratic movement;~~
~~Changes in an employee's behavior, including involvement in verbal or physical altercations;~~
~~Unsteady walking and movement;~~
~~Slurred speech or alcohol odor on breath;~~
~~An accident involving the employee;~~
~~An employee's possession of drugs or alcohol;~~
~~Failure to follow TCHD's procedure for wastage of controlled drugs or an employee's abuse of TCHD's Pyxis Pharmacy override system; and/or~~
~~Objective information obtained from another employee, law enforcement official, security service, or other person believed to be reliable.~~

~~C.~~D. USE OF LEGAL/PRESCRIBED DRUGS:

1. Using or being under the influence of any legally obtained drug while performing TCHD business or while in a TCHD facility is prohibited to the extent that such use or influence affects job safety or efficiency, or interferes with an employee's essential job functions.
2. No legal drug shall be possessed or used by any employee other than the employee for whom the drug was prescribed by a licensed medical practitioner. A legal drug shall be used only in the manner, combination, and quantity prescribed.
3. If an employee is using a legal drug during work hours that could result in the employee being under the influence as defined above, it is the employee's responsibility to advise **their**~~his/her~~ supervisor of the use or influence of the prescription drug before beginning work and to advise **their**~~his/her~~ supervisor of the specific impairments that may result.
   a. **The supervisor should refer the employee to Employee Health, or if after hours, to the Administrative Supervisor, for review.** An employee may continue to work if **Employee Health or the Administrative Supervisor**~~TCHD~~ determines that the employee does not pose a safety threat and that job performance is not affected by use of the drug. Otherwise, the employee may be required to take a leave or comply with other appropriate measures.
      i. To accommodate the leave, the employee may use accrued **Paid Time Off** (PTO).

   ~~a. The employee may work his/her assigned shift if his/her supervisor TCHD determines that the employee does not pose a safety threat and that job performance is not likely to be affected by use of the drug.~~

   b. TCHD may consult with the prescribing physician to learn the expected effect of the drug and/or require a written statement from the physician that continued working will be safe and efficient. Employees will be requested to grant their physician written authorization to provide information regarding expected effects

of prescribed medication. TCHD has the right to request a fitness-for-duty examination from a physician of their choice.

c. Disclosures made to TCHD concerning the use of legal drugs will be treated with confidentiality and will not be revealed to other TCHD management staff, unless there is an important work-related reason (e.g., employee safety) to do so in order to determine whether it is advisable for the employee to continue working.

~~**a. An employee may continue to work if TCHD determines that the employee does not pose a safety threat and that job performance is not affected by use of the drug. Otherwise, the employee may be required to take a leave or comply with other appropriate measures.**~~

~~**i. To accommodate the leave, the employee may use accrued PTO.**~~

~~**b.**~~**d.** The employee's supervisor will place the employee on ~~paid~~ Administrative Leave if the supervisor determines either:

i. **B**~~**b**~~efore the employee's shift starts, ~~that~~ the nature of the employee's position means that the risk that the employee may become under the influence while on duty is unacceptable; or

ii. **D**~~**d**~~uring the course of the shift, ~~that~~ the employee has come under the influence.

~~**c.**~~**e.** Employees who are placed on ~~paid~~ Administrative Leave may be requested by TCHD to give their physician written authorization to provide information to TCHD regarding expected effects of prescribed medication.

i. TCHD may consult with the prescribing physician to learn the expected effect of the drug and/or require a written statement from the physician that continued working will be safe and efficient.

ii. Disclosures made to TCHD under an employee's written authorization will be confidential and will be disclosed to and used by TCHD staff only to the extent permitted by law.

~~**d.**~~**f.** TCHD retains the right to direct an employee to submit to a fitness for duty examination by a physician selected by TCHD.

4. Marijuana is an illegal substance under federal law and will be treated as an illegal drug under this policy. ~~California law does not prescribe that an employer must employ an individual who uses marijuana even for medicinal purposes.~~ Accordingly, TCHD reserves the right to terminate the employment of any individual who reports to work under the influence of marijuana or who tests positive for marijuana.

E. SAFETY OF WORK FORCE, ~~MEDICAL EXAMINATIONS,~~ ALCOHOL AND/OR DRUG TESTS

~~5.~~**1. Each employee may be asked to submit to ~~a medical examination and/or~~ an appropriate test to determine the use of alcohol and/or drugs if there is a reasonable suspicion that the employee has used or is under the influence of alcohol and/or drugs.**

a. See ~~**Guidelines for**~~ Alcohol and/**or** Drug Testing **Management Guidelines**~~**of Employees**~~

2. Alcohol and drug testing may be requested following work-related accidents or any suspected violation of safety rules or standards, regardless of whether ~~or not~~ injury or damage resulted from the accident or safety violation, if there is a reasonable suspicion that there is a violation of this policy.

~~**Alcohol and drug testing may be requested following a failure to follow TCHD's procedure for wastage of controlled drugs or for an abuse of TCHD's Pyxis Pharmacy override system where reasonable suspicion exists.**~~

3. An employee determined to be unable to perform ~~his~~their duties in a satisfactory or safe manner based on reasonable suspicion of violation of this policy may be placed on Administrative Leave.

4. Any employee may report a complaint with their~~his/her~~ Supervisor, Manager, Director, or the ~~Vice President of~~ head of Human Resources/designee ~~or his/her designee~~ regarding a suspected violation of this policy by any other TCHD employee.

5. **If an employee charges that a fellow employee has violated this policy and subsequently the allegations are shown to be malicious, knowingly false or were made so as to harass the employee, appropriate discipline will be imposed on the complaining employee.**

F. **REFUSAL OF AN EMPLOYEE TO SUBMIT TO A ~~MEDICAL EXAMINATION AND/OR~~ ALCOHOL OR DRUG TEST**

1. **An employee's refusal to consent to ~~a medical examination and~~ alcohol and/or drug test will result in the immediate placement on aAdministrative Lleave ~~for the employee~~ pending the outcome of ~~the~~ TCHD's investigation of the employee.**
2. **An employee who, upon request, refuses to consent to ~~a medical examination,~~ alcohol and/or drug test shall be subject to disciplinary action up to and including termination.**
3. **An employee who, upon request, refuses to consent to ~~a medical examination,~~ alcohol and/or drug test may be disciplined for misconduct or unsatisfactory job performance.**
4. **Discipline may be imposed regardless of whether an employee is charged with and/or convicted of a crime relating to any violation of this policy. (Refer to Administrative Policy #424 Coaching and Counseling for Work Performance).**

~~D. DISCIPLINE:~~

~~1. Employees who violate this policy shall be subject to disciplinary action up to and including termination. Discipline may be imposed regardless of whether an employee is charged with and/or convicted of a crime relating to any violation of this policy.~~

~~2. Conduct violating this policy includes, but is not limited to:~~

~~a. Reporting for work or being at work under the influence of alcohol or drugs;~~

~~b. The illegal use, possession, transfer, purchase or illegal sale, or the attempted illegal use, possession, transfer, purchase or illegal sale of drugs during work hours or while on TCHD premises;~~

~~c. The use or attempted use of alcohol in any manner during work hours or while on TCHD premises;~~

~~d. Using TCHD property or premises to manufacture alcohol or drugs;~~

~~e. Criminal conviction for the use, possession, transportation, transfer, purchase, theft or sale of illegal drugs whether or not on TCHD premises;~~

~~f. Failure to report in writing any conviction under D.2.e. within five days of such conviction;~~

~~g. Refusal to submit to a drug or alcohol test when requested to do so by a manager or lLead Vice President, Human Resources Officer; or his/her (designee).~~

~~h. Failure to provide, within 24 hours of a positive drug test, bona fide verification of a current valid prescription in the employee's name for any potentially impairing legal drug identified in the drug test.~~

~~3.1. Violations of this policy that may constitute criminal conduct will be reported to the appropriate law enforcement agency and State licensing agencies and the California Department of Public Health Services, as required by law.~~

~~A. PROCEDURES FOR ALCOHOL OR DRUG TESTING OF EMPLOYEES:~~

~~1. These procedures are to be used by Directors, managers, and supervisors for testing employees where they have a reasonable suspicion that the employee may be under the influence of alcohol and/or drugs.~~

~~a. If a Director, manager, or supervisor has reasonable suspicion that an employee is under the influence of alcohol or drugs, or has otherwise violated this policy, the Director, manager or supervisor shall document the bases of suspicion. If possible, the Director/manager/supervisor shall ask another Director/manager/supervisor witness the behavior and independently document it.~~

~~b. The Director/manager/supervisor shall then accompany the employee to a private office, room, or other area and advise the employee that his/her behavior or performance warrants a medical examination and alcohol and drug test.~~

~~c. The examination and test will be conducted in the employee health department by the Employee Health Nurse, administrative coordinator or an emergency department physician. The Administrative Coordinator is to be contacted when Employee Health~~

~~2. If the employee agrees to an alcohol and drug test, the following procedures should be carried out.~~

~~a. The employee shall be asked to read and sign an Authorization for Testing form and an Authorization for Release and Use of Testing Information (both forms are maintained by Employee Health); and~~

~~b. If the results of the test(s) administered are negative or inconclusive no further action will be taken by TCHD with regard to the violation of this policy.~~

~~3. If the employee refuses to consent to a medical examination, alcohol and drug test, the following procedures should be carried out:~~

~~a. The Director/manager/supervisor shall explain to the employee that the requested medical examination, alcohol and drug test is used to establish the employee's compliance with this policy and/or fitness to perform his/her job;~~

~~b. The Director/manager/supervisor shall inform the employee that his/her refusal to consent to a medical examination, alcohol and drug test will be interpreted as a deliberate failure to comply with a reasonable request and the employee will be subject to discipline up to and including termination. The employee should also be advised that he/she will not be allowed to use evidence of alcohol or drug abuse as a mitigating factor regarding any discipline imposed for misconduct or unsatisfactory job performance; and~~

~~c. The employee will be immediately placed on administrative leave if he/she refuses to consent to a medical examination and alcohol and drug test. If an employee refuses to submit to a medical exam and/or alcohol and drug test this refusal will not serve to reduce the discipline for misconduct or unsatisfactory job performance resulting from a positive test.~~

~~4. If the employee refuses to cooperate in the testing process in such a way that prevents completion of the test, or interferes with a test by adulterating or diluting the specimen, substituting the specimen with that from another person or sending an impostor to be tested, the employee will be subject to the same consequences as if he or she had been tested and the result had been positive.~~

~~5. If the drug or alcohol screen is positive, the employee will be placed immediately on administrative leave and arrangements will be made to transport the employee home.~~

~~a. If a positive drug screen identifies a legal drug, the employee may be requested to provide within 24 hours a bona fide verification of a valid current prescription in the employee's name for the drug identified in the drug screen.~~

~~b. A positive alcohol and/or drug test result will be confirmed.~~

~~c. A chain of custody of the tested blood, urine or other sample will be established and maintained by the testing clinic or laboratory.~~

~~d. Laboratory reports and/or test results shall not be placed in an employee's personnel file. Laboratory reports and/or the results shall be maintained in a separate confidential medical records file in the Employee Health Department. Laboratory reports and/or test results shall be disclosed only to individuals on a need to know basis and to the employee upon request.~~

~~e. Upon request the employee may have the original sample retested at an approved forensic accredited laboratory of their choice. This retest will be at the employee's expense.~~

~~E.~~G. PROCEDURES FOR ALCOHOL AND DRUG TESTING OF APPLICANTS:

1. As part of TCHD's employment screening process, applicants must pass a test for controlled substances, ~~under the procedures described in Section E.2. of this Policy~~. The offer of employment is condition**aled** on a negative test result. ~~Job announcements will contain notice of TCHD's drug testing policy and identify the positions subject to pre-employment testing.~~

a. A positive result for a drug and/or alcohol **test**~~analysis~~ may result in the applicant not being hired.
   i. If a drug screen is positive at a pre-employment physical, the applicant may be requested to provide within 24 hours a bona fide verification of a valid current prescription in the employee's name for the drug identified in the drug screen.
   ii. If the applicant does not provide acceptable verification, or the drug may impair the applicant's ability to perform essential job functions, the applicant may not be hired.

~~**A positive alcohol and/or drug test result will be confirmed.**~~

~~**A chain of custody of the tested blood, urine or other sample will be established and maintained by the testing clinic or laboratory.**~~

~~**Laboratory reports and/or test results shall not be placed in an employee's personnel file. Laboratory reports and/or the results shall be maintained in a separate confidential medical records file in the Employee Health Department. Laboratory reports and/or test results shall be disclosed only to individuals on a need to know basis and to the employee upon request.**~~

~~2. **Upon request the employee may have the original sample retested at an approved forensic accredited laboratory of their choice. This retest will be at the employee's expense**~~

~~F. **RELATION TO DISABILITIES:**~~

~~1. Nothing in this Policy shall affect TCHD's obligation to not discriminate and to reasonably accommodate those individuals with alcohol or drug dependencies, who have completed a rehabilitation program in accordance with applicable state and federal laws. Employees and applicants should be aware that none of these laws prohibit TCHD from taking disciplinary action against employees who are currently using illegal drugs, misusing legal drugs or abusing alcohol.~~

~~2. Employees who believe they have a drug or substance abuse problem should be aware of the counseling services that are available through TCHD's Employee Assistance Program ("EAP"). Information about EAP services is available in the Employee Handbook and from Employee Health.~~

~~G.~~H. **INSPECTION BASED ON REASONABLE SUSPICION OF POSSESSION OF ILLEGAL DRUGS:**

1. To promote an alcohol and drug free, safe, productive and efficient workplace, TCHD reserves the right to search or inspect all property which it owns or controls to determine the presence of alcohol or drugs.
   a. TCHD expressly reserves the right to inspect TCHD owned or controlled property. ~~including, but not limited to, buildings, break areas, lunch rooms, restrooms, loading docks, lockers, desks, filing cabinets, tool boxes, vehicles, packages, containers and other articles within the work area.~~
   b. TCHD shall neither physically search ~~the person of~~ an employee**'s person** nor search **their** personal possessions ~~of employees~~ without **the employee's** freely given consent, ~~by the employee that is~~ witnessed by the **head of** ~~lead~~ Human Resources **department** ~~official~~ or **their**~~his/her~~ designee.
2. If the **head of**~~lLead~~ Human Resources **department** ~~Officer~~ or **their**~~his/her~~ designee has reason to believe that an employee may have illegal drugs in **their**~~his/her~~ possession in an area not jointly or fully controlled by TCHD **they**~~he/she~~ shall notify the appropriate law enforcement agency.

~~H. **PROCEDURES:**~~

~~1. Employee Health Procedures provide detailed guidelines for testing listed in this policy and can be found in Employee Health & Wellness: Alcohol and Drug Testing Guidelines.~~

I. **FORM(S):**

1. Authorization for Testing Form ~~– Sample~~
2. Authorization for Release and Use of Testing Information ~~– Sample~~
~~2.~~3. **Reasonable Suspicion Form**

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

~~Employee Health & Wellness: Alcohol and Drug Testing Guidelines~~

1. **Authorization for Testing**
2. **Authorization for Release**
3. **Alcohol and Drug Testing: Guidelines for Directors, Managers or Supervisors**
~~1.~~4. **Administrative Policy: Business Visitor Visitation Requirements 203**

Alcohol and/or Drug Testing
Management Guidelines ~~For Directors, Managers Or Supervisors~~

1. The suspicion of alcohol or drug use must be based ~~upon~~ objective factors related to the employee's appearance, conduct, speech, behavior, and/or other objective factors. If a department head, manager, or supervisor has reason to believe an employee is under the influence of alcohol or drugs, or has otherwise violated this policy, they are ~~Director, manager or supervisor is~~ required to document the basies of suspicion using the Reasonable Suspicion form and carry out the following procedures:
   a. Accompany the employee to Employee Health. If after hours, contact the Administrative Supervisor for direction.~~a private office, room, or other area. If possible, a witness should accompany the employee and the department head, manager or supervisor.~~ Upon request, the employee may have another employee act as a witness on their~~his/her~~ behalf. Action regarding the employee shall not be delayed by the request for an employee-selected witness.
   b. If it is determined that this policy may have been violated, the ~~Vice President of~~ head of the Human Resources department or their~~his/her~~ designee should be advised of the situation. After receiving authorization to conduct an ~~medical examination and~~ alcohol and drug test, the employee should be informed~~told~~ that their~~his~~ behavior or performance warrants an ~~medical examination and~~ alcohol and drug test. The ~~examination and~~ test will be conducted at TCHD's preferred occupational provider. ~~in the. The Administrative Coordinator is to be contacted when Employee Health Services is closed.~~
2. If the employee agrees to ~~a medical examination,~~ an alcohol and/or drug test, the following procedures should be carried out.~~:~~
   a. The employee should be asked to read and sign an Authorization for Testing form, and an Authorization for Release and Use of Testing Information form.
   b. If the results of the ~~medical examination,~~ alcohol and/or drug test indicate another medical or psychological cause for the employee's behavior, the employee will be placed on Aadministrative Lleave and will be required to provide TCHD with a medical release from a physician before returning to work. TCHD may require the employee to be examined and evaluated by a TCHD selected physician before being allowed to return to work.
   c. If the results of the ~~medical examination,~~ alcohol and/or drug test are negative or inconclusive no further action will be taken by TCHD with regard to the violation of this policy.
3. If the employee refuses to consent to ~~a medical examination,~~ an alcohol and/or drug test, the following procedures should be carried out:
   a. The d~~D~~irector, manager or supervisor must explain to the employee that the requested ~~medical examination,~~ alcohol and/or drug test is used to establish the employee's compliance with this policy and/or fitness to perform their~~his/her~~ job.
   b. The d~~D~~irector, manager or supervisor must inform the employee that their~~his/her~~ refusal to consent to ~~a medical examination,~~ an alcohol and/or drug test will be interpreted as a deliberate failure to comply with a reasonable request, and the employee will be subject to discipline up to and including termination. ~~-~~The employee should also be advised that they~~he/she~~ will not be allowed to use evidence of alcohol or drug abuse as a mitigating factor regarding any discipline imposed for misconduct or unsatisfactory job performance.
   c. The employee will be immediately placed on Aadministrative Lleave if they~~he/she~~ refuse~~s~~ to consent to ~~a medical examination and~~ an alcohol and/or drug test. If an employee refuses to submit to ~~a medical exam and/or~~ an alcohol and/or drug test, this refusal will not serve to reduce the discipline for misconduct or unsatisfactory job performance.
4. The Administrative Supervisor~~Coordinator,/Vice President of~~ head of the Human

Resources department ~~or their~~~~his/her~~ designee must be informed of the situation by the d~~D~~irector, manager or supervisor. The decision to place the employee on A~~a~~dministrative L~~l~~eave will be made by the ~~Vice President of~~ head of the Human Resources department ~~or their~~~~his/her~~ designee.

5. **If the employee is placed on A~~a~~dministrative L~~l~~eave, the d~~D~~irector, manager or supervisor should arrange for the employee to be transported home.**
6. **All d~~D~~irectors, managers and supervisors involved in any incident investigated under this policy must prepare a written record of the incident within twenty-four (24) hours of its occurrence.**

Authorization for Testing Form ~~- Sample~~

AUTHORIZATION FOR TESTING

Agreement to Submit to Drug and Alcohol Screen by Blood and Urine Tests

I have been informed that Tri-City Healthcare District (TCHD), based on my behavior and appearance, is concerned that I may be under the influence of drugs or alcohol, or may otherwise have violated TCHD's rules against drug and alcohol use, and that my ability to perform my job duties, is therefore, in question; and as a result, I have been requested to submit to a drug and alcohol screen.

I have been informed and I understand, that my agreement to submit to the requested alcohol and drug screens by blood and urine tests is completely voluntary on my part, and that I have the right to refuse to submit to the tests. I am aware and have been told, that my refusal to submit to the drug and alcohol screen by blood and urine tests **will be subject to**~~may be grounds for~~ disciplinary action against me, up to and including termination.

I have also been informed and am aware that the results of this drug and alcohol screen by blood and urine tests may be released to other TCHD officials, including but not limited to my supervisor as applicable, and that the results of such test(s) may form the basis for disciplinary action against me, up to and including termination.

With full knowledge of the above information, I have decided to voluntarily submit to the requested drug and alcohol screen by blood and urine tests, in recognition of this agreement, do sign this consent form.

Date:_____ Employee:_____

Date:_____ Witness:_____

Authorization for Release and Use of Testing Information ~~- Sample~~

~~**Tri-City Medical Center**~~
~~4002 Vista Way, Oceanside, California 92056 (760) 724-8411~~

AUTHORIZATION FOR RELEASE AND USE OF TESTING INFORMATION

I have voluntarily agreed to submit to a drug and alcohol screen by blood and urine tests to be administered by Tri-City Healthcare District (TCHD). I hereby authorize the release of the results of the above-mentioned drug and alcohol screen by blood and urine tests to the ~~Director for~~ Human Resources **department head or their designee**, and such other TCHD officials and employees as the ~~Director for~~ Human Resources **department head** may determine it is necessary to disclose such information.

I understand the information so released to TCHD will be used to determine whether I was fit to perform my job duties, and/or whether I had violated TCHD's work rules concerning drug and alcohol use. ~~TCHD Emergency Department and~~ **Independent** Laboratory Services, as applicable, only is authorized to disclose the results of my drug and alcohol screen, ~~as described above, for 120 days after the date I executed this Authorization.~~ I understand that I have a right to receive a copy of this authorization, and that one will be provided upon request.

Date:_____ Employee:_____

Date:_____ Witness:_____

Tri-City Medical Center
Oceanside, California

Reasonable Suspicion Form

Document all pertinent behavior and physical signs and symptoms that lead you to reasonably believe the employee has recently used, or is under the influence of, alcohol and/or drugs. Mark any applicable items on this form and describe in detail any additional facts or circumstances of note.

Employee Name:		**Employee ID#:**	
Department:		**Job Title:**	
Shift:		**Employee's Direct Supervisor:**	
Observing Supervisor Name:		**Observation Date:** **Observation Time:**	
Observing Supervisor Signature:			
Second Observing Supervisor Name:		**Observation Date:** **Observation Time:**	
Second Observing Supervisor Signature:			

Reasonable suspicion - Based on current first-hand observations concerning the appearance, behavior, speech, or body odors. Independently observed & documented behavior from two managers.

Unusual Behavior:

o Staggering/Swaying o Unable to Walk o Tremors/Shakes o Holding on While Walking	o Falling Down o Drowsy/Sleepy/ Lethargic o Depressed/Withdrawn o Irritable/Moody	o Agitated/Anxious/ o Restless o Unresponsive/ Distracted o Suspicious/Paranoid o Uncooperative	o Hostile/Belligerent o Clumsy/ Uncoordinated o Hyperactive/Fidgety

Appearance:

o Flushed Complexion o Alcohol-like Smell o Marijuana-like Smell o Runny Nose/Nostril Sores	o Profuse Sweating o Unkempt hair/clothing o Dizziness or Fainting o Puncture Marks/ "Tracks"	o Bloodshot Eyes o Unfocused, Blank Stare o Wearing Sunglasses Indoors	o Glassy Eyes/ Dazed o Dilated (large) Pupils o Constricted (small) Pupils

Speech:

o Slurred o Incoherent	o Confused o Mumbling/Rambling	o Excessively Talkative o Yelling	o Whispering o Nonsensical/Silly

Job Performance and Interpersonal Behavior:

o Unexplained Disappearances o Inappropriate Behavior or Verbal Responses	o Sleeping on Job o Verbal Abusiveness o Patient and/or Co-Worker Complaints	o Physical Abusiveness o Argumentative o Extreme Aggressiveness o Profanity	o Hostile o Disregard for Safety o Damaging Company Property

Other:

Employee Health Received: _____

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE ~~POLICY~~
HUMAN RESOURCES

ISSUE DATE: 04/86

SUBJECT: Fair Treatment For ~~Supervisory and Management~~ Employees

REVISION DATE: 07/09; 08/12; 02/13; 10/13 12/15, 08/20

POLICY NUMBER: 8610 – 427

Administrative Content Expert~~Human Resources Department~~ Approval:	~~02/2011/239/24~~08/25
Administrative Policies & Procedures Committee Approval:	~~03/209/24~~09/25
Medical Executive Committee Approval:	n/a
Administration Approval:	~~07/20~~09/25
Professional Affairs Committee:	n/a
Board of Directors Approval:	08/20

A. **PURPOSE:**

1. At Tri-City Healthcare District (TCHD), we are committed to maintaining a workplace environment that fosters respect, fairness, and equity for all employees. TCHD believes that every employee has the right to be treated with dignity and to have their concerns heard and addressed in a timely and effective manner.

~~1.~~2. To uphold these values, we have established a Fair Treatment and Grievance Process to ensure that all employees have access to a transparent and structured mechanism for resolving workplace issues, disputes, or grievances. This process is designed to address concerns related to unfair treatment, or any other work-related issues that may arise.~~To provide an orderly process for supervisors, managers, directors and above to receive fair treatment in connection with employment performance issues, intent to suspend or terminate their employment.~~

B. **DEFINITIONS:**

~~Fair Treatment Process: In the case of corrective actions involving disciplinary final written warning or intent to terminate, employee supervisors, managers, directors and above with more than who has completed ninety (90) days of active service may proceed with the Fair Treatment Process.employment shall be entitled to follow the process set forth below. A Human Resources representative will shall be available to facilitate the Fair Treatment process.~~

1. Ensure Fair Treatment: Provide a work environment where all employees are treated fairly and with respect, without discrimination or bias.
2. Promote Open Communication: Encourage employees to voice their concerns, provide feedback, and seek resolution to any issues that may affect their work or well-being.
3. Resolve Grievances: Establish a clear and efficient process for resolving grievances in a manner that is fair, impartial, and respectful of all parties involved.

~~1.~~4. Prevent Retaliation: Protect employees from retaliation for raising concerns or filing grievances, ensuring their right to a safe and supportive workplace.

C. **POLICY:~~NON-MANAGEMENT PROCESS~~**

1. This policy applies to all employees at TCHD, including managers, supervisors, and other non-unionized staff members. The policy covers all work-related concerns, including but not limited to issues of unfair treatment, and conflicts with colleagues or supervisors.~~Step 1: Meeting with Management~~

~~If a non-management employee has received a final written warning or a notification of intent to terminate their employment, and wishes to initiate the Fair Treatment~~

~~**Process, they must contact Human Resources to schedule a meeting with the next level of management, beyond their direct supervisor, to discuss the issue. This initial contact shall be made within 5 working days (M-F) from the date of the suspension or intent to term notification. If the non-management employee fails to contact Human Resources within 5 working days (M-F), their opportunity to continue the Fair Treatment process shall end.**~~

- ~~**The manager and a Human Resources representative will meet with the non-management employee, listen to the issues and inquire if the non-management employee can offer information for further investigation and analysis. The manager will respond in writing with their decision to the non-management employee within five working days (M-F) following the meeting.**~~
- ~~**If the Fair Treatment Process has been initiated due to a termination then the date of the letter from the manager to the non-management employee at completion of Step 1 becomes the effective date of the non-management employee's termination. Although the non-management employee has been terminated, they may choose to continue the Fair Treatment Process by contacting Human Resources within 5 working days (M-F) of the notification of the manager's decision.**~~

~~**Step 2: Fair Treatment Form**~~

- ~~**If the non-management employee still feels after Step I that the decision is unfair, , the non-management employee may commence a formal grievance process within 5 working days (M-F) of the decision by the non-management employee's manager in Step I. The formal grievance process begins with the submission to Human Resources of a completed Fair Treatment form, signed by the non-management employee and describing in specific detail the nature of the grievance and the facts giving rise to it. If the non-management employee fails to submit the completed Fair Treatment form within the above time frame, the Fair Treatment process shall end.**~~
- ~~**The Director or Vice President will review, investigate and analyze the complaint. The Director or Vice President will then respond to the non-management employee in writing. The decision letter will be sent no later than 5 working days (M-F) after concluding their analysis.**~~

~~**Step 3: Fair Treatment Form/Final review by the Head of Human Resources**~~

- ~~**If the matter is still unresolved to the non-management employee's satisfaction after Step II, the non-management employee may request review by the Head of Human Resources. This request for review must be initiated within five working days (M-F) from the completion of Step 2. If the non-management employee fails to contact the Human Resource Representative within this time frame, their opportunity to continue the Fair Treatment Process will end.**~~
- ~~**The complaint is sent to the Head of Human Resources who will review the information. The Head of Human Resources will respond in writing to the non-management employee no later than five working days (M-F) after concluding their analysis.**~~
- ~~**Decisions of the Head of Human Resources shall be in writing and be binding.**~~
- ~~**No employee will be subject to reprimand, retaliation or harassment by anyone as a result of initiating a formal or an informal complaint, truthfully answering questions during an investigation, assisting a fellow employee, and/or providing truthful testimony.**~~

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

~~C.~~ D. **FAIR TREATMENT ~~SUPERVISOR/MANAGEMENTR LEVEL~~ PROCESS:**

1. Step I: **Informal Resolution: Resolve the issue quickly and at the closest level to where the grievance arose.**~~Meeting with Management~~

a. **Initial Discussion: Employees are encouraged to first raise their concerns directly with their immediate supervisor or manager. Many issues can be effectively resolved through open communication and collaboration.**~~If a supervisor/manager has received a final written warning or notification of intent to terminate their employment, and wishes to initiate the Fair Treatment Process, they must contact Human Resources to schedule a meeting with the next level of management, beyond their direct supervisor/manager, to discuss the issue. This initial contact shall be made within 5 working days (M-F) from the date of the suspension or intent to term notification. If the employee fails to contact Human Resources within 5 working days (M-F), their opportunity to continue the Fair Treatment process shall end.~~

b. **Alternative Contact: If the grievance involves the supervisor or if the employee feels uncomfortable addressing the issue with them, the employee may choose to discuss the matter with another manager or the Human Resources (HR) Department.**~~The employee's manager, beyond their direct supervisor/manager, and a Human Resources representative shall meet with the employee, and the manager shall respond to the employee within 5 working days (M-F) after the meeting with their decision.~~

c. **Timeframe: This step should be initiated as soon as possible after the incident occurs, ideally within five (5) business days (M-F).**~~If the Fair Treatment Process has been initiated due to a termination then the date of the letter from the manager to the employee at completion of Step 1 becomes the effective date of the employee's termination. Although the employee has been terminated, they may choose to continue the Fair Treatment Process by contacting Human Resources within 5 working days (M-F) of the notification of the manager's decision.~~

2. Step II: **Formal Grievance and Departmental Hearing: Conduct a formal review of the grievance within the employee's department.**~~Fair Treatment Form~~

   a. **Written Submission: If the issue is not resolved through informal discussions, the employee may file a formal grievance by:**
      i. **Submitting a written grievance to the HR Department, detailing the nature of the grievance,**
      ii. **Date(s) of the incident(s),**
      iii. **Individual(s) involved, and any relevant evidence.**
      iv. **Submit the formal grievance.**
         1) **The formal grievance must be submitted within ten (10) business (M-F) days of completing Step I.**

   b. **Departmental Hearing: Upon receiving the formal grievance, the HR Department will coordinate a hearing within the employee's department. This hearing will include:**
      i. **The employee**
      ii. **Their supervisor or manager**
      iii. **A representative from HR**
      ~~i.~~iv. **Any other relevant parties as determined by HR**~~If the employee still feels after Step I that the decision is unfair, the employee may commence a formal grievance process within 5 working days (M-F) of the decision by the employee's manager in Step I. The formal grievance process begins with the submission to Human Resources of a completed Fair Treatment form, signed by the employee and describing in specific detail the nature of the grievance and the facts giving rise to it. If the employee fails to submit the completed Fair Treatment form within the above time frame, the Fair Treatment process shall end.~~

   c. **Hearing Process:**
      i. **The employee presents their grievance and supporting evidence.**
      ii. **The supervisor or manager responds to the grievance.**
      iii. **HR may ask questions or request further information.**
      ~~ii.~~iv. **Both parties have the opportunity to discuss possible resolutions.**~~A Human Resources representative shall forward a copy of the completed Fair~~

~~Treatment form to the Head of Human Resources within 5 working days (M-F) of receipt of the form.~~

d. Decision and Response: After the hearing, HR will issue a written decision within ten (10) business days (M-F), outlining the findings and any corrective actions to be taken.

~~b.~~**e. Timeframe: The departmental hearing and decision should be completed within fifteen (15) business days (M-F) of the grievance submission.**~~The Head of Human Resources, or designee, shall review, investigate, and analyze the matter and shall respond in writing with their decision no later than 5 working days (M-F) after concluding their analysis. The employee is deemed notified on the date the decision letter is postmarked.~~

3. Step III: **Executive Review and Final Hearing: Provide a final review and resolution of the grievance by a member of the executive team.**~~Final Review by Chief Executive Officer~~

a. **Appeal Submission: If the employee is not satisfied with the outcome of the departmental hearing, they may appeal the decision. The appeal must be submitted in writing to the head of Human Resources within ten (10) business days (M-F) of receiving the Step II decision.**~~If the matter is still unresolved to the employee's satisfaction after Step II, the employee may request review by the Chief Executive Officer. Human Resources shall present the completed Fair Treatment form to the Chief Executive Officer within 5 working days (M-F) of notification of the Head of Human Resources decision. If the employee fails to request review by the Chief Executive Officer within the time frame specified for this Step III, the Fair Treatment process shall end.~~

b. **Executive Hearing: Upon receiving the appeal, HR will arrange a final hearing to be conducted by a member of the hospital's executive team. The hearing will include:**
   - **i. The employee**
   - **ii. The Head of HR**
   - **iii. The executive team member overseeing the hearing**
   - **iv. Any other relevant parties as determined by HR**~~The Chief Executive Officer, or designee shall review, investigate, and analyze the matter and render a decision within 5 working days (M-F) after concluding their analysis. The employee is deemed notified on the date the decision letter is postmarked. Decisions of the Chief Executive Officer are final and binding.~~

c. **Hearing Process:**
   - **i. The employee presents their appeal and any additional information.**
   - **ii. A review of the previous findings from the departmental hearing.**
   - **iii. Discussion of the appeal and any further evidence.**

d. **Final Decision: The executive team member will issue a final, binding decision within ten (10) business days (M-F) of the hearing. This decision will be communicated to the employee in writing and will include any final actions to be taken by the hospital.**

~~b.~~**e. Timeframe: The executive hearing and final decision should be completed within twenty (20) business days (M-F) of the appeal submission.**

4. **Tri-City Healthcare District strictly prohibits any form of retaliation against employees who raise concerns, file grievances, or participate in the grievance process. Retaliation will be subject to disciplinary action, up to and including termination of employment.** ~~**PROCESS FOR DIRECTORS AND ABOVE**~~

~~5. Step I: Meeting with Executive~~

~~6. If a Director or above has received a final written warning or notification of intent to terminate their employment, and wishes to initiate the Fair Treatment Process, the employee must contact Human Resources to schedule a meeting with the Head of Human Resources and C-Suite member, as appropriate based on their reporting hierarchy, to discuss the issue. This initial contact shall be made within 5 working days (M-F) from the date of notification of the intended suspension or termination. If the employee fails to contact Human Resources within this time frame, the opportunity to continue the Fair Treatment process shall end.~~

~~7. The appropriate Executive shall meet with the employee and will respond within 5 working days (M-F) with their decision.~~

~~8. Step II: Fair Treatment Form/Final Review by the CEO~~

~~9. If the appropriate Executive does not resolve the employee's complaint to their satisfaction, the employee shall complete the Fair Treatment form and Human Resources shall present the written form to the Chief Executive Officer within 5 working days (M-F) of the appropriate Executive's decision.~~

~~The Chief Executive Officer or designee shall review, investigate and analyze the matter and render a decision within 5 working days after concluding their analysis. The employee is deemed notified on the date the decision letter is postmarked. Decisions from the Chief Executive Officer are final and binding. If the employee fails to request review by the Chief Executive Officer within the set time frame, the Fair Treatment process shall end.~~

~~D.~~E. ~~FORM~~REFERENCED FORM WHICH CAN BE REQUESTED FROM HR:

1. Fair Treatment Form

F. RELATED DOCUMENTS:

1. **Administrative Policy: Discrimination, Harassment and Retaliation Prevention 403**

Tri-City Medical Center
Oceanside, California

Fair Treatment Form			
Complete form if resolution not obtained during Step I of Fair Treatment Process (Policy 8610-427 Open Communication and Fair Treatment for Employees)			
Employee Name:		**Employee ID#:**	
Department:		**Job Title:**	
Shift:		**Direct Supervisor:**	
Cell Phone:		**Home Phone:**	
Personal E-Mail:			
Mailing Address:			
Employee Signature:			
Please provide details regarding Step I: Step I meeting date (within 5 business days after incident occurred): _____ Reason(s) why unable to resolve (use additional sheets of paper if needed):			
Step II filing date (within 10 business days of completing Step I): _____ **Grievance Information: Detail nature of the grievance, including date(s) of the incident(s), individual(s) involved and any relevant evidence**			

Received in Human Resources:	Name:	Date:	
Step II scheduled:	Scheduled with:	Date:	
Outcome of Step II:	Written decision sent to employee within 10 business days of Step II meeting	Date:	
Step III Initiated by employee:	Yes / No Scheduled with:	Date:	
Final Decision	Final decision sent to employee within 20 business days of Step III meeting	Date:	

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Human Resources

RETIRE – Incorporated into Administrative Policy: Fair Treatment for Employees 427

ISSUE DATE: 04/88 **SUBJECT: Fair Treatment For Non-Management**

REVISION DATE(S): 03/05; 04/12; 02/13, 10/13 **POLICY NUMBER: 8610-428**

Administrative Content Expert Approval:	~~07/20~~08/25
Administrative Policies & Procedures Committee Approval:	~~08/20~~09/25
Medical Executive Committee Approval:	n/a
Administration Approval:	09/25
Professional Affairs Committee Approval:	~~n/a~~
~~**Human Resources Department Approval:**~~	~~11/16~~08/25
~~**Human Resources Committee Approval:**~~	~~11/16~~08/25
Board of Directors Approval:	12/16

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

~~1. To provide an orderly mechanism **process** for non-management employees **to receive fair treatment in connection with** employment **performance issues**related complaints, **intent to suspend or terminate employment**. (**Tri-City Health District (TCHD)** Administrative Policy #427 Fair Treatment for Supervisory and Management Employees **427**).~~

~~B. **DEFINITION:**~~

~~1. Fair Treatment Process: In the case of corrective actions involving a disciplinary final written warning or intent to terminate, any employee who has completed ninety (90) days of active service may proceed with the Fair Treatment Process. A Human Resources representative will facilitate the Fair Treatment Process.~~

~~C. **PROCESS:**~~

~~1. Step 1: Meeting with Management~~

~~a. If an **non-management** employee has received a final written warning or a notification of intent to terminate his or her **their** employment, and wishes to initiate the Fair Treatment Process, he or she **they** must contact Human Resources to schedule a meeting with the next level of management, beyond their direct supervisor, to discuss the issue. This initial contact shall be made within 5 working days (M-F) from the date of the suspension or intent to term notification. If the **non-management** employee fails to contact Human Resources within 5 working days (M-F), his or her **their** opportunity to continue the Fair Treatment process shall end.~~

~~i. The manager and a Human Resources representative will meet with the **non-management** employee, listen to the issues and inquire if the **non-management** employee can offer information for further investigation and analysis. The manager will respond in writing with his or her **their** decision to the **non-management** employee within five working days (M-F) following the meeting.~~

~~ii. If the Fair Treatment Process has been initiated due to a termination then the date of the letter from the manager to the **non-management** employee at completion of Step 1 becomes the effective date of the **non-management** employee's termination. Although the **non-management** employee has been terminated, he or she **they** may choose to continue the Fair Treatment Process by contacting Human Resources within 5 working days (M-F) of the notification of~~

the manager's decision.

2. Step 2: Fair Treatment Form
   a. If the **non-management** employee still feels after Step I that the decision is unfair, , the **non-management** employee may commence a formal grievance process within 5 working days (M-F) of the decision by the **non-management** employee's manager in Step I. The formal grievance process begins with the submission to Human Resources of a completed Fair Treatment form, signed by the **non-management** employee and describing in specific detail the nature of the grievance and the facts giving rise to it. If the **non-management** employee fails to submit the completed Fair Treatment form within the above time frame, the Fair Treatment process shall end.
   b. The Director or Vice President will review, investigate and analyze the complaint. The Director or Vice President will then respond to the **non-management** employee in writing. The decision letter will be sent no later than 5 working days (M-F) after concluding his/her **their** analysis.
3. Step 3: Fair Treatment Form/Final review by lead **the Head of** Human Resources official
   a. If the matter is still unresolved to the **non-management** employee's satisfaction after Step II, the **non-management** employee may request review by the lead **Head of** Human Resources official. This request for review must be initiated within five working days (M-F) from the completion of Step 2. If the **non-management** employee fails to contact the Human Resource Representative within this time frame, his or her **their** opportunity to continue the Fair Treatment Process will end.
   b. The complaint is sent to the Lead **Head of** Human Resources Official who will review the information. The Lead **Head of** Human Resources Official will respond in writing to the **non-management** employee no later than five working days (M-F) after concluding his/her **their** analysis.
   c. Decisions of the Lead **Head of** Human Resources Official shall be in writing and be binding.

   No employee will be subject to reprimand, retaliation or harassment by anyone as a result of initiating a formal or an informal complaint, truthfully answering questions during an investigation, assisting a fellow employee, and/or providing truthful testimony.
   d. **To the extent that any applicable collective bargaining agreement that is consistent with applicable law conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement prevails.**

D. **REFERENCED FORM WHICH CAN BE REQUESTED FROM HR:**
   1. Fair Treatment Form

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE ~~POLICY~~
HUMAN RESOURCES

ISSUE DATE: 7/87 **SUBJECT: Leave of Absence**

REVISION DATE: 08/12, 12/13, 12/16 **POLICY NUMBER:** 8610– 435

Administrative Content Expert~~Human Resources Department Approval~~: ~~03/2010/24~~07/25
Administrative Policies & Procedures Committee Approval: ~~03/20~~09/25
Medical Executive Committee Approval: n/a
Administration Approval: ~~08/2009~~/25
Professional Affairs Committee Approval: n/a
Board of Directors Approval: 08/20

A. **PURPOSE:**
1. To establish guidelines for authorized time away from work for Tri-City Healthcare District (TCHD) employees.

B. **POLICY:**
1. It is the policy of TCHD to grant time away from work to eligible employees. Eligibility and leave entitlement vary under legislated leave provisions.
2. The following conditions apply to all types of leave time:
   a. Requesting a Leave of Absence
      i. Requests for a leave of absence must be submitted through the appropriate third--party administrator as far in advance as possible.
      ii. Other than planned **Paid Time Off** (PTO), if there are more than three (3) consecutive scheduled missed work days, employees need to contact the third-party administrator to request a leave.
      iii. Employees are responsible for notifying their manager or direct supervisor and the third party administrator as far in advance as possible for the time away from work.
         1) For foreseeable events, the employee should notify their manager or direct supervisor and third party administrator at least thirty (30) days in advance of the anticipated leave start date.
         2) If the event is unforeseeable, notice must be given by the employee as soon as possible.
         3) In some instances, failure to give advance notice may result in postponement or denial of the leave.
         4) Intermittent uses need to be reported to the third party administrator within forty-eight (48) hours of the absence for the absence to be protected. Employees must also follow normal call out procedures for their given department when using approved intermittent.
      iv. Documentation to authorize or renew the leave may be required based on the nature and anticipated duration of the leave.
         1) Any leave of absence requiring certification from a health care provider will be denied if the appropriate certification is not received by the due date or is incomplete. This may result in the leave being designated as unapproved and will be subject to the Administrative Policy: Absence and Tardiness Policy # 408.
         2) TCHD may require recertification of the condition for an employee who is

on leave due to their own or a qualified family member's medical condition, including intermittent leave requests. TCHD may also request periodic reports during an employee leave regarding the leave status and intent to return to work.

b. Compensation and Benefits
   i. Any accrued Paid Time Off (PTO) must be used during a leave (except for Work Related Injury/Illness, Pregnancy Disability, and Military Leave).
      1) Work Related Injury/Illness: An employee is placed on temporary or total disability leave for more than three (3) **scheduled work** days for a work place injury/illness will be compensated by the Workers Compensation insurance carrier at the appropriate compensation rate established by the state of California.
   ii. Employees who have Annual Leave Bank (ALB) and/or Extended Leave Bank (ELB) hours must use the accrued hours during any leave attributable to the employee's own medical condition.
   iii. It is the responsibility of the employee to apply for compensation and benefits through California Workers' Compensation Insurance (WCI), State Disability Insurance (SDI) or Paid Family Leave (PFL).
   iv. Benefits will be continued during a leave as required by the statutes and regulations that apply to the particular type of leave. Benefits through TCHD will continue for **up to** 12 ~~cumulative~~ weeks ~~in a rolling year~~ that an employee is on **a protected** leave of absence. **For ~~–~~ADA leaves that do not follow a leave under FMLA, benefits under TCHD will stop at the end of the month of the approved ADA start date.** Premiums will continue to be deducted from your pay while using approved PTO, ALB and/or ELB. After benefits are terminated, employees will be given the opportunity to enroll with COBRA. **While on leave if your benefit deductions should go into arrears, payroll will process arrear deductions from your payroll when you return from leave.**

c. Returning from a Leave of Absence
   i. An employee who is on an approved leave is expected to return to work at the time designated in the leave documentation or in accordance with applicable federal and California state statutory provisions. If the employee does not return as indicated, the absence will be subject to the provisions of Administrative Policy: Absences and Tardiness 408.
   ii. An employee who is returning from a leave due to their own medical condition must provide a medical release to the Human Resources department (HR) or third~~–~~party administrator at least **three (3) business days**~~twenty-four (24) hours~~ prior to the employee returning to work.
      1) An employee returning from leave with work restrictions is responsible for requesting any accommodations through HR. HR **will** ~~may~~ coordinate an interactive process with the employee and the employee's manager to review the request. A determination is made based on the essential functions of the employee's position, medical certification, and needs of the department without creating an undue hardship on the organization.
      2) Disability related information, including medical documentation, is treated as confidential and access is limited to protect the requesting party's privacy. Requests for accommodations and accompanying documentation are kept separate from the employee's personnel file.
   iii. An employee returning from an approved, protected leave will be returned to the same or an equivalent position, unless the position has ceased to exist for reasons of business necessity or unless otherwise exempted by law.
   iv. An employee's benefits will be reinstated upon return from a leave **on the first day of the month following the return from leave.**~~–~~

d. TCHD will not interfere with, restrain, or deny employees their rights to protected leave

time.

e. TCHD may delay or continue with any counseling, performance review, or disciplinary action, including discharge, that was contemplated or started prior to an employee's request for or receipt of a leave of absence or that has come to TCHD's attention during the leave. If any such action is delayed during the leave of absence, TCHD may proceed with the action upon the employee's return to work.

f. Employees on an authorized leave of absence may not work for another health care facility during the leave that is the same or substantially the same in nature to the work performed by TCHD. Such outside employment may be grounds for dismissal.

g. An employee misrepresenting the reason for requesting time off or applying for a leave of absence may be subject to disciplinary actions, up to and including termination.

3. To the extent that any applicable collective bargaining agreement, that is consistent with applicable law, conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement **shall** prevail~~s~~.

C. **FAMILY AND MEDICAL LEAVE (FMLA) AND CALIFORNIA FAMILY RIGHTS ACT (CFRA):**

1. In accordance with federal and California state law, TCHD provides an eligible employee up to 12 work weeks of leave during a rolling 12-month period for a qualifying reason with accompanying certification. This leave can be taken continuously, intermittently, or on a reduced work schedule based upon medical certification.
2. Intermittent leaves require semi-annual certification. According to Section 825.308 of the U.S. Department of Labor, an employer may request recertification more frequently if circumstances described by the previous certification have changed significantly, or the employer receives information that casts doubt upon the employee's stated reason for the absence.
3. An employee is eligible for FMLA/CFRA if the employee has:
   a. Completed 12 months of employment and
   b. Worked at least 1250 hours in the 12 consecutive months immediately preceding the leave start date.
4. FMLA/CFRA may be granted for the following reasons:
   a. Birth of an employee's child (within one year of birth). A portion of the 12 weeks is paid under CPFL (California Paid Family Leave).
   b. Placement of a child (age 18 or less) with an employee through adoption or foster care (within one year of placement).
   c. To care for an employee's qualifying family member with a serious health condition.
   d. An employee's own serious health condition makes them unable to perform one or more of the essential functions of -their job.
   e. To bond with the child of a domestic partner (CFRA only).
   f. To care for an employee's domestic partner with a serious health condition (CFRA only).
5. Any FMLA/CFRA leave taken by an eligible employee will be designated as such and will be counted against the employee's leave entitlement whether the leave is paid or unpaid.

D. **PREGNANCY DISABILITY LEAVE (PDL) and PREGNANT WORKERS FAIRNESS ACT (PWFA):**

1. In accordance with California state law, TCHD provides pregnancy disability leave for up to four months (17 weeks and 3 days) to any employee who becomes disabled and is unable to perform the essential functions of their position as a result of pregnancy, childbirth, or related medical condition. This leave can be taken continuously, intermittently, or on a reduced work schedule based upon medical certification. **The Pregnant Workers Fairness Act (PWFA) provides reasonable accommodations to a worker's known limitations related to pregnancy, childbirth or related medical conditions unless the accommodation would cause an undue hardship.**

E. **~~KIN CARE LEAVE~~PAID SICK LEAVE (PSL):**

1. In accordance with California state law, TCHD provides ~~eligible~~ employees with **Paid Sick Leave (PSL). PSL can be used:**

a. Tto recover from physical/mental illness or injury;

b. Tto seek medical diagnosis, treatment, or preventative care;

c. ~~or~~ Tto care for a ~~qualifying~~ family member who is ill or needs medical diagnosis, treatment, or preventative care;

~~Kin Care Leave for care, diagnosis, or treatment of an existing health condition of, or preventative care for an employee's qualifying family.~~

~~a.~~**d.** A ~~qualifying~~ family member is defined as:

i. Child, which for purposes of this article means a biological, adopted, or foster child, stepchild, legal ward, or a child to whom the employee stands in loco parentis. This definition of a child is applicable regardless of age or dependency status;~~.~~

ii. Biological, adoptive, or foster parent, stepparent, or legal guardian of an employee or the employee's spouse or registered domestic partner, or a person who stood in loco parentis when the employee was a minor child;~~.~~

iii. Spouse;~~.~~

iv. Registered domestic partner;~~.~~

v. Grandparent;~~.~~

vi. Grandchild;~~.~~

vii. Sibling~~.~~

~~b.~~**e. May be used for a partial day.**

2. An employee is eligible for ~~Kin Care~~**PSL** immediately upon becoming eligible to use accrued PTO as outlined in Administrative Policy: Paid Time Off Program 433. **Benefitted/**~~E~~eligible employees may use up to a maximum of one-half of their ~~annual PTO accrual~~**accrued PTO up to five (5) days annually if the PTO is available in their bank.** ~~if the PTO is available.~~

3. **Per Diem employees accrue one (1) hour of PSL for every 30 hours worked. Annual usage limited to five (5) days. Only hours that have been accrued in the current year are available to use.**

~~2. Per Diem Employees will accrue 1 hour of PSL for every 30 hours worked. An employee must have accrued enough PTO for the entire shift to be eligible to use PSL.~~

F. **AMERICAN DISABILITY ~~ACT~~ (ADA) REASONABLE ACCOMMODATION LEAVE**

1. In Accordance with ADA, TCHD may provide time off work as an accommodation if the employee is not eligible for FMLA and/or any other applicable leave entitlement.

2. HR **and the employee will**~~may coordinate~~ **engage in** an Interactive Process ~~with the employee and the employee's manager to review the leave~~ **to identify and review the accommodation** request.

a. In certain situations, an accommodation may not be possible or required. Examples include when the medical condition is not a qualifying disability under the ADA; the requested accommodation would relieve an employee if performing an essential job function or the requested accommodation would cause an undue hardship or would pose a direct threat to the safety of the employee or others. **Undue hardship may be determined based on factors such as business, operational and financial impact on TCHD.**

b. Should the employee be granted a leave of absence as a reasonable accommodation and later become eligible for FMLA and/or any other applicable leave entitlement, the remaining requested time off may be counted against the employee's leave time entitlement under those leave laws.

3. Disability related information, including medical documentation, is treated as confidential and access is limited to protect the requesting party's privacy. **It will be the responsibility of the employee to obtain the required documentation from the healthcare provider(s) within fifteen (15) days of the request.** ~~Request for accommodation and accompanying documentation are kept separate from the employee's personnel file.~~

G. **MILITARY AND MILITARY FAMILY LEAVE:**

1. Uniformed Services Employment and Reemployment Rights Act (USERRA):
   a. Leave without pay is provided when an employee enters military service of the Armed Forces of the United States or the Armed Forces Reserves. The employee is afforded reemployment rights and retains full seniority benefits for all prior service upon reemployment in accordance with the USERRA and the California Military and Veterans Code. The employee needs to file for leave through the third party vendor.
2. Unpaid Spousal Leave:
   a. In accordance with CA MVC §395.10, a qualified spouse of a qualified member of the Armed Forces, National Guard or Reserves may take up to 10 days of unpaid leave when the qualified member is on leave from deployment during a period of military conflict). PTO may be declined for this leave.
3. Qualifying Exigency Leave:
   a. Eligible employees who are a spouse, registered domestic partner, son, daughter, or parent of a military member, including active duty and reserves, may- -take up to 12-weeks of FMLA during any ~~12-month~~**12-month** period -to address qualifying exigencies. Qualifying exigencies may include attending military sponsored events, ~~arranging alternative~~**arranging alternative** childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.
4. Military Caregiver Leave:
   a. Eligible employees who are a spouse, son, daughter, parent or next of kin of a covered service member, including active duty and reserves, may take up to 26 weeks of FMLA during a single 12-month period to care for a service member who has a serious injury or illness incurred or aggravated in the line of duty on active duty who is undergoing medical treatment, recuperation, or therapy; or is in outpatient status, or is otherwise on the temporary disability retired list.

H. **WORK RELATED INJURY OR ILLNESS :**

1. In accordance with California state law, TCHD provides any employee who sustains a work-related injury or illness with workers' compensation leave and benefits. Workers' compensation leave will simultaneously count toward any available FMLA/CFRA leave time.

I. **PERSONAL LEAVE:**

1. Personal leaves are requested and granted for a minimum of seven (7) calendar days and a maximum of 31 calendar days, at the sole discretion of TCHD, and can only be authorized by a department manager or director. Among the concerns taken into consideration will be TCHD's legitimate business needs and the ability to find a temporary replacement, or to leave the position vacant for the expected duration of the leave. An employee must have worked a minimum of ninety (90) days before they can request a personal leave. An additional 30 days may be approved with administrative approval by C-Suite and Head of HR. **No more than a total of 61 days can be requested for personal leave in a calendar year**.

J. **SHORT TERM ABSENCES**

1. Parental School Leave:
   a. An employee who is a parent, guardian, stepparent, foster parent, or grandparent of, or a person who stands in loco parentis to one or more children of the age to attend Kindergarten or grades 1 to 12, inclusive, or a licensed child care provider, may take off up to forty (40) hours per calendar year but not exceeding eight (8) hours in any calendar month of the year to:
      i. Find, enroll, or reenroll the child in a school or with a licensed child care provider.
      ii. Participate in activities ~~of~~**if** the school or licensed child care provider of the child.
      iii. Address a school or child care provider emergency

b. The employee, ~~if~~of requested by TCHD, shall provide documentation from the school or licensed child care provider as proof that the employee engaged in child-related activities permitted in subdivision (a) on a specific date and at a particular time.

2. Bereavement Leave:
   a. Refer to ~~Administrative Policy:~~ Bereavement Leave for Benefited Employees **Process**~~435.01~~
3. Subpoena/Jury Duty:
   a. Refer to ~~Administrative Policy:~~ Subpoena/Jury Duty **Process** ~~435.02~~

K. **RELATED DOCUMENTS:**

1. Administrative Policy: Annual and Extended Leave Bank 489
2. Administrative Policy: Paid Time Off Program 433
3. Administrative Policy: Absences and Tardiness 408
4. **PSL Guide**
5. ~~Administrative Policy:~~ Bereavement Leave **Process**~~for Benefited Employees 435.01~~
6. ~~Administrative Policy:~~ Subpoena/Jury Duty **Process**~~435.02~~

Tri-City Medical Cent
Oceanside, California

Move from Pay Practice Manual to Related Document to Administrative Policy: Leave of Absence 435

~~**ADMINISTRATIVE**~~
~~**HUMAN RESOURCES - PAY PRACTICE**~~

ISSUE DATE: 10/04 **SUBJECT:** Bereavement Leave

REVISION DATE(S): 10/04 **POLICY NUMBER:** 8610-435.01

Administrative Human Resources Content Expert Approval:	**~~03/19~~08/25**
Administrative Policy & Procedures Committee Approval:	**~~03/19~~08/25**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~06/19~~09/25**
Professional Affairs Committee:	**n/a**
Board of Directors:	**06/19**

BEREAVEMENT LEAVE PROCESS

A. **PURPOSE:**

1. To provide guidelines for the payment of time away from work to benefited employees for bereavement. While every attempt will be made to accommodate an employee during his/her time of bereavement, the department Director may be unable to grant a specific request for time off due to the workload and staffing needs.

B. **DEFINITION(S):**

1. Immediate Family Member: An immediate family member shall be defined as the employee's spouse, child (including adoption child, minor ward of employee guardian, foster-child, step-child or grandchild), mother, father, mother-in-law, father-in-law, individual who serves as the legal guardian for either the employee the spouse, or the domestic partner of the employee, brother, sister, step-mother, step-father, brother-in-law, sister-in-law, daughter-in-law, son-in-law, grandparents, and California State registered domestic partners and domestic partner who is a bona fide spousal equivalent either of the employee, the spouse or the domestic partner of the employee.

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

1. Benefited employees are eligible for bereavement leave upon employment.
2. **Employees are eligible for five (5) days of unpaid bereavement leave for eligible family members.**
   - **a.** Employees shall receive up to three (3) days off with pay**, coded as bereavement leave in timekeeping system,** if time off is requested and taken within ninety (90) days of the death of an eligible family member.
   - ~~a.~~**b. Employees may use available PTO for the remaining two (2) days of bereavement leave or take unpaid.**
3. Paid time off (PTO) shall be based on the employee's regular scheduled hours.
4. Managers may require employees to provide appropriate documentation**, within 30 days of the first day of leave,** if deemed necessary. **Appropriate documentation includes, but is not limited to, a death certificate, a published obituary, or written verification of death, burial, or memorial services from a mortuary, funeral home, burial society, crematorium, religious institution, or governmental agency.**
5. ~~Employees may use available PTO for time away from work due to the death of an immediate family member.~~
6. ~~5.~~ Time spent away from work for bereavement will not be included in the calculation of overtime.
7. ~~6.~~ Part-time employees shall receive bereavement pay on a pro-rated basis.

~~8.~~**7.** To the extent that any applicable collective bargaining agreement, that is consistent with applicable law, conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement **shall** prevails.

~~D.~~ ~~**PROCEDURE(S):**~~

~~1.~~**8.** Employee informs manager of the need to take bereavement leave.
~~Employee completes Request for Time Off form requesting time off and/or PTO.~~

9. Manager arranges for employee to be removed from the schedule **and updates the timekeeping system to reflect bereavement hours, not to exceed three (3) days.**

~~2.~~**10. Employee must designate the additional days as PTO or unpaid in their timecard.**

~~3. Time taken off for bereavement leave shall be coded on the employee's time card accordingly~~

~~**FORM(S):**~~

~~Request for Time Off~~

Move from Administrative Human Resources Manual to Related Document to Administrative Policy: Leave of Absence 435

Tri-City Medical Cent
Oceanside, California

~~ADMINISTRATIVE~~
~~HUMAN RESOURCES~~

~~ISSUE DATE: 10/04~~ ~~SUBJECT: Subpoena/Jury Duty~~

~~REVISION DATE: 10/05~~ ~~POLICY NUMBER: 435.02~~

~~Human Resources Department Approval:~~ ~~02/2008/25~~
~~Administrative Policies & Procedures Committee Approval~~ ~~03/2009/25~~
~~Medical Executive Committee:~~ ~~n/a~~
Administration Approval: ~~08/2009/25~~
Professional Affairs Committee: n/a
Board of Directors Approval: 08/20

SUBPOENA/JURY DUTY PROCESS

A. **PURPOSE:**

1. To provide guidelines for time off to **Tri-City Healthcare District** (TCHD) employees who are **subpoenaed** ~~summoned~~ to testify **on behalf or related to TCHD, as well as those required** ~~or~~ to **attend** jury duty.

B. **PROCEDURE:**

1. TCHD shall grant benefited employees time off with or without pay for actual time spent on mandatory jury duty or is **subpoenaed**~~summoned~~ to testify if the jury duty or summons results in the employees missing scheduled workdays.
2. Employees shall receive up to eight (8) hours of regular base pay for each day **subpoenaed**~~summoned~~ to testify or served on jury duty for up to five (5) scheduled workdays if the testimony or jury duty results in the employee missing scheduled work.
3. If the subpoena or jury duty exceeds five (5) scheduled workdays, employees may be placed on leave of absence without pay for the balance of their subpoena or jury duty.
4. Benefited employees may use their available **Paid Time-Off** (PTO) to receive pay for their regularly scheduled hours.
5. Exempt employees whose subpoena or jury duty exceeds five (5) scheduled workdays shall be paid consistent with their salary as required under federal law.
6. Benefited employees who regularly work ten (10) or twelve (12) hour shifts shall be paid up to eight (8) hours of subpoena or jury duty pay and may use their available PTO to supplement their additional normally scheduled hours of work missed while serving.
7. Benefited employees serving a minimum of six (6) hours per day shall be paid for eight (8) hours.
8. Benefited employees serving less than six (6) hours per day shall be paid for the actual hours served and may use their available PTO to supplement their additional scheduled hours of work missed while serving.
9. Employees who normally work evening or night shifts may elect to work their regularly scheduled shift in addition to testifying or serving jury duty or may elect to take time off.
10. Time off for subpoena or jury duty shall not be included in the calculation of overtime.
11. Non-benefited and per diem employees –may receive unpaid leave of absence to perform mandatory jury duty or who are subpoenaed.
12. Employee presents a copy of the subpoena or jury summons to **their**~~his/her~~ supervisor or manager immediately upon receipt of it.
13. ~~Employee completes Request for Time Off form or designated process per manager.~~
14. **13.** Manager arranges for ~~time off for~~ **the** employee **to be removed from the schedule**.

~~15.~~**14.** Employee submits official subpoena or jury duty time~~-~~ sheet to **their manager**~~payroll~~.

~~16.~~**15.** Time taken off for subpoena or jury duty shall be coded on the employee's timecard as ~~Subpoena /JD -~~ Jury Duty.

~~17.~~**16.** To the extent that any applicable collective bargaining agreement, ~~that is~~ consistent with applicable law, conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement **shall** prevail~~s~~.

~~C. **FORMS:**~~

~~1. Request for Time Off Form~~

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

~~1. Administrative Policy: Leave of Absence 435~~

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE
HUMAN RESOURCES

ISSUE DATE: 08/85

SUBJECT: Monitoring Licenses, Professional Registrations and Certificates

REVISION DATE(S): 09/91, 11/94, 10/97, 10/02, 02/03, 02/05, 02/06, 01/08, 04/09, 07/11, 09/13, 09/16

POLICY NUMBER: 8610-430

Administrative ~~Human Resources~~ Content Expert Approval:	**~~04/19~~04/25**
Administrative Policies & Procedures Committee Approval:	**~~04/19~~09/25**
Medical Executive Committee Approval;	**n/a**
Administration Approval:	**~~05/19~~09/25**
Professional Affairs Committee:	**n/a**
Board of Directors Approval:	**05/19**

A. **PURPOSE:**

1. To ensure that all licensed, professional, registered and certified personnel have and maintain their licensure, certifications, or registrations and the appropriate documentation of the same is provided to Tri-City Healthcare District (TCHD).

B. **~~APPLICATION OF POLICY:~~**

1. The policy applies to all **TCHD employees~~staff~~** required to be licensed, or who have technical registrations or certifications, whether from a state agency, a state licensing board or from any other source.
2. Primary Source Verification – The Human Resources **(HR) d~~D~~**epartment **~~(HRD)~~** must **~~be able to~~** verify licensure,**~~/~~** certification, **~~/~~or** registration directly with the source **issuing~~providing~~** the credential, such as the State Licensing Board or agency **authorized~~designated~~** by the State Licensing Board to provide verification. Secondary sources, **including~~such as~~** letters, copies of letters, documents or copies of documents**, are not acceptable for licensure verification ~~will not suffice for verification of licensure~~**.
3. Employees **~~and contractors~~** are required to maintain all licenses required for their position and to provide proper notification as outlined below in the event of the suspension or revocation of a license.
4. Any employee **~~or contractor~~** found to be working with an expired license or **without** a required certification will be **removed from the schedule and may be subject to** termination**~~d~~**.
5. **~~Licensed staff E~~**employee**~~s~~d ~~by TCHD~~** must notify **~~the~~** HR**~~D~~** if they have sanctions in California or any other states in which they are licensed within five (5) days. Failure to notify **~~the~~** HR**~~D~~** constitutes grounds for disciplinary action up to and including termination.

C. **~~PROCEDURE~~PROCESS FOR VERIFICATION OF LICENSURE:**

1. Initial Verification:
   a. **Human Resources~~The HRD~~** is responsible for verifying the candidate's Primary Source for professional license, **~~/~~**certification, **or~~/~~** registration as applicable prior to the start date.
   b. If HR**~~D~~** is unable to verify licensure, **~~/~~**certification, **~~/~~or** registration prior to the first day of employment, the candidate will not be able to commence employment until HR**~~D~~** is able to verify via Primary Source that a candidate's credentials are valid and current.
      i. If required pre-employment documents are not submitted timely, thereby delaying the start date, TCHD reserves the right to rescind the offer of employment.

2. Maintaining Current Licensure, ~~/~~Certification, /Registration Post Hire:
   a. Supervisors are responsible for ensuring employees do not work without a valid license, ~~/~~certification, ~~/~~ **or** registration. Failure of the supervisor to comply constitutes grounds for disciplinary action up to and including termination.
   b. Upon renewal, the employee will forward the licensure, ~~/~~certification, ~~/~~**or** registration to ~~the~~ HR~~D~~ and their immediate supervisor.
      i. For electronic license, ~~/~~certification, ~~/~~ **or** registration, employees will claim and forward a copy to ~~the~~ HR~~D~~ and their immediate supervisor.
   c. Employees are required to renew their license, ~~/~~certification, ~~/~~ or registration ~~ten (10) calendar days~~ before it expires. If an employee does not renew ~~his/her license~~**prior to expiration** ~~in the appropriate timeframe~~, the employee **will be removed from the schedule** ~~-~~**and** may be subject to termination **after 10 days of non-compliance**. **Employee may not use Paid-Time Off (PTO) when removed from the schedule for non-compliance.**
   d. In the event that any action is taken by any licensing agency or any credentialing body which might result in the accusation, sanction, revocation or suspension of a license, ~~/~~certification, ~~/~~**or** registration, it is the employee's responsibility to notify **HR and their**~~his/her~~ supervisor immediately following notice of any such activity by credentialing boards. Failure to comply may result in disciplinary action, up to and including termination of employment.
   e. ~~The~~ HR~~D~~ will notify the appropriate d~~D~~epartment Supervisors of expiring licenses, ~~/~~certifications, ~~/~~ **or** registrations through email and reports.

~~**CONTRACT EMPLOYEES:**~~

~~f. The individual Departments, the HRD, and Staffing Resources track contracted employees in the same manner as all licensed personnel.~~

~~g. Each contracted Traveler will have Primary Source Verification of his/her license/certification/registration maintained in the HRD.~~
~~Registry personnel, utilized on a shift-by-shift basis, will have their license/certification/registration verified by their agency prior to their first shift and this information will be noted on each Registry employees Letter of Competency (LOC). Copies of the LOC are maintained and filed in Staffing Resources.~~

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE ~~POLICY~~
HUMAN RESOURCES

ISSUE DATE: 06/87 **SUBJECT:** Paid Time-Off Program

REVISION DATE: 09/10, 09/13, 01/16, 10/17 **POLICY NUMBER:** 8610- 433

Administrative Content Expert Approval:	**~~08/2210/2407/25~~**
Administrative Policies & Procedures Committee Approval:	**~~08/229~~/25**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~03/2309~~/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**03/23**

A. **PURPOSE:**

1. The Paid Time-Off Program is designed to provide eligible Tri-City Healthcare District (TCHD) employees with compensated time away from their regular assignment in order to ensure their physical and mental well-being. It is also designed to encourage advance scheduling of time off in order to provide for optimum staffing.

B. **POLICY:**

1. The Paid Time-Off Program provides for the utilization and compensation of accrued time off.
2. Paid Time Off is to be used for absences to cover vacations, holidays, illnesses or injuries of employees or their immediate family members, and personal reasons.

C. **PAID TIME-OFF (PTO) ELIGIBILITY, ACCRUAL AND USE:**

1. All benefitted full-time, part-time ~~and weekend professional~~ employees are eligible to accrue Paid Time Off (PTO) hours each pay period in accordance with the Paid Time Off (PTO) Accrual Grid~~.~~:

FULL TIME EMPLOYEE ACCRUAL RATE			80% TIME EMPLOYEE (64-79 hrs/pay period) ACCRUAL RATE			60% TIME EMPLOYEE (48-63 hrs/pay period) ACCRUAL RATE		
Years of Tenure	Pay Period Accrual	Maximum Hours	Years of Tenure	Pay Period Accrual	Maximum Hours	Years of Tenure	Pay Period Accrual	Maximum Accrual
0-3	7.38	384	0-3	5.91	307.2	0-3	4.43	230.4
4-9	8.92	464	4-9	7.14	371.2	4-9	5.35	278.4
10-14	10.46	544	10-14	8.37	435.2	10-14	6.28	326.4
15-19	10.77	560	15-19	8.62	448	15-19	6.46	336.0
20+	11.08	575	20+	8.86	460.8	20+	6.65	345.6

2. Per Diem Week-End Professionals accrue PTO at a rate of 1.6~~1.23~~ hours/pay period.
3. Tenure is defined as the number of years worked since the most recent benefit eligibility date.
4. Eligible employees begin to accrue PTO on the first of the month following thirty (30) days of employment in a benefited status and are eligible to use PTO upon its accrual. ~~In compliance with the~~
4~~.~~5. **Employees may use PTO for protected sick leave as outlined in Administrative Policy: Leave of Absence 435.**~~CA Paid Sick Leave Law (PSL), benefited employees are eligible to~~

~~utilize up to three days of their accrued PTO for PSL.~~ **Only hours that have been accrued in the current year are available to use.** ~~(See Administrative Policy: Leave of Absence 435).~~

~~5.~~**6.** PTO is used for the first sixteen (16) consecutive hours of~~/~~ any absence.

~~6.~~**7.** PTO is used to compensate employees for both scheduled and unscheduled absences.

a. Scheduled PTO – In order to provide for optimum staffing, absences must be planned and scheduled in advance. An employee must have their **d**~~D~~epartment Director/Manager/designee's prior approval to schedule PTO. Vacations, holidays, personal business, doctors' appointments, or other similar absences, will be paid through PTO provided appropriate, prior approval has been obtained. The amount of advance notice required is two weeks prior to the affected schedule.

b. Unscheduled PTO – Absences due to illness or emergencies are not possible to predict but may be compensated through unscheduled PTO. An employee who will be unable to report to work must notify their immediate supervisor, two (2) hours prior to the scheduled starting time of their workday, in accordance with Administrative Policy: Absences and Tardiness 408.

c. For absences related to the employee's own illness, see the Administrative Policy: Annual and Extended Leave Bank Policy 489.

d. An employee who misses work due to an illness or injury may be required to obtain a physician's statement.

e. Employee Health Services is available to assist with situations involving illness or injury, and fitness for duty.

f. Requests for PTO may be denied based upon departmental operational requirements.

~~7.~~**8.** TCHD **applies available hours from the employee's leave banks** ~~requires the use of PTO~~ to supplement other payments such as State Disability Insurance (SDI) and Family Paid Leave (FPL). PTO may be used to supplement workers compensation payments, if the employee chooses.

~~8.~~**9.** The maximum amount that an employee can accrue in their PTO account is two (2) times the employee's annual accrual rate as determined by designated FTE (see Paid Time Off (PTO) Accrual Grid). When an employee's PTO account reaches this cap, accrual will stop until such time as the employee reduces their PTO balance.

~~9.~~**10.** The payment of accrued PTO hours is automatic for scheduled and unscheduled **absences** except in flex/float activity occurrences and is intended to compensate the employee at the level of ~~-~~their regularly scheduled hours.

11. In accordance with Administrative Policy: Absences and Tardiness 408, an employee may not use PTO for a "No Call, No Show" absence.

12. In accordance with Administrative Policy: Monitoring Licenses Professional Registrations and Certificates 430, an employee may not use PTO when removed from the schedule for license, certification, registration expiration.

~~10.~~**13. Employees may not use PTO when removed from the schedule for non-compliance with Annual NetLearning modules.**

~~11.~~**14.** In the event that an employee suffers a severe financial hardship resulting from an unforeseeable emergency, TCHD may in its sole and absolute discretion, permit the employee to withdraw from their PTO account the amount necessary to eliminate the hardship. Use of PTO Hours for Hardship procedure can be found in Use of PTO Hours for Hardship Guidelines.

D. **PTO CASH OUT:**

1. Employees are given the opportunity to be paid for a portion of their PTO once each year under conditions designed to comply with Internal Revenue Service requirements regarding constructive receipt see Paid Time Off (PTO) Cash Out Guidelines.

E. **CHANGE IN STATUS:**

1. When changing from benefited to non-benefited status, an employee will be paid all eligible accrued PTO hours at their benefited base rate of pay.

2. When changing from full time to part time status, an employee will be paid the number of eligible accrued PTO hours required to reduce their PTO balance relative to the part time maximum accrual.

F. **TERMINATION:**

1. Upon termination of employment, an employee will be paid all eligible accrued PTO hours at their base rate of pay.

G. **ADMINISTRATION:**

1. The Head of Human Resources, with approval from the Chief Executive Officer, has authority and responsibility for administration of this policy. Practices and procedures to support the administration of this policy will be developed by the Head of Human Resources. Exceptions to this policy must be approved by the Head of Human Resources and Chief Executive Officer.
2. To the extent that any applicable collective bargaining agreement, that is consistent with applicable law, conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement **shall** prevails.

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

1. Administrative Policy: Absences and Tardiness 408
2. Administrative Policy: Annual and Extended Leave Bank Policy 489
3. Administrative Policy: Leave of Absence 435
4. PTO Cash Out ~~Guidelines~~
5. Use of PTO Hours for Hardship ~~Guidelines~~
~~5.~~**6. PTO Hardship Withdrawal Request Form**
~~6.~~**7.** ~~Paid Time Off (PTO) Accrual Grid~~

I. **REFERENCE(S):**

1. Healthy Workplace Healthy Family Act of 2014 (AB1522, amended with AB304)
2. Wage Theft Protection Act of 2011 (AB469)

Tri-City Medical Center
Oceanside, California

RETIRE – Incorporated into Policy 433

~~Paid Time Off (PTO) Accrual Grid~~

~~FULL TIME EMPLOYEE ACCRUAL RATE~~			~~80% TIME EMPLOYEE (64-79 hrs/pay period) ACCRUAL RATE~~			~~60% TIME EMPLOYEE (48-63 hrs/pay period) ACCRUAL RATE~~		
~~Years of Tenure***~~	~~Pay Period Accrual~~	~~Maximum Hours~~	~~Years of Tenure***~~	~~Pay Period Accrual~~	~~Maximum Hours~~	~~Years of Tenure***~~	~~Pay Period Accrual~~	~~Maximum Accrual~~
~~0-3~~	~~7.38~~	~~384~~	~~0-3~~	~~5.91~~	~~307.2~~	~~0-3~~	~~4.43~~	~~230.4~~
~~4-9~~	~~8.92~~	~~464~~	~~4-9~~	~~7.14~~	~~371.2~~	~~4-9~~	~~5.35~~	~~278.4~~
~~10-14~~	~~10.46~~	~~544~~	~~10-14~~	~~8.37~~	~~435.2~~	~~10-14~~	~~6.28~~	~~326.4~~
~~15-19~~	~~10.77~~	~~560~~	~~15-19~~	~~8.62~~	~~448~~	~~15-19~~	~~6.46~~	~~336.0~~
~~20+~~	~~11.08~~	~~575~~	~~20+~~	~~8.86~~	~~460.8~~	~~20+~~	~~6.65~~	~~345.6~~

~~**Note:** Tenure is defined as the number of years worked since the most recent benefit eligibility date~~

Tri-City Medical Center
Oceanside, California

PAID TIME OFF (PTO) CASH OUT PROCESS~~GUIDELINES~~

1. Employees are given the opportunity to be paid for a portion of their PTO once each year under conditions designed to comply with Internal Revenue Service requirements regarding constructive receipt:
2. The employee must complete an irrevocable election form during the designated election period, indicating the number of PTO hours to be paid. The employee may elect to be paid a minimum of twenty (20) hours and a maximum of eighty (80) hours. To be eligible to be paid PTO, the employee must maintain a minimum balance of forty (40) PTO hours following subtraction of the designated hours from their accrued PTO.
3. Once an employee has elected to be paid PTO hours, the designated hours are subtracted from their PTO balance and cannot be used for scheduled/unscheduled absences. The designated hours will be paid at the employee's base hourly pay rate in effect at the time of the payment.
4. Generally, irrevocable elections will be made during the last calendar quarter of the year for payout during the last quarter of the following year.

PROCEDURE:

1. The payroll department will send out a notice regarding PTO Cash Out that will include PTO Cash Out deadlines.
2. Eligible PTO Cash Out forms will be available in Lawson Employee Self Service on designated date provided by payroll.
3. Eligibility is based on sufficient PTO balance as of qualifying date.
    a. If you wish to receive a PTO Cash Out for the end of next calendar year (e.g. December), you must fill the form available in Employee Self Service.
    b. Indicate the PTO hours requested to cash out for the end of next calendar year (e.g. December), sign and return the form by emailing it to PTObuyback@tcmc.com or drop it off in the secured lockbox outside of the payroll window no later than 5:00 p.m. on due date.
    a. A minimum of 20 hours and a maximum of 80 hours may be cashed out annually provided that the employee's PTO balance does not go below 40 hours.
    c. The PTO hours elected for cash out are removed from the employee's PTO balance after the election form has been signed and turned in to Payroll.
4. Pay will be made using the current pay method you have on file. (Direct deposit or check will be MAILED to the address on payroll file – No Exceptions for pick up)

EXAMPLE PAY OUT USING 2019 DATES. Employee Jane Doe has a PTO balance of 150 hours as of December 06, 2019.

1. Payroll just announced the PTO Cash out from is available on Employee Self Service.
2. The election form is due on December 27, 2019 by 5:00 p.m. Jane Doe decides to cash out 80 hours of PTO, then signs and returns the form to payroll by sending an email to ptobuyback@tcmc.com by the due date.
3. Jane Doe's PTO balance will then be reduced from 150 hours to 70 hours, reflecting her buyback election of 80 hours.
4. Jane Doe receives a direct deposit on pay date December 17, 2020 for 80 hours of PTO.

Tri-City Medical Center
We're Always Here for You.

PTO HARDSHIP WITHDRAWAL REQUEST

I, _____ [print name] am applying for a PTO hardship withdrawal from my TCHD PTO account based upon the unforeseeable emergency described below. I understand that if this withdrawal is approved, the amount distributed to me will not exceed the amount supported by my emergency need. (This emergency must be an event which is beyond the employee's control).

I need _____ PTO hours ***or*** $_____ for the following unforeseeable emergency:

_____

_____

_____

I certify that this hardship request does not exceed my present financial need. I also certify that I have exhausted all other sources of funding available to me and that no payment plan option is available to me. I understand that if this withdrawal is approved, the money received will constitute taxable income. I must have a remaining balance of **40** PTO hours after this withdrawal.

Copies of supporting documentation are attached to this form.

_____ _____
Employee Signature Date

_____
Employee ID#

This hardship withdrawal has been approved by:

_____ _____
Department Director Date

_____ _____
VP of Human Resources Date

Tri-City Medical Center
Oceanside, California

USE OF PAID TIME OFF (PTO) HOURS FOR HARDSHIP GUIDELINES

PURPOSE:

1. In the event that an employee suffers a severe financial hardship resulting from an unforeseeable emergency, Tri-City Healthcare District (TCHD) may in its sole and absolute discretion, permit the employee to withdraw from their PTO account the amount necessary to eliminate the hardship.

PROCEDURES:

1. Hardship withdrawals are limited to unforeseeable emergency circumstances such as sudden or unexpected illness or accident, which results in uninsured, severe financial hardship. Employee must be able to demonstrate that the hardship is not otherwise covered by insurance or that the liquidation of the employee's assets would not reasonably cure the hardship. If a hardship distribution is granted, the employee may only withdraw the amount reasonably necessary to satisfy the emergency hardship.
2. Hardship withdrawal distributions are treated as taxable income and all applicable federal and state tax will be withheld. An employee must have a minimum PTO balance of forty (40) hours ~~3.~~ remaining after the withdrawal and is limited to two (2) circumstances per calendar year.
~~4.~~3. Hardship withdrawal forms are available from the Human Resources Department. The completed form with all supporting documentation is submitted to the Department Director for approval and then to the Head of Human Resources for approval.
~~5.~~4. Upon approval of the hardship pay, the Head of Human Resources or designee forwards the documentation to the Payroll Office for check preparation. The hardship request is to be filed in the employee's personnel file.

FORMS/TABLES/SCHEDULES:

1. PTO Hardship Withdrawal Request Form

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY
HUMAN RESOURCES

ISSUE DATE: 03/04

SUBJECT: Premium ~~&~~and Specialty ~~Program~~ Pay

REVISION DATE(S): 09/08, 04/12, 04/15

POLICY NUMBER: 8610-473

Human Resources Content Expert Approval:	~~08/18~~10/~~19~~03/25
Administrative Policies & Procedures Committee Approval:	~~n/a~~09/~~18~~03/~~20~~09/25
Medical Executive Committee Approval:	n/a
~~**Human Resources Committee Approval:**~~	
Administration Approval:	09/25
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/15

A. **PURPOSE:**

1. To establish premium and specialty ~~program~~ pay plans for Tri-City Healthcare District (TCHD) employees in order to support staffing requirements.

B. **POLICY:**

1. TCHD recognizes that staffing requirements may be best met by the establishment of premium and specialty pay plans designed to compensate employees for ~~the inconvenience of~~ working non-traditional hours or to meet special staffing needs.
2. TCHD has established premium pay plans as **defined**~~described~~ below for which ~~all~~ **some** ~~-~~non-exempt employees ~~are~~ **may be** eligible ~~for~~. ~~With administrative approval, specific job codes and/or designated exempt employees may also be eligible.~~
   a. Holiday Premiums:
      i. TCHD observes the following holidays:
         1) **Winter holidays: Thanksgiving Day, Christmas Day,** New Year's Day, Presidents' Day;~~,~~
         ~~1~~)**2) Summer holidays:** Memorial Day, ~~July 4th~~**Independence Day**, Labor Day, ~~Thanksgiving Day, and Christmas Day.~~
      ~~ii. TCHD pays holiday premiums in order to compensate eligible employees for working on observed holidays.~~
      ~~iii.~~**ii.** Holiday premium is **fifty percent** (50%) of the employee's base hourly rate for working on New Year's Day, ~~July 4th~~**Independence Day,** Labor Day, Thanksgiving Day, and/or Christmas Day.
      iii. Holiday premium is **ten percent** (10%) of the employee's base hourly rate for working on President's Day~~,~~ and/or Memorial Day.
      iv. Holiday premiums are paid for hours worked on the actual holiday (all hours worked between 12:01 AM and midnight), not a designated day of observance. (i.e. in cases where the holiday falls on a Saturday and is observed on the preceding Friday, holiday premium pay will be paid only for the hours worked on the actual holiday, Saturday.) In ~~these~~ cases where a holiday falls on a Sunday and is observed on the following Monday, the holiday premium will be paid on the actual holiday, i.e. Sunday.
      v. Holiday differential premiums will be paid in addition to other applicable differentials and premium pays (i.e. shift premium).
      ~~iv. Voluntary Non-Payment Of Holiday Premium: Employee must have~~

~~approval from their manager to work a Holiday shift without Holiday Premium.~~

vi. Employees covered by a Collective Bargaining Agreement ("CBA") will be paid in accordance with their CBA.

~~v.~~**vii. Scheduled Holiday shifts are subject to the provisions of Administrative Policy: Absences and Tardiness 408.**

b. On-Call and Call-Back:

i. TCHD compensates employees **in designated job codes** for being available to return, or for actually returning~~,~~ to work during scheduled non-working hours for designated staffing needs.

1) On-Call is the process through which employees are scheduled to be available to report to work.

~~1~~)2) Call-Back is the time an On-Call employee is actually called to return to work or is required to remain after their normal shift but was pre-scheduled to be on-call.

ii. Acceptance of On-Call shifts may be mandatory in some areas.

iii. On-Call hours will be paid for the duration of a designated on-call shift at an established hourly rate.

iv. Employees returning to work as Call-Back hours will be compensated at **one and one half (1 ½)** ~~**eleven-half** (11/2)~~ times their regular rate of pay. ~~(Refer to Pay Practice **Policy: #473.04 On-Call and Call-Back** for details). Shift Premiums will be paid in accordance with established levels.~~

v. **While the employee is On-Call, they must be available by telephone** ~~**or pager**~~ **and be able to return to work within 30 minutes** ~~**or within a timeframe approved by the department director if travel time is greater than 30 minutes.**~~ **During On-Call time, the employee must be** ~~**is free to pursue their own personal activities provided they are**~~ **accessible by telephone** ~~**or pager.**~~

vi. **Employees will not be compensated for travel time to and from the medical center.**

vii. **Employees who are called back to work will be paid a minimum of two (2) hours of Call-Back pay.**

viii. **Employees who are on Call-Back hours during evening or night shift will receive applicable shift premium for the Call-Back hours regardless of the number of hours worked on the shift.**

~~**Employees who are scheduled to be On-Call following the end of their regular shift but due to an assignment (eg, surgical case, procedure or treatment) work beyond the end of their scheduled shift, will be entitled to receive Call-Back pay. In this case, Call-Back pay will only apply to the actual time worked without regard to the 2-hour minimum outlined in vii. of this document. Example: Employee normally works a 7:00 AM to 3:30 PM shift. The department rotation had placed the employee On-Call for today beginning at 3:30 PM. At 3:30 PM, the employee was in the middle of a patient treatment and was unable to leave at their normal time. The employee completed the patient treatment at 4:15 PM (45 minutes beyond the end of their normal shift). This employee will be paid Call-Back for the 45 minutes worked into their scheduled On-Call time. The 2-hour minimum does not apply in the case where the employee's regular shift extends into the On-Call period.**~~

ix. **Call-Back hours will only be paid for designated On-Call shifts and will end when a regular scheduled shift begins. For Example: An employee is scheduled On-Call from 11PM to 7AM and is scheduled for a regular shift beginning at 7AM. The employee is called back and reports to work at 6AM. The employee will receive 1 hour of Call-Back pay at 1 ½ times their regular**

rate of pay~~.~~ (from 6-7AM). The two-hour Call-Back minimum does not apply because the employee is scheduled to end the On-Call shift and begin a regular shift at 7:00 AM.

x. Cancellation of a scheduled shift and placing an employee On-Call activates the On-Call Pay Practice. An employee is eligible for On-Call pay if they have been flexed off for an entire scheduled shift or portion thereof and placed On-Call. Additionally, the scheduled shift (or portion thereof) is considered cancelled. Thus, if an On-Call employee is called back in to work for a canceled but previously scheduled shift, the employee will be eligible for Call-Back pay.

xi. An employee may also be "flexed" for an entire shift or a portion thereof and not be placed On-Call; at which time the Call-Back practice does not apply (refer to Administrative Policy: Flex/Float to Activity 437).

xii. When an employee reports to work and begins to earn Call-Back time, the payment of On-Call pay will stop.

xiii. Call-Back hours worked are considered hours worked for the purpose of computing overtime.

xiv. On-Call and Call-Back hours shall be noted on the employee's electronic time record; totaled separately and approved by the department director or designee.

~~iv.~~xv. Scheduled On-Call shifts are subject to the provisions of Administrative Policy: Absences and Tardiness 408.

c. TCHD compensates employees in designated job codes and areas of the facility where evening and/or night shifts are required. The amount of shift ~~premium~~ **differential** pay will be established as a flat rate and paid for eligible hours actually worked on an evening or night shift.

3. In addition to premium pay~~s~~, specialty ~~program~~ pay may be established from time to time to meet special targeted needs of TCHD. Specialty ~~program~~ pay may include, but is not limited to, charge differential, ~~report in pay, special shift pay,~~ sign-on bonus, referral bonus, relocation allowance, or as directed by Union member's collective bargaining unit. Specialty ~~program~~ pay may be established by the ~~lead H~~**head of** Human Resources ~~Officer~~ or ~~his/her~~ designee with the approval of the Chief Executive Officer **(CEO)**.

4. The ~~lead H~~**head of** Human Resources ~~Officer~~ or ~~his/her~~ designee, with approval from the Chief Executive Officer **(CEO)**, has authority and responsibility for administration of this policy.

~~4.~~5. To the extent that any applicable ~~that any applicable~~ collective bargaining agreement, ~~that is~~ consistent with applicable law, conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement shall prevail~~s~~.

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

1. **Administrative Policy: Flex/Float to Activity - 437**
2. **Administrative Policy: Absences and Tardiness - 408**

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY
PAY PRACTICES

RETIRE – covered in Collective Bargaining Agreements

ISSUE DATE: 02/20/05 **SUBJECT:** Charge Pay

REVISION DATE(S): **POLICY NUMBER:** 473.01

Human Resources Content Expert Approval:	~~10/19~~03/25
Administrative Policies & Procedures Committee Approval	~~03/20~~09/25
Medical Executive Committee Approval:	n/a
Administration Approval:	09/25
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~TITLE: Charge Pay~~
~~EFFECTIVE DATE: 2/20/05~~
~~NUMBER: 473.01~~
~~REVISION DATE:~~
~~POLICY REFERENCE: Premium and Specialty Program Pay – AP # 473~~
~~RESPONSIBLE PARTY: VP/Human Resources APPROVAL:~~

~~A. PURPOSE:~~
~~1. To establish guidelines for the payment of additional compensation for~~~~ed~~ ~~work, in a charge or lead position, for a designated shift.~~

~~B. PROCEDURES:~~
~~1 Charge duties are assigned for a limited time interval by the department Manager~~
~~2 The date, shift, and duration of the Charge assignment are documented on the schedule.~~
~~3 Those individuals who have been assigned a permanent job classification as Charge Nurse are exempt from shift specific Charge pay.~~
~~4 Charge differential will be compensated at a rate of 5% above the employee's base salary pay rate for the designated time the employee functions in the charge role.~~
~~5 The Employee is to document "chg" in the comment section of the time card. The manager will initial this section.~~
~~6 Shift differential will be paid at the applicable rate for the shift worked.~~

~~C. RELATED DOCUMENT(S):~~
~~1. Administrative Human Resources Policy: Premium Specialty Pay 473~~

~~Pay Practice Manual – Effective 2/20/05 1 of 1~~

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY
PAY PRACTICES

RETIRE – incorporated into Administrative Policy: Premium Specialty Pay 473

ISSUE DATE: 02/~~20~~/05

SUBJECT: Holiday and Holiday Premiums

REVISION DATE(S):

POLICY NUMBER: 473.02

Human Resources Content Expert Approval:	~~10/19~~03/25
Administrative Policies & Procedures Committee Approval	~~03/20~~09/25
Medical Executive Committee Approval:	n/a
Administration Approval:	~~n/a~~09/25
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~**TRI-CITY MEDICAL CENTER**~~
~~**PAY PRACTICE MANUAL**~~

~~**TITLE: Holiday and Holiday Premiums**~~
~~**NUMBER: 473.02**~~
~~**POLICY REFERENCE: Premium and Specialty Program Pay – AP # 473**~~
~~**EFFECTIVE DATE: 2/20/05**~~
~~**NUMBER: 473.02 REVISION DATE:**~~
~~**POLICY REFERENCE: Premium and Specialty Program Pay – AP # 473 RESPONSIBLE PERSON: VP, Human Resources**~~
~~**APPROVAL:**~~

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

~~1. To identify those holidays observed by Tri-City Medical Center and outline the conditions under which eligible employees are paid Holiday Premiums.~~

~~**B. ELIGIBILITY:**~~

~~1. All **Some** non-exempt full time, part time and per diem employees are eligible.~~
~~2. Designated exempt job codes scheduled on a shift basis may be eligible for holiday premium. Determination is made by the VP, Human Resources /Area Administrator.~~

~~**C. OBSERVED HOLIDAYS:**~~

~~1. New Year's Day, President's Day, Memorial Day, July 4th, Labor Day, Thanksgiving Day, Christmas Day.~~

~~**D. PROCEDURES:**~~

~~1. Holiday premium will be paid to eligible employees for all hours worked on the actual holiday (all hours worked between 12:01 AM and midnight).~~
~~2. All eligible employees will receive a holiday premium of 50% of the employees base hourly rate for working on the following days; New Year's Day, July 4th, Thanksgiving Day and Christmas Day.~~
~~3. All eligible employees will receive a holiday premium of 10% of the employee's base hourly rate for working the following holidays: Presidents' Day, Memorial Day and Labor Day.~~
~~4. Holiday premiums are paid for hours worked on the actual holiday, not a designated day of observance. (i.e. in cases where the holiday falls on a Saturday and is observed on the preceding Friday, holiday premium pay will be paid only for the hours worked on the actual holiday, Saturday.) In those cases where a holiday falls on a Sunday and is observed on the following Monday, the holiday premium will be paid only on the actual holiday, i.e. Sunday.~~

5. 5. Holiday differential premiums will be paid in addition to other applicable differentials and premium pays (i.e. shift premium).

E. VOLUNTARY NON PAYMENT OF HOLIDAY PREMIUM

1 1. Employee must have approval from their manager to work a Holiday shift without Holiday Premium.

2 Documentation for Non-Payment of Holiday Premium differential must be on the employee's timecard and signed by the Director or Manager of their area.

Pay Practice Manual – Effective 2/20/05 2 of 2

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY
PAY PRACTICES

RETIRE – change in practice see Patient Care Services Policy: Interpretation and Translation Servics

ISSUE DATE: 02/20/05 **SUBJECT:** Interpreter Premium

REVISION DATE(S): **POLICY NUMBER:** 473.03

Human Resources Content Expert Approval:	~~10/19~~03/25
Administrative Policies & Procedures Committee Approval:	~~03/20~~09/25
Medical Executive Committee Approval:	n/a
Administration Approval:	09/25
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~**TRI-CITY MEDICAL CENTER PAY PRACTICE MANUAL**~~

~~**TITLE: Interpreter Premium EFFECTIVE DATE: 2/20/05 NUMBER: 473.03 REVISION DATE: POLICY REFERENCE: Premium and Specialty Pay – AP #473 RESPONSIBLE PARTY: VP, Human Resources APPROVAL:**~~

~~**PURPOSE:** To establish payment guidelines for the provision of needed interpreter services to qualifying employees when requested.~~

~~**PROCEDURES:** Participation as an Interpreter is voluntary. Employees are compensated for interpreting only for services requested and provided outside his/her department. Eligible employees are fluent in English as a second language and can accurately speak, read and readily interpret. Employees who can sign and read sign language are also eligible for interpreter premium. Qualifying employee volunteers must sign an Interpreters Voluntary Participation Sheet and be placed on the interpreters listing maintained by Human Resources. The list is also available in the nursing staff office and PBX. Compensation for interpreter services will be $2.00 per hour (paid in 15 minute increments) and is in addition to the employee's regular rate of pay. Documentation for payment of the Interpreter Premium must be on the employee's timecard and signed by the Director or Manager of the department.~~

~~1~~

~~**RELATED DOCUMENT(S):**~~

~~2 **Administrative Human Resources Policy: Premium Specialty Pay 473**~~

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY
PAY PRACTICES

RETIRE – incorporated into Administrative Policy: Premium Specialty Pay 473

ISSUE DATE: 10/3/04 **SUBJECT:** On-Call and Call-Back

REVISION DATE(S): 07/23/08 **POLICY NUMBER:** 473.04

Human Resources Content Expert Approval:	~~10/1003/25~~
Administrative Policies & Procedures Committee Approval:	03/2009/25
Medical Executive Committee Approval:	n/a
Administration Approval:	09/25
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~**TRI-CITY MEDICAL CENTER**~~
~~**PAY PRACTICE MANUAL**~~

~~**TITLE: On-Call and Call BackEFFECTIVE DATE: 10/3/04**~~
~~**NUMBER: 473. 04 REVISION DATE: 7/23/08**~~
~~**POLICY REFERENCE: Premium & Specialty Pay AP&P #473**~~
~~**RESPONSIBLE PARTY: VP, Human Resources APPROVAL:**~~

~~**PURPOSE:**~~

~~1. To establish compensation guidelines for employees scheduled to be on-call and able to return to work for designated staffing needs.~~

~~B. **ELIGIBILITY:**~~

~~1. All non-exempt full-time, part time and per diem employees are eligible.~~

~~C. **DEFINITIONS:**~~

~~1. **On-Call** is the process through which employees are scheduled to be available to report to work.~~
~~2. **Call-Back** is the time an On-Call employee is actually called to return to work or is required to remain after their normal shift but was pre-scheduled to be on-call.~~

~~D. **PROCEDURES:**~~

~~1) Employees may be placed On-Call in accordance with department director/designee based on staffing requirements of the department.~~
~~2) Employees will be placed On-Call in accordance with department guidelines based on such criteria as rotation, voluntary basis and required skill set.~~
~~1. 3) Acceptance of On-Call shifts may be mandatory in some areas.~~
~~2. While the employee is On-Call, they must be available by telephone or pager and be able to return to work within 30 minutes or within a timeframe approved by the department director if travel time is greater than 30 minutes. During On-Call time, the employee is free to pursue their own personal activities provided they are accessible by telephone or pager.~~

~~5) Where an on-call rate has been established for a position, the On-Call hours will be paid for the duration of a designated On-Call shift.6) Employees who are on Call-Back hours will receive compensation at 1½ times their regular rate of pay for Call-Back hours actually worked regardless of the hours worked during the work week.~~
~~a) Employees who are called back to work will be paid a minimum of two hours of Call-Back pay.~~
~~b) Employees who are on-Call-Back hours during evening or night shift will receive~~

applicable shift premium for the Call-Back hours regardless of the number of hours worked on the shift.

c) Employees will not be compensated for travel time to and from the medical center.

7) Employees who are scheduled to be On-Call following the end of their regular shift but due to an assignment (eg, surgical case, procedure or treatment) work beyond the end of their scheduled shift, will be entitled to receive Call-Back pay. In this case, Call-Back pay will only apply to the actual time worked without regard to the 2-hour minimum outlined in 6 a) of this document. Example: Employee normally works a 7:00 AM to 3:30 PM shift. The department rotation had placed the employee On-Call for today beginning at 3:30 PM. At 3:30 PM, the employee was in the middle of a patient treatment and was unable to leave at their normal time. The employee completed the patient treatment at 4:15 PM (45 minutes beyond the end of their normal shift). This employee will be paid Call-Back for the 45 minutes worked into their scheduled On-Call time. The 2-hour minimum does not apply in the case where the employee's regular shift extends into the On-Call period.

8) Call-Back hours will only be paid for designated On-Call shifts and will end when a regular scheduled shift begins. For Example: An employee is scheduled On-Call from 11PM to 7AM and is scheduled for a regular shift beginning at 7AM. The employee is called back and reports to work at 6AM. The employee will receive 1 hour of Call-Back pay at 1 ½ times their regular rate of pay. (from 6-7AM) The two-hour Call-Back minimum does not apply because the employee is scheduled to end the On-Call shift and begin a regular shift at 7:00AM.

9) Cancellation of a scheduled shift and placing an employee On-Call activates the On-Call Pay Practice. An employee is eligible for On-Call pay if they have been flexed off for an entire scheduled shift or portion there of and placed On-Call. Additionally, the scheduled shift (or portion thereof) is considered cancelled. Thus, if an On-Call employee is called back in to work for a canceled but previously scheduled shift, the employee will be eligible for Call-Back pay.

3. 10) An employee may also be "flexed" for an entire shift or a portion thereof and not be placed On-Call; at which time the Call-Back practice does not apply (refer to **Administrative Human Resources Policy:** AP&P# 437 Flex/Float to Activity **437**).

4. 11) When an employee reports to work and begins to earn Call-Back time, the payment of On-Call pay will stop.

5. 12) Call-Back hours worked are considered hours worked for the purpose of computing overtime.

6. 13) On-Call and Call-Back hours shall be noted on the employee's timerecord; totaled separately and approved by the department director/designee.

14) Scheduled On-Call shifts are subject to the provisions of **Administrative Human Resources** Policy: #408,Absences and Tardiness **408**.

15) Exceptions to this policy must be reviewed and approved by the Vice President of Human Resources.

RELATED DOCUMENT(S):

Administrative Human Resources Policy: Absences and Tardiness 408

Administrative Human Resources Policy: Flex/Float to Activity 437

7.1. **Administrative Human Resources Policy: Premium Specialty Pay 473**

Tri-City Medical Center
Oceanside, California

RETIRE – no longer used

ADMINISTRATIVE POLICY
PAY PRACTICES

ISSUE DATE: 2/20/05 **SUBJECT:** Special Pay Practices

REVISION DATE(S): **POLICY NUMBER:** 473.08

Human Resources Content Expert Approval:	~~10/19~~03/25
Administrative Policies & Procedures Committee Approval:	~~10/19~~09/25
Medical Executive Committee Approval:	n/a
Administration Approval:	09/25
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~**TRI-CITY MEDICAL CENTER PAY PRACTICE MANUAL**~~

~~**TITLE: Special Pay Practices EFFECTIVE DATE: 2/20/05 NUMBER: 473.08 REVISION DATE: POLICY REFERENCE: Premium and Special Program Pay AP #473 RESPONSIBLE PERSON: VP, Human Resources APPROVAL:**~~

~~**PURPOSE:**~~

~~To provide Directors with a method to staff emergent staffing vacancies in order to ensure quality patient care in the most cost effective manner available.~~

~~**PROCEDURE:**~~

~~1. The Director may request enactment of a special pay plan by submitting a proposal to their area Vice President for review and submission to the Human Resources Steering Committee for final approval.~~

~~2. The department proposal must include:~~

~~a. Reason for the request~~

~~b. Other measures taken to fill staffing vacancies, including recruitment efforts, current staffing vacancy status and attempts to schedule;~~

~~i. Part time staff~~

~~ii. Per Diem personnel~~

~~c. Anticipated time period for implementation, with specified end date for the special pay request.~~

~~d. Proposed job classification(s) for special pay.~~

~~3. Following final approval by the Human Resources Steering Committee, the Director will inform Payroll (in writing) of the specifications of the plan, time limitations and applicable department and job classifications.~~

~~4. Upon expiration of the approved time limitations, the Director will follow up with Payroll (in writing) to ensure that the special pay is no longer utilized.~~

~~5. Special pay practices will be in effect only for the designated time interval approved.~~

~~6. Extension of the special pay time interval requires area Vice President approval and must be reported to the Human Resources Steering Committee.~~

~~7. Approval will be for specific cost centers and for specific job classifications.~~

~~1 Department Director/Clinical Manager approval is required before the beginning of the shift, or before special pay is offered to any employee.~~

~~2 Special pay eligibility must be in excess of any regularly and previously scheduled hours/shifts.~~

~~3 Use of unscheduled PTO, ALB, ELB during a pay period exempts the employee from special pay.~~

~~4 The Department Director/Clinical Manager must sign each line on the time card corresponding to the shift to which special pay applies.~~

~~5 Directors and Clinical Managers are generally exempt from special pay practices.~~

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE ~~POLICY~~
HUMAN RESOURCES

ISSUE DATE: 07/96 **SUBJECT:** Severance Plan

REVISION DATE(S): 09/12, 08/15 **POLICY NUMBER:** 8610-454

Administrative Human Resources Content Expert Approval:	**~~08/18~~3/25**
Administrative Policies & Procedures Committee Approval:	**~~09/18~~09/25**
Administration Approval:	**~~12/18~~09/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/18**

A. **PURPOSE:**

1. To provide continued compensation for a specified period of time to eligible Tri-City Healthcare District (TCHD) employees whose employment is affected when a separation occurs as a result of reduction in force; business decline; department, program or hospital reorganization; or other business reason.

B. **ELIGIBILITY:**

1. Benefited Employees - All benefited employees may be eligible for a severance benefit under this policy.
2. Temporary or per diem employees shall not be eligible for severance benefits under this policy.
3. Employees with signed employment agreements that include a severance arrangement shall be subject to the terms of those agreements in lieu of the provisions of this plan.
4. Subject to below, eligible employees shall be entitled to severance pay when:
   a. Their employment is not terminated for cause but for reasons beyond their control due to reduction of work force; business decline; department, program or hospital reorganization or other business reason; or
   b. They elect to participate in and are selected for a voluntary reduction-in-force.
5. Severance shall not be payable under this plan in any of the following circumstances:
   a. Where an employee who has had **their**~~his/her~~ position eliminated is offered and declines alternative benefited TCHD employment that is not less than seventy percent (70%) of **their**~~his/her~~ current base hourly compensation and scheduled pay period hours.
   b. Where an employee who is terminated by TCHD due to the outsourcing or transfer of operations is offered and declines benefited TCHD employment at a facility which is not more than thirty-five (35) miles farther from the employee's residence than the site of **their**~~his/her~~ present employment.
   c. Where an employee has been terminated for cause.
6. TCHD will require as a condition for payment to an otherwise eligible employee, that **they**~~he/she~~ execute and deliver a Settlement Agreement and General Release form acceptable to TCHD.

C. **PAYMENT OF SEVERANCE:**

1. Payment of severance will **commence** ~~begin on the first pay date following separation or following the execution and non-revocation of the Settlement Agreement and General Release or~~ as ~~otherwise~~ **outlined** ~~provided~~ in **the** ~~such~~ Settlement Agreement and General Release.
2. Amount and distribution of severance payment for benefited employees:
   a. An eligible employee will receive a severance at **their**~~his/her~~ final base rate of pay, less applicable required withholding and deductions as identified in the Severance Schedule set forth below.

b. ~~For non-exempt employees, Aa~~ "week's salary" shall be defined as an amount equal to the product of the employee's final base hourly rate of pay, multiplied by the **employee's final FTE** ~~number of hours the employee was regularly scheduled to work each week~~ at the time of **their**~~his/her~~ termination of employment with TCHD.

~~c. For exempt employees, a week's salary shall be determined by multiplying **their**his/her monthly salary by twelve (12) and dividing that number by fifty-two (52).~~

~~d.~~**c.** The severance payments provided under this Plan will be paid out in equal installments consistent with TCHD's normal pay dates. ~~Lump sum payments, if applicable, will be made at the end of the severance period.~~

~~e.~~**d.** TCHD will pay the cost of COBRA (medical, vision and dental) benefits for one (1) month for the employee only. Such coverage shall be effective the first day of the month following the employee's termination date and shall cease at the end of the last day of that month. **Employee must elect COBRA to receive this benefit.**

D. **DISCONTINUANCE OF SEVERANCE PAYMENTS:**

1. Severance benefits under this plan are not available to an employee's beneficiaries or to **their**~~his/her~~ estate.
   a. Employees who are rehired by TCHD in a regular position before receiving all their severance payments will not receive their remaining severance payments.

E. **CHANGES TO TCHD SEVERANCE PLAN:**

1. This Plan is entirely voluntary on the part of TCHD, which has the right to and may terminate or amend it at any time, with or without notice to employees.
2. Plan variations, amendments or the decision to terminate the Plan can be made only by either the TCHD Board of Directors (BOD) or the Chief Executive Officer (CEO) or **their**~~his/her~~ designated representative.
3. If the Plan is amended or terminated, all employees' rights under this Plan, except for those who were terminated and had already begun receiving payments under the Plan, will be governed exclusively by the new plan document or will cease to exist in the case of a plan termination.

F. **ATTACHMENT(S):**

1. Severance Schedule

SEVERANCE SCHEDULE:

Number of Years of Service	Number of Weeks		
	Non-Exempt Exempt Non-Manager	Manager	Director
Less than 1 Year	2	3	4
1	2	3	4
2	2	3	4
3	3	4	5
4	4	5	6
5	5	6	7
6	6	7	8
7	7	8	9
8	8	9	10
9	9	10	11
10	10	11	12
11	10	11	12
12	10	11	12
13	10	11	12
14	10	11	12
15	10	11	12
16	10	11	12
17	10	11	12
18	10	11	12
19	10	11	12
20+	10	11	12
Other	1 month COBRA paid by TCHD for single coverage.		

Tri-City Medical Cer
Oceanside, California

RETIRE – incorporated into Administrative Policy: Alcohol and Drug Testing for Employees 429

EMPLOYEE HEALTH AND WELLNESS

ISSUE DATE: 5/86

SUBJECT: Alcohol and Drug Testing Guidelines for Employees

REVISION DATE: 05/08, -12/11

Employee Health Department Approval:	**06/20**
Infection Control Committee Approval:	**n/a**
Environmental Health & Safety Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~11/24~~09/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/11**

~~A. **PURPOSE**~~

~~1. Tri-City Hospital District (TCHD) has an obligation to its officers, employees, patients, and members of the public to take reasonable steps to provide an alcohol and drug free workplace and to provide services to the public in a safe manner. These guidelines are to be used by Directors and Managers for testing employees where they have a reasonable suspicion that the employee may be under the influence of alcohol and/or drugs.~~

~~2. The following acts are strictly prohibited and constitute cause for disciplinary action up to and including termination. (Refer to Administrative Policy #424 Coaching and Counseling for Work Performance)~~

~~a. Reporting for work or being at work under the influence of alcohol or drugs;~~

~~a. The use, possession, transportation, transfer, purchase or sale, or attempted use possession, transport, of alcohol or drugs in any manner during work hours, including rest breaks and meal periods, or while on TCHD premises;~~

~~b. Using TCHD property or premises to manufacture alcohol or drugs.~~

~~c. Criminal conviction for the use, possession, transportation, transfer, purchase or sale of illegal drugs whether or not on TCHD premises.~~

~~d. Failure to adhere to TCHD's procedure for wastage of controlled drugs or an inappropriate or unauthorized use of TCHD's Pyxis Pharmacy override system. (Refer to Administrative Policy #424 Coaching and Counseling for Work Performance)~~

~~B. **DEFINITIONS**~~

~~1. Alcohol – any beverage that has an alcohol (ethyl alcohol or ethanol) content in excess of three percent (3%) by volume.~~

~~2. TCHD premises – all buildings, parking lots, service yards, patios, lunch rooms, break areas, rest rooms, loading docks, TCHD-owned vehicles, work sites or any other sites where employees perform services for TCHD regardless of the location or TCHD ownership or control of the property.~~

~~3. Drug – any chemical substance (other than alcohol) capable of altering the coordination, reflexes, moods, perception, pain level, attention span, or judgment of the individual consuming it which is recognized as a drug in the United States Pharmacopoeia, the National Formulary, the Homeopathic Pharmacopoeia, or other drug compendia, or supplement to any of those compendia. This includes without limitation narcotics, hallucinogens, depressants, stimulants or other controlled substances, including prescription drugs.~~

~~4. Employee – any individual employed by TCHD except elected officials. Employee includes all individuals on TCHD payroll and, for purposes of this policy, anyone performing services on behalf of TCHD on a voluntary basis.~~

5. Illegal Drug – any drug which is illegal under federal, state or local law to use, sell, transfer, possess, manufacture or consume.
6. Legal drug – any drug or medication lawfully prescribed for use by the employee by a licensed medical practitioner, or an obtainable over the counter drug.
7. Under the influence – behavior modified by alcohol or drugs, resulting in substandard or modified job performance; diminished motor reflexes, impairment of coordination, speech, or mental concentration; or conduct that poses a safety hazard to the employee, co-workers or others.
8. Possession - Where an employee has the substance on his or her person or otherwise in an area under the employee's control.
9. Reasonable suspicion - includes a suspicion based on specific personal observations such as an employee's manner, disposition, appearance, behavior, speech, breath, muscular movements, information provided to management by another employee, law enforcement official, security service, or other persons believed to be reliable; or a suspicion that is based on other surrounding circumstances.

C. **DISCIPLINE**

1. Any violation of this policy is cause for disciplinary action up to and including termination. Discipline may be imposed regardless of whether an employee is charged with and/or convicted of a crime relating to any violation of this policy. (Refer to Administrative Policy # Coaching and Counseling for Work Performance)

D. **PRESCRIPTION DRUGS**

1. Using or being under the influence of any legally obtained drug while performing TCHD business or while in a TCHD facility is prohibited to the extent that such use or influence affects job safety or efficiency, or interferes with an employee's essential job functions.
2. No prescription drug shall be possessed or used by any employee other than the employee for whom the drug was prescribed by a licensed medical practitioner. A prescription drug shall be used only in the manner, combination and quantity prescribed.
3. If an employee is using a prescription drug during work hours, that could result in the employee being under the influence as defined above, it is the employee's responsibility to advise his/her supervisor of the use or influence of the prescription drug before beginning work. TCHD may consult with the prescribing physician to learn the expected effect of the drug and/or require a written statement from the physician that continued working will be safe and efficient. Employees will be requested to grant their physician written authorization to provide information regarding expected effects of prescribed medication. TCHD has the right to request a fitness for duty examination from a physician of their choice.
4. Disclosures made to TCHD concerning the use of legal drugs will be treated with confidentiality and will not be revealed to other TCHD management staff, unless there is an important work-related reason (e.g., employee safety) to do so in order to determine whether it is advisable for the employee to continue working.
5. An employee may continue to work if TCHD determines that the employee does not pose a safety threat and that job performance is not affected by use of the drug. Otherwise, the employee may be required to take a leave or comply with other appropriate measures.

a. To accommodate the leave, the employee may use accrued PTO.

E. **REPORTING OF VIOLATIONS THAT MAY CONSTITUTE CRIMINAL CONDUCT**

1. Violations of this policy that may constitute criminal conduct will be reported to the appropriate law enforcement agency and State licensing agencies and the Department of Health Services.

F. **PRE-EMPLOYMENT TESTS**

1. All applicants for employment are required to submit to a post offer physical examination, including an alcohol and/or drug test. (Refer to Administrative Policy #429 Alcohol and Drug Testing for Employees)

G. SAFETY OF WORK FORCE, MEDICAL EXAMINATIONS, ALCOHOL AND/OR DRUG TESTS

1. Each employee may be asked to submit to a medical examination and/or an appropriate test to determine the use of alcohol and/or drugs if there is a reasonable suspicion that the employee has used or is under the influence of alcohol and/or drugs.
2. Alcohol and drug testing may be requested following work-related accidents or any suspected violation of safety rules or standards, whether or not injury or damage resulted from the accident or safety violation, if there is a reasonable suspicion that there is a violation of this policy.
3. Alcohol and drug testing may be requested following a failure to follow TCHD's procedure for wastage of controlled drugs or for an abuse of TCHD's Pyxis Pharmacy override system where reasonable suspicion exists.
4. An employee determined to be unable to perform his duties in a satisfactory or safe manner based on reasonable suspicion of violation of this policy may be placed on Administrative Leave.
5. Any employee may report a complaint with his/her Supervisor, Manager, Director, or the Vice President of Human Resources or his/her designee regarding a suspected violation of this policy by any other TCHD employee.
6. If an employee charges that a fellow employee has violated this policy and subsequently the allegations are shown to be malicious, knowingly false or were made so as to harass the employee, appropriate discipline will be imposed on the complaining employee.

H. REFUSAL OF AN EMPLOYEE TO SUBMIT TO A MEDICAL EXAMINATION AND/OR ALCOHOL OR DRUG TEST

1. An employee's refusal to consent to a medical examination and alcohol or drug test will result in the immediate placement on administrative leave for the employee pending the outcome of the TCHD's investigation of the employee.
2. An employee who, upon request, refuses to consent to a medical examination, alcohol and drug test shall be subject to disciplinary action up to and including termination.
3. An employee who, upon request, refuses to consent to a medical examination, alcohol and drug test may be disciplined for misconduct or unsatisfactory job performance. Discipline maybe imposed regardless of whether an employee is charged with and/or convicted of a crime relating to any violation of this policy. (Refer to Administrative Policy #424 Coaching and Counseling for Work Performance)

I. INSPECTION TO ADMINISTER AND ENFORCE POLICY

In order to promote an alcohol and drug free, safe, productive and efficient workplace, TCHD reserves the right to search or inspect all property which it owns or which is found on its premises and property in the employee's control or possession to determine the presence of alcohol or drugs. The TCHD expressly reserves the right to inspect TCHD owned or controlled property including, but not limited to, lockers, desks, filing cabinets, tool boxes, vehicles, packages, containers and other articles within the work area.

1. If the Vice President of Human Resources or his/her designee has reason to believe that alcohol or drugs are present in a work area in violation of this policy, the appropriate law enforcement agency may be contacted and asked to conduct a search of the work area.

J. TEST RESULTS

1. A positive alcohol and/or drug test result will be confirmed.
2. A chain of custody of the tested blood, urine or other sample will be established and maintained by the testing clinic or laboratory.
3. Laboratory reports and/or test results shall not be placed in an employee's personnel file. Laboratory reports and/or the results shall be maintained in a separate confidential medical records file in the Employee Health Department. Laboratory reports and/or test results shall be disclosed only to individuals on a need to know basis and to the employee upon request.

4. Upon request the employee may have the original sample retested at an approved forensic accredited laboratory of their choice. This retest will be at the employee's expense.

K. Guidelines For Directors, Managers Or Supervisors

1. The suspicion of alcohol or drug use must be based upon objective factors related to the employee's appearance, conduct, speech, behavior, and/or other objective factors. If a department head, manager, or supervisor has reason to believe an employee is under the influence of alcohol or drugs, or has otherwise violated this policy, the Director, manager or supervisor is required to document the bases of suspicion and carry out the following procedures:
   a. Accompany the employee to a private office, room, or other area. If possible, a witness should accompany the employee and the department head, manager or supervisor. Upon request, the employee may have another employee act as a witness on his/her behalf. Action regarding the employee shall not be delayed by the request for an employee-selected witness.
   b. If it is determined that this policy may have been violated, the Vice President of Human Resources or his/her designee should be advised of the situation. After receiving authorization to conduct a medical examination and alcohol and drug test, the employee should be told that his behavior or performance warrants a medical examination and alcohol and drug test. The examination and test will be conducted at TCHD's preferred occupational provider. in the. The Administrative Coordinator is to be contacted when Employee Health Services is closed.
2. If the employee agrees to a medical examination, alcohol and drug test, the following procedures should be carried out.
   a. The employee should be asked to read and sign an Authorization for Testing form (Attachment A), and an Authorization for Release and Use of Testing Information (Attachment B)
   b. If the results of the medical examination, alcohol and drug test indicate another medical or psychological cause for the employee's behavior, the employee will be placed on administrative leave and will be required to provide TCHD with a medical release from a physician before returning to work. TCHD may require the employee to be examined and evaluated by a TCHD selected physician before being allowed to return to work.
   c. If the results of the medical examination, alcohol and drug test are negative or inconclusive no further action will be taken by TCHD with regard to the violation of this policy.
3. If the employee refuses to consent to a medical examination, alcohol and drug test the following procedures should be carried out:
   a. The Director, manager or supervisor must explain to the employee that the requested medical examination, alcohol and drug test is used to establish the employee's compliance with this policy and/or fitness to perform his/her job.
   b. The Director, manager or supervisor must inform the employee that his/her refusal to consent to a medical examination, alcohol and drug test will be interpreted as a deliberate failure to comply with a reasonable request and the employee will be subject to discipline up to and including termination. The employee should also be advised that he/she will not be allowed to use evidence of alcohol or drug abuse as a mitigating factor regarding any discipline imposed for misconduct or unsatisfactory job performance.
   c. The employee will be immediately placed on administrative leave if he/she refuses to consent to a medical examination and alcohol and drug test. If an employee refuses to submit to a medical exam and/or alcohol and drug test this refusal will not serve to reduce the discipline for misconduct or unsatisfactory job performance.
4. The Administrative Coordinator/Vice President of Human Resources or his/her designee must be informed of the situation by the Director, manager or supervisor. The decision to place the employee on administrative leave will be made by the Vice President of Human Resources or his/her designee.

5. If the employee is placed on administrative leave, the Director, manager or supervisor should arrange for the employee to be transported home.
6. All Directors, managers and supervisors involved in any incident investigated under this policy must prepare a written record of the incident within twenty-four (24) hours of its occurrence.

L. REPORTING CONVICTIONS

1. Employees, as a condition of employment, must report any conviction under a criminal drug statute for violations occurring on or off TCHD premises while working for the TCHD. A report of a conviction must be made within five (5) days after the conviction.

M. CONDITIONS OF EMPLOYMENT

1. Employees must as a condition of employment abide by the terms of this policy.

N. ATTACHMENTS

1. Authorization for Testing Form. (Attachment A)
2. Authorization for Release and Use of Testing Information. (Attachment B)

AUTHORIZATION FOR TESTING

Agreement to Submit to Drug and Alcohol Screen by Blood and Urine Tests

I have been informed that Tri-City Healthcare District (TCHD), based on my behavior and appearance, is concerned that I may be under the influence of drugs or alcohol, or may otherwise have violated TCHD's rules against drug and alcohol use, and that my ability to perform my job duties, is therefore, in question; and as a result, I have been requested to submit to a drug and alcohol screen.

I have been informed and I understand, that my agreement to submit to the requested alcohol and drug screens by blood and urine tests is completely voluntary on my part, and that I have the right to refuse to submit to the tests. I am aware and have been told, that my refusal to submit to the drug and alcohol screen by blood and urine tests may be grounds for disciplinary action against me, up to and including termination.

I have also been informed and am aware that the results of this drug and alcohol screen by blood and urine tests may be released to other TCHD officials, including but not limited to my supervisor as applicable, and that the results of such test(s) may form the basis for disciplinary action against me, up to and including termination.

With full knowledge of the above information, I have decided to voluntarily submit to the requested drug and alcohol screen by blood and urine tests, in recognition of this agreement, do sign this consent form.

Date:_____ Employee:_____

Date:_____ Witness:_____

Attachment A

AUTHORIZATION FOR RELEASE AND USE OF TESTING INFORMATION

I have voluntarily agreed to submit to a drug and alcohol screen by blood and urine tests to be administered by Tri-City Healthcare District (TCHD). I hereby authorize the release of the results of the above-mentioned drug and alcohol screen by blood and urine tests to the Director for Human Resources, and such other TCHD officials and employees as the Director for Human Resources may determine it is necessary to disclose such information.

I understand the information so released to TCHD will be used to determine whether I was fit to perform my job duties, and/or whether I had violated TCHD's work rules concerning drug and alcohol use. TCHD Emergency Department and Laboratory Services, as applicable, only is authorized to disclose the results of my drug and alcohol screen, as described above, for 120 days after the date I executed this Authorization. I understand that I have a right to receive a copy of this authorization, and that one will be provided upon request.

Date:_____ Employee:_____

Date:_____ Witness:_____

Attachment B

Tri-City Medical Center
Oceanside, California

EMPLOYEE HEALTH AND WELLNESS

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

REVISION DATE: 06/02, 09/03, 06/06, 10/06, 07/08, 07/09, 07/12, 04/15, 06/22

Employee Health Department Approval:	**~~03/22~~05/25**
Infection Control Committee Approval:	**~~04/22~~07/25**
Medical Executive Committee Approval:	**~~05/22~~09/25**
Administration Approval:	**~~06/22~~09/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**06/22**

A. **INTRODUCTION:**

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

B. **PURPOSE:**

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

C. **DEFINITIONS**:

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

D. **POLICY:**

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

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

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

2. Hepatitis A Vaccine:
   a. Any employee who handles or assists in the preparation of food in the Food & Nutrition department will be offered the vaccine.
   b. Engineering employees who are exposed to raw sewage will be offered the vaccine.
   c. Employees who decline the Hepatitis A vaccine when offered must sign a declination statement.
   d. Post vaccination monitoring is not recommended.
3. Measles, Mumps, and Rubella (MMR) Vaccine:
   a. HCWs must have documented immunity to measles, mumps and rubella.
   b. Documented immunity includes:
      i. Birth before 1957 can considered immune only if they have written documentation of appropriate vaccination or laboratory evidence of immunity.
      ii. HCWs with 2 documented doses of MMR are considered to have presumptive immunity to measles, mumps and rubella
         1) Not recommended to be serologically tested for immunity.
         2) If serological testing is performed and results are negative or equivocal for measles, these HCW should **not** be considered to have presumptive evidence of immunity to measles and ~~do not~~ need **an** additional MMR dose~~s~~
   c. HCW born in 1957 or later without serologic evidence of immunity or written documentation of prior vaccination (verbal documentation is not acceptable):
      i. Give 2 doses of live 0.5 mL MMR vaccine by subcutaneous route separated by at least 28 days
   d. Personnel without evidence of immunity will be offered MMR vaccine during the employment process unless contraindicated.
   e. Routine serologic screening for measles, mumps, or rubella before administering MMR vaccine to personnel is not performed.
   f. MMR is the vaccine of choice. If the recipient is known to be immune to one or more of the components, monovalent or bivalent vaccine may be used.
4. Tetanus-Diphtheria-acellular Pertussis (Tdap) Vaccine:
   a. Pertussis is highly contagious. Vaccinating HCWs with Tdap will protect them against pertussis and is expected to reduce transmission to patients, other HCWs, household members, and persons in the community.
   b. HCWs who have not received Tdap previously should receive a single dose of Tdap regardless of the time since their last Td (Tetanus-diptheria) dose. Tdap is not licensed for multiple administrations; therefore, after receipt of Tdap, HCWs should receive Td for future booster vaccination (every 10 years) against tetanus and diphtheria.
   c. Pre- and post–vaccination testing for antibodies is not recommended.
5. Varicella Vaccine:
   a. HCWs must have documented immunity to varicella. This includes laboratory or healthcare provider confirmation of prior disease or written documentation of two varicella vaccine doses.
   b. Serological testing for varicella will be performed if there is no documentation of

immunity.

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

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

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

6. Influenza Vaccine:

a. Influenza vaccine is required annually by November 30 of each year for all TCMC employees, volunteers, and medical staff

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

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

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

~~d.~~**e. Students will require proof of flu vaccination or signed declination no later than the start date of their clinicals.**

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

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

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

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

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

~~d. HCW may be exempt from the COVID-19 vaccination requirements only upon providing a written declination statement, signed by the HCW stating either:~~

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

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

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

~~e. HCW who have completed their primary vaccination series and provide proof of subsequent COVID-19 infection may defer booster administration for up to 90 days from the date of clinical diagnosis or first positive test.~~

CALIFORNIA IMMUNIZATION REQUIREMENTS FOR COVERED HCP

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

E. **REFERENCES:**

1. APIC Text of Infection Control and Epidemiology, revised edition, 202~~4~~14
2. CDC. Immunization of health-care personnel- Advisory Committee on Immunization Practices (ACIP). MMWR 2014. CDC: Recommended Vaccines for Healthcare Workers https://www.cdc.gov/vaccines/adults/rec-vac/hcw.html **(reviewed 11.12.2024)**
3. CDC Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR, 2011; 60(RR-7) **(reviewed 11.12.2024)**

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE: 10/05

SUBJECT: Educational Planning, Needs Assessment, Objectives and Evaluation of a Continuing Medical Education (CME) Activity-Ensure Content is Valid

REVISION DATE: 05/09, 08/12, 12/15, 06/18, 03/19 04/21, 12/22, 03/24

POLICY NUMBER: 8710-600

Medical Staff Department Approval:	~~12/23~~07/25
CME Committee Approval:	~~01/24~~07/25
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~02/24~~09/25
Administration Approval:	~~03/24~~09/25
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/24

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

1. To outline criteria utilized for educational planning and evaluation of a Continuing Medical Education (CME) activity.

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

1. Prioritization Grid – a tool utilized to organize the educational needs of the medical staff and assigning a CME scheduling priority according to the impact topics have on performance, **Health Worker Opportunity Program** (HWOP), **The** Joint Commission functions, cultural/linguistic implications, and National Patient Safety Goals.
2. ~~-~~Plan Do Study Act (PDSA) model – **A problem-solving model used for improving processes, implementing changes and** ~~Simple yet powerful tool for~~ accelerating quality improvement
3. Professional Practice Gap – The difference between health care processes or outcomes observed in practice and those potentially achievable on the basis of current professional knowledge.

C. **POLICY:**

1. **All recommendations for patient care in accredited continuing education must be based on current science, evidence, and clinical reasoning, and give a fair, balanced view of diagnostic and therapeutic options.**
2. **Scientific research used in accredited education must conform to accepted standards of experimental design, data collection, analysis, and interpretation.**
3. **New and evolving topics should facilitate engagement with these topics without promoting unproven practices.**
4. **Organizations cannot be accredited if they advocate for unscientific approaches to diagnosis or therapy, or if their education promotes recommendations, treatment, or manners of practicing healthcare that are determined to have risks outweighing benefits or are known to be ineffective in the treatment of patients.**

~~C.~~D. **EDUCATIONAL PLANNING – NEEDS ASSESSMENT~~:~~**

1. **An** ~~A~~annual~~ly our~~ physician~~'s~~ learning needs ~~are~~ survey~~ed~~ **will be completed** to:

a. ~~a) i~~Identify educational needs or professional practice gaps.~~, and~~
b. ~~b) e~~Evaluate the performance of the continuing medical education component at Tri-City Healthcare District **(TCMC)**.
~~1.~~**c.** ~~This d~~Data **will be**~~is then~~ summarized and ~~provided to the CME Committee to~~ **used by the CME Committee to** ~~in~~ plan~~ning~~ educational activities. ~~and in determining the potential value of the activity.~~

2. **Educational** ~~Identified~~ needs **identified** from multiple sources are used to initiate and support the planning process. **Documentation of** ~~N~~**needs** ~~documentation~~ is the first step in planning a CME activity.
3. Each source of need **must have** ~~requires a~~ supporting documentation~~-~~to **inform the** ~~use in setting~~ methodology, design, objectives, and evaluation of the CME activity.

~~D.~~E. EDUCATIONAL PLANNING – OBJECTIVES~~:~~

1. ~~Based upon the identified needs, the o~~Objectives **will be** ~~are~~ developed **based on identified needs** for each CME activity.
2. The purpose or objectives **must** ~~of the activity~~ describe~~s~~ learning outcomes in terms of physician performance or patient health and **be** ~~are consistently~~ communicated to ~~the~~ learners.
3. The target audience **must be** ~~is~~ identified and stated in all learning materials.
4. **Participant** ~~B~~background requirements **will be** ~~of the prospective participants are~~ listed when **relevant**~~indicated~~.
5. Learning outcomes **related to** ~~in terms of~~ competence, performance and patient outcomes **must**~~are~~ **be specified** ~~indicated~~ and communicated to ~~the~~ learners.

~~E.~~F. EVALUATION & IMPROVEMENT~~:~~

1. All educational activities are evaluated for effectiveness in meeting identified educational needs~~,~~ **by** ~~as~~ measure**ingd** ~~by~~ competence, performance and patient outcomes.
2. When applicable, educational activities are evaluated for ~~effectiveness in meeting identified educational needs, as measured by~~ practice application and/or health status improvement.
3. The overall CME program is **reviewed**~~evaluated~~ regularly by the CME committee**, including** ~~with review of~~ its mission and activities **from the prior**~~of the previous~~ year.
4. **Program** ~~I~~improvements are made ~~in the CME program~~ by incorporating **CME Committee** suggestions ~~of the CME committee~~ into the operating ~~CME~~ policies and procedures.
5. Outcomes **affecting** ~~in~~ physician behavior ~~which influence the health of the~~ **and** population **health** are measured when applicable **via** ~~by~~ repeated surveys or statistical review of morbidity data.

~~F.~~G. PROCEDURE:

1. Activity Request:– Upon request, the CME Coordinator will provide the activity planner with a "Quick Tool for planning Accredited Continuing Education" from **Accreditation Council for Continuing Medical Education** (ACCME) Tool kit form for **American Medical Association** (AMA) **Physician's Recognition Award** (PRA) Category I Credit™.
2. CME Committee Review/Approval ~~Process~~:
   a. The CME Coordinator ~~will~~ submit**s** the completed **planning form** ~~"Quick Tool for planning Accredited Continuing Education" form~~ to the CME Committee for review/approval.
   b. A quorum ~~of~~ the CME Committee members **may approve CME activity request via email; electronic responses must be filed with the planning form**~~has the authority to approve a CME Activity Request outside of committee via electronic mail response. The CME Coordinator will make a copy of the electronic mail responses and file with the "Quick Tool for planning Accredited Continuing Education"~~.
   c. AMA PRA Category I Credit™ requests **are** ~~shall be~~ granted at the **CME Committee's** discretion, ~~of the CME Committee.~~ U**u**tilizing **ACCME** ~~the P~~peer ~~R~~review form.~~from the ACCME toolkit.~~

d. The CME Committee may ~~use~~utilize prioritization grids and/or the FOCUS-PDCA tool **to**~~in planning CME activities to organize and prioritize topics~~ maximize~~ing the~~ impact ~~CME activities have~~ on physician competence, performance and patient outcomes.

3. Documents **Provided:**

~~3.~~a. **Upon approval,** ~~—T~~the CME Coordinator **provides** ~~may utilize the ACCME toolkit for each activity, and will provide~~ the following documents to the activity planner **(as applicable):** ~~following approval by the CME Committee:~~

~~a.~~i. Faculty disclosure form ~~(for disclosure of relevant~~ financial relationships **and** ~~with~~ **conflict** resolution)~~ declaration should a conflict of interest exists;~~

~~b.~~ii. Cultural diversity form;

~~c.~~iii. Content validation form;

~~d.~~iv. **ACCME** Commercial **g**Guidelines ~~(ACCME Commercial Support Standards);~~

~~e.~~v. W-9 form (if **needed**~~applicable)~~

4. Required Documen**tation:**

~~4.~~a. ~~s —T~~The CME Coordinator ~~shall~~ ensure**s the following are** ~~documentation is~~ on file for each approved CME activity **before the course date; activies will not be assigned without:** ~~per the CME Checklist. The activity planner will provide the following completed and signed documents to the CME Coordinator. Note: AMA PRA Category I Credit™ will not be assigned to a course if the following are not provided in a timely manner before the course date~~.

~~a.~~i. Faculty's curriculum vitae (mandatory);

~~b.~~ii. Faculty disclosure form (mandatory);

~~c.~~iii. Content validation form (mandatory);

~~d.~~iv. Original ~~handout material,~~ and/or electronic (PowerPoint) **course materials** ~~presentation~~ (if applicable);

~~e.~~v. W-9 (if applicable);

~~f.~~vi. Audio-visual (AV) requirements (if applicable);

5. Processing Time:~~—Processing time for~~ CME requests **are**~~is~~ typically **processed within** 60-90 days.

6. Advertisement:~~ For~~ **A**All AMA PRA Category I Credit™ approved activities, ~~shall be~~ advertise**mentsd** to the Medical Staff **must include: (**~~—~~The CME Coordinator will assure ~~that~~ the advertisements include:

a. Title ~~of the activity~~ and topics to be presented

b. ~~Statement of d~~**D**esired outcomes

c. ~~The~~ CME accreditation and credit designation statement

d. Acknowledgement of educational grants or other financial contributions (if known)~~ at the time of the publication)~~

7. Relevant Financial Relationships: (Ineligible Company) – Disclosure of relevant financial relationships will be provided at **each**~~very~~ CME activity. **(**~~–~~See Commercial Support and Prevent Commercial Bias and Marketing policy).

8. Evaluations/Sign-In Sheets:~~—An~~**Each CME** activity **will include an activity** evaluation form and a sign-in sheet. ~~shall be provided at every~~ CME activity where AMA PRA Category I Credit™ is awarded.

9. Faculty:~~–~~ The CME Coordinator **will** ~~shall~~ summarize the evaluations and provide a copy of the evaluation summary, a letter of appreciation and honorarium (if applicable) to the speaker within four weeks of activity closure.

10. Learners:~~—~~ The CME Coordinator may send a follow-up e-mail to the learners six (6) weeks **after** ~~following~~ the activity.

11. CME Committee:~~—~~The CME Coordinator **will**~~shall~~ provide the CME Committee with a summary of evaluations.

12. CME Credit:~~—~~The CME Coordinator shall provide T**ri-City Hospital District (**TCHD) Medical Staff members a copy of their CME records upon request.

13. Record Maintenance:~~–~~ CME records **will** ~~shall~~ be maintained for a minimum of six (6) years.

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

~~1. Accreditation Council for Continuing Medical Education (ACCME) Standard 1~~

~~2. All recommendations for patient care in accredited continuing education must be based on current science, evidence, and clinical reasoning, while giving a fair and balanced view of diagnostic and therapeutic options.~~

~~3. All scientific research referred to, reported, or used in accredited education in support or justification of a patient care recommendations must conform to the generally accepted standards of experimental design, data collection, analysis, and interpretation.~~

~~4. Although accredited continuing education is and appropriate place to discuss, debate and explore new and evolving topics, these areas need to be clearly identified as such within the program and individual presentations. It is the responsibility of accredited providers to facilitate engagement with these topics without advocating for, or promoting, practices that are not, or not yet, adequately based on current science, evidence, and clinical reasoning.~~

~~5. Organizations cannot be accredited if they advocate for unscientific approaches to diagnosis or therapy, or if their education promotes recommendations, treatment, or manners of practicing healthcare that are determined to have risks or dangers that outweigh the benefits or are known to be ineffective in the treatment of patients~~.

1. Accreditation Council for Continuing Medical Education (ACCME) Standard 1

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: 06/19 **SUBJECT: Medications**

REVISION DATE: 9/24~~06/19~~

Department Approval:	~~11/20~~09/24
Division of Psychiatry Approval:	~~01/23~~11/24
Pharmacy and Therapeutics Approval:	~~03/23~~02/25
Medical Executive Committee Approval:	~~03/23~~09/25
Administration Approval:	~~04/23~~09/25
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/23

A. **PURPOSE:**
1. To identify Patient, Physician and RN responsibilities regarding medication education, documentation and reconciliation.

B. **POLICY:**
1. Patients are responsible for providing their own medications needed during Program hours and, as outpatients, they, a responsible caregiver, or their licensed residential care facility assume the responsibility for administration of medications. Program physicians may prescribe medications for their patients or work in collaboration with a community physician who is the prescribing physician. Program RNs are responsible for taking medication orders, medication education, reconciliation and documentation.

C. **PROCEDURE:**
1. Who May Perform/Responsible: Physicians and RN
2. If medications are being managed by the attending Program physician they may enter orders for medications in the medical record, after obtaining informed consent by the patient. The prescription will be directed to the patient's pharmacy or in some circumstances, the RN may call the order in to the pharmacy.
3. In circumstances when orders are called in to a pharmacy by the RN, the medications may be delivered to the patient's place of residence.
4. The RN is responsible for assessing the patient for competency to take medications independently and educating the patient about their medications.
5. The RN maintains a current list of each patient's medications. Medications must be reconciled upon admission, when medication changes occur or routinely on a quarterly basis, and upon discharge. Reconciliation will be completed with the patient, the patient's pharmacy, other physicians who may be treating the patient concurrently, the patient's caregiver, the Board and Care Manager and upon discharge with the clinician or agency that will be treating the patient in the community.
6. The RN is responsible for completing the Medication History within the prescribed Program timelines.
7. If the patient is co-treated with another community physician, medications must be updated and reconciled when medication changes occur.
8. Telephone and written orders are accepted only from TCMC physicians and entered in the medical record by the Program RN.
9. The Program physician may authorize the RN to notify the pharmacy for medication refills. Refills are noted in the patient's medical record.

10. Telephone orders are signed by the ordering physician within 48 hours.
11. If a patient is ordered an injectable medication, a Program RN may perform this process. All injectable medications must be verified by the issuing pharmacy for accuracy prior to the injection. Injectable medications will be stored properly and according to manufacturer's directions.
12. **Clinic administered intramuscular/injectable~~ive~~ medications may be ordered through Tri-City Medical Center's pharmacy.**
13. **If needed Tri-City Medical Center IOP staff obtains insurance authorization.**
14. **Injectable medication orders are entered as inpatient orders, and can be delivered by a pharmacy technician.**
~~11.~~**15. Oral medications for home use are ordered by the physician as prescriptions.**
~~12.~~**16.** After opening multi dose vials, the RN will write in the expiration date on the vial (28 days from date of open unless shorter expiration date indicated on original vial)
~~13.~~**17.** The use of psychopharmacological agents for patients will be monitored for drug interactions, appropriateness and safety.
~~14.~~**18.** Physicians will review for drug interaction and appropriateness of dose during each patient visit.
~~15.~~**19.** In the event that patients receive more than seven scheduled psychotropic medications, more than two regularly scheduled psychopharmacological agents, within the hypnotics, or anxiolytic class, or more than three within the antipsychotics, mood stabilizers, and antidepressants class, then the patient is identified as receiving polypharmacy. An exception to this is an additional agent that is used only as a PRN, on an as needed basis, during periods of increased acuity of symptoms.
~~16.~~**20.** When circumstances warrant larger doses than approved by the FDA label, or a higher number of medications within the same class, the physician will review for drug interactions and appropriateness of care and will document specific rationale in the medical record.
~~17.~~**21.** It is the responsibility of the prescribing physician to order psychopharmacologic agents in an appropriate and safe manner. Appropriateness of dose and number of psychotropics will be determined at the discretion of the physician in order to address current patient condition and the severity of presenting symptoms.

D. **REFERENCE(S):**
1. Joint Commission Standards for Behavioral Health MM.01.01.05

Tri-City Medical Center
Oceanside, California

RETIRE – follow Administrative Policy: New Hire Orientation 457

OUTPATIENT INFUSION CENTER

ISSUE DATE: 03/13 **SUBJECT:** Department-Specific Orientation

REVISION DATE:

Department Approval:	~~06/16~~, ~~04/2009/22~~
Division of Oncology Approval	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~09/2209/25~~
Professional Affairs Committee Approval:	~~07/17~~ n/a
Board of Directors Approval:	07/17

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

~~1. Because of the complexity of the services offered, comprehensive orientation to the processes and protocols of the Outpatient Infusion Center (Center) is essential to adequately prepare associates to work in this environment. This document delineates the responsibilities of Tri-City Healthcare District (TCHD), the Center and the associate and defines the processes necessary for equipping each employee to safely/effectively perform his/her job duties.~~

~~B. **RESPONSIBILITY:**~~

~~1. TCHD assumes responsibility for the initial and annual orientation programs.~~
~~2. The department is responsible for department-specific orientation, the department-specific safety and environment of care training and for staff development programs throughout the year that meet the identified needs of the staff and the Center operations.~~
~~3. The Center manager assumes overall responsibility for the design, implementation and evaluation of the orientation process.~~
~~4. The associate, in partnership with the hospital assumes responsibility for:~~
~~a. Professional education/licensing and certifications.~~
~~b. Identifying their own learning needs.~~
~~c. Pursuing opportunities to meet their learning needs.~~

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

~~1. All employees joining the Center team will have a department-specific orientation and training.~~
~~2. The orientation/training content will be current, applicable, and systematic.~~
~~3. The orientation/training experience is individualized and designed to provide pertinent policy and procedural knowledge to be followed by the new associate.~~
~~4. Instruction will be clear, succinct, and administered at the level of the learner.~~
~~5. Competency assessments, where applicable, will be completed before the end of the department orientation and filed in the associate employment folder in the Human Resources department.~~
~~6. Orientation will be provided during the associate's assigned work shift.~~
~~7. Orientees will be acquainted with their new surroundings and receive sufficient orientation and training to become a member of the Center team.~~
~~8. Cross training of an associate may also occur when appropriate. The training will be sufficient in content and duration to prepare the associate for their new position.~~

~~D. **PROCEDURE:**~~

~~1. All associates will receive general TCHD orientation.~~

2. Department-specific orientation and training will occur in the initial period of the associate's employment and prior to taking full responsibility for their assigned duties.
3. A job description will be given to each orientee.
4. The duration of the orientation period will be sufficient to prepare the employee for full participation in Center activity.
5. Each new staff member will be assigned to a resource person(s) by the manager.
6. During the 90-day initial employment period, the new employee will be observed by the Center manager and/or designee for progress and adjustments to the training will be made accordingly.
7. Department-specific orientation schedule includes:
    a. All Center staff members
        a. Job descriptions
        b. Safety
            1) MSDS
            2) Emergency plans (fire, disaster, etc.)
            3) Hazardous waste
        c. Infection control
            1) Standard (Universal) precautions
            2) Personal protective equipment
            3) Biohazardous waste
            4) Hand washing
        d. Review of abuse report policy
        e. Performance improvement program
        f. Risk management program
    b. Clinic staff orientation
        a. Department orientation
        b. Center policies and procedures
        c. Clinic flow
        d. Equipment
            1) Infusion pumps
            2) Pyxis supply and medication station
        e. Blood drawing/transporting/storage techniques
        f. Medical records/documentation
        g. Supplies/protective devices
        h. Cerner documentation system
    c. Support staff
        a. Department orientation
        b. Center flow
        c. Medical records
        d. Database
        e. Bill/reimbursement/registration
        f. Phone techniques/etiquette
        g. Equipment
            1) Copier
            2) Fax
            3) Computer/printer
            4) Telephone system
            h. Cerner documentation system

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE:	**11/88**	**SUBJECT:**	**Computer Downtime/Printer Malfunction**
REVISION DATE:	**01/91, 01/94, 07/97, 10/99, 01/03, 12/03, 01/06, 09/08, 01/09, 03/12, 05/12, 01/18**		

Department Approval:	**~~08/22~~08/25**
Department of Medicine Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval;	**~~08/22~~09/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/22**

A. **POLICY:**

1. Occupational therapy, Physical Therapy and Speech- Language Pathology is accountable through the Leadership Structure of Rehabilitation Services to follow Patient Care Services Policy: Cerner Downtime. When the computer system is unavailable for use, therapy orders will ~~be faxed or telephoned to the department by the~~ **texted to the applicable therapy supervisor (PT/OT/SLP) and the Manager of Rehabilitation Services by the** Unit Secretary/appropriate hospital staff responsible for transcribing physician orders.

B. **PROCEDURE:**

1. All therapy orders must be initiated via a physician's order **and written into the patient's paper chart. The orders, including patient room and FIN#, should be texted to the applicable therapy supervisor and the Manager by the unit secretary/appropriate hospital staff.** ~~and be faxed (x4007) or telephoned (x7272) to the Rehabilitation Services Department by the appropriate hospital staff.~~
2. ~~Department personnel will check the fax server or answer the phone calls and record the order and relay order to the appropriate therapist.~~ **Once the order is assigned to a therapist, that therapist will confirm the orders in the paper chart.**
3. ~~2.~~ **Paper documentation of the evaluation or treatment session will be placed in the patient's hard chart with billing codes documented.**
4. ~~3.~~ When computer/printer is functioning properly, the ordering department personnel will input any received orders into the current computer system. The Rehabilitation Services assigned staff will verify orders received with the orders already recorded.
5. ~~4.~~ In the event of downtime for the current computer billing system, Rehabilitation Services staff will bill when the system is operational to update billing for past services.

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

1. Patient Care Services Policy: Cerner Downtime

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE:	**01/09**	**SUBJECT:**	**Hydroworx Therapy Pool Contamination**
REVISION DATE:	**05/12, 01/16, 10/19**		

Department Approval:	**~~08/22~~09/25**
Department of Medicine Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~09/22~~09/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**09/22**

A. **POLICY:**
1. The pool will be maintained in a manner consistent with manufacturer and Department of Environmental Health regulations.
2. The following steps are taken should the Hydroworx Therapy Pool become contaminated.

B. **PROCEDURE**:
1. Upon observation or discovery of pool contamination, the treating therapist will discretely inform patrons to immediately evacuate pool.
2. Patrons will be instructed to take a shower using soap for a minimum of 5 minutes.
3. Tri-City Medical Center engineers will be contacted at 760-940-7148 for de-contamination.
   a. Immediately drain pool.
   b. Clean filter and pool shell.
   c. Refill pool.
   d. Backwash filter.
   e. Start system.
   f. Balance chemicals.
   g. A water contamination response log will be maintained onsite to record a contamination episode that occurs. This log will be maintained in the common binder with other maintenance logs for the Hydroworx pool.

C. **FORM(S):**
1. Water Contamination Response Log

D. **REFERENCES:**
1. Department of Environmental Health Food and Housing Division. (2015). *Title 22 CCR Changes Effective January 1, 2015.* San Diego, CA: Department of Environmental Health.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE:	**SUBJECT:** **Hydroworx Therapy Pool - General Operations**
REVISION DATE: **05/12, 01/16, 10/19**	
Department Approval:	**~~08/22~~09/25**
Department of Medicine Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~09/22~~09/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**09/22**

A. **POLICY:**

1. The Wellness Center pool is operated under rules set forth in the County of San Diego Department of Environmental Health.

B. **PROCEDURE:**

1. Water Testing
   a. It is important that daily testing is done with care and accuracy. The water is tested for pH and Chlorine.
   b. The readings of hand testing shall be compared to the reading of the "CHEMTROL." The CHEMTROL is an automatic chemical feeder and monitors Chlorine and pH
   c. A detailed log of hand testing and CHEMTROL readings are kept as a means of check and balances.
2. County of San Diego Department of Environmental Health
   a. Daily pool testing and maintenance records are available for review.
3. Shutdowns
   a. The pool is shut down approximately every 6 weeks.
      i. The shutdowns take place at routine intervals in accordance with manufacturer guidelines for maintenance and cleaning.
      ii. The shutdowns will allow appropriate cleaning and maintenance of the filter and chemical systems that ensure pH balance.
   b. The pool is drained using the main drain valve. Maintenance and therapy staff that has received proper training on draining/refilling the pool may perform this task. This may also be performed by a Wellness Center contracted service provider that assists with pool drainage and routine water change.
   c. Maintenance and repairs are done as needed when the pool is drained.
4. Pool Operators
   a. All pool operators are CPR certified and are encouraged to become certified in water safety.

C. **REFERENCE(S):**

1. Department of Environmental Health Food and Housing Division. (2015). Title 22 CCR Changes Effective January 1, 2015. San Diego, CA: Department of Environmental Health.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE:	**09/15**	**SUBJECT:**	**Mission Statement, Goals and Objectives**
REVISION DATE:	**09/15, 11/18**		

Rehabilitation Department Approval:	**~~08/22~~08/25**
Department of Medicine Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~08/22~~09/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/22**

A. **POLICY:**

1. Tri-City Healthcare District Rehabilitation Services is dedicated to providing comprehensive, individualized and high quality healthcare to maximize the function and quality of life for all patients and members of our community.
2. Goals and Objectives:
   a. To render high quality rehabilitation services to assist each patient in reaching their maximum potential so they may assume their rightful place in society, while learning to live within the limits of their capabilities.
   b. To alleviate pain, restore function, and improve quality of life by using accepted and current techniques & approaches in physical, occupational, speech, audiology and therapeutic recreation. These include tests, measurements, procedures, modalities, treatment programs, and wellness education. Caregivers and family members are integrated into the treatment programs whenever possible. Therapeutic equipment is provided as appropriate.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE: 12/88 **SUBJECT:** Productivity Reporting System

REVISION DATE: 01/91, 01/94, 09/97, 10/00, 01/06, 03/12, 09/15, 10/19

Department Approval:	~~08/22~~08/25
Department of Medicine Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~09/22~~09/25
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	09/22

A. **POLICY:**

1. Internal productivity will be monitored on a daily basis with reports generated at routine intervals.

B. **PROCEDURE:**

1. Each therapeutic area and/or discipline will have a productivity system.
2. Each system will vary based upon the specific needs of each area and/or discipline.
3. After each treatment and/or at the completion of the day, patient encounters are recorded through the Cerner EMR.
4. A productivity report for each area is generated and reviewed weekly.
5. The Rehabilitation Services Leadership Team will review the reports periodically and adjust staffing resources as is deemed appropriate.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE:	**01/09**	**SUBJECT:**	**Rehabilitation Dress and Appearance Policy**
REVISION DATE:	**05/12, 02/18**		

Department Approval:	**~~08/22~~08/25**
Department of Medicine Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~08/22~~09/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/22**

A. **POLICY:**

1. Occupational therapy, Physical Therapy and Speech-Language Pathology is accountable through the Leadership Structure of Rehabilitation Services to demonstrate professionalism, competency and respect by adhering to the mandated dress code as per Administrative Policy: Dress and Appearance Philosophy Policy 415.

B. **PROCEDURE:**

1. Employee Attire:
   a. The department manager and/or designee will review the dress code with new staff.
2. Employees are required to wear the designated department uniform.
   a. Black scrub top, preferably with Tri-City Medical Center Rehabilitation Services logo.
   b. Solid earth toned scrub bottoms, slacks, or dress pants only (i.e. khaki, grey, muted green, black).
3. Staff providing treatment in pool will wear:
   a. Conservative one (1) piece bathing suit with or without shorts/neat T-shirt
   b. When out of pool between treatments or when off duty, staff will wear cover-ups for brief trips out of pool area, but when not providing treatment in pool, must adhere to department dress code.

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

1. Administrative Policy: Dress and Appearance Philosophy 415

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE: 7/91 **SUBJECT: Service Locations**

REVISION DATE: 01/94, 04/97, 10/00, 01/09, 03/12, 09/15, 12/18

Rehabilitation Services Department Approval:	**~~08/22~~08/25**
Department of Medicine Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~12/18~~09/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/22**

A. **POLICY:**

1. This Policy / Procedure applies to the following Rehabilitation Services' locations:
   - a. Rehabilitation Services is located in 1 North wing of Tri-City Medical Center
   - **b.** Tri-City Medical Center OP Rehab 4002 Vista Way, Oceanside, CA 92056
   - **~~b.~~c. Tri-City Acute Rehabilitation Unit is located in 1 South wing of Tri-City Medical Center.**
   - **~~c.~~d.** ~~Tri-City Wellness Center is located at 6250 El Camino Real, Carlsbad, CA 92009.~~

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE:	**11/88**	**SUBJECT:**	**Staff Rotations**
REVISION DATE:	**01/91, 11/94, 05/97, 01/00, 01/06 01/09, 04/12, 09/15, 05/18**		

Department Approval:	**~~08/22~~08/25**
Department of Medicine Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~08/22~~09/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/22**

A. **POLICY:**

1. Occupational Therapy, Physical Therapy and Speech Language Pathology is accountable through Leadership Structure of Rehabilitation Services to promote a varied clinical experience, through the change in their primary work area, while maintaining a system of continuity of care in each work area.

B. **PROCEDURE:**

1. A minimum of one therapy staff member will be the primary therapy provider in each designated area which includes but is not limited to:
   a. Outpatient services
      i. Orthopedics
      ii. Neurologic
      iii. ~~Lymphedema~~
      iv. Hands
      v. ~~Aquatics~~
      vi. Swallow Studies
      vii. ~~Pediatrics~~
      viii. Other Specialties based on current practice
   b. Inpatient services
      i. Medical/Surgical
      ii. Acute Rehabilitation
      iii. Orthopedics
      iv. Intensive Care Unit (ICU)
      v. Emergency Department (ED)
      ~~iii.~~vi. Telemetry
2. Upon request, the staff may be given the option of rotating to another primary work area, or as deemed appropriate by the Leadership Structure of Rehabilitation Services.
3. Rotations will proceed with the following considerations:
   a. Each area must maintain a minimum of one staff member or as indicated based on patient care needs
   b. Staff will orient to the work area
   c. Staff will be notified of upcoming rotations as appropriate/applicable

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE: 6/88 **SUBJECT: Statement of Accountability**

REVISION DATE: 01/94, 04/97, 10/99, 10/00, 02/03, 01/09, 11/09, 03/12, 09/15, 11/18

Rehabilitation Department Approval:	**~~08/22~~08/25**
Department of Medicine Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~08/22~~09/25**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/22**

A. **POLICY:**

1. The **Manager of Rehabilitation Services** ~~Director of Rehabilitation Services~~ is responsible to the ~~Senior Director~~ **Chief Operating Officer (COO)** and the Rehabilitation Services Staff for the overall direction and supervision of the department and the administrative direction of Rehabilitation Services.
2. In the event of the absence of the **Manager**~~Director~~, an appropriate designee will be assigned, which may include the **COO**~~Senior Director~~, a therapy supervisor, a vice president, a supervisor of another department, or other designee.

CDPH

Health and Human Services Agency
California Department of Public Health

Tomás J. Aragón, MD, DrPH
Director and State Public Health Officer

Gavin Newsom
Governor

License Renewal Notice

FACILITY LICENSE RENEWAL FEE INVOICE

Licensee:
TRI-CITY HOSPITAL DISTRICT
4002 VISTA WAY
OCEANSIDE, CA 92056

Facility:
TRI-CITY MEDICAL CENTER (GACH)
4002 VISTA WAY
OCEANSIDE, CA 92056-4506

LICENSE NUMBER: 080000099
EXPIRATION DATE: 10/31/2025
INVOICE #: 0000268110
INVOICE DATE: 07/15/2025
PERIOD OF 11/01/2025 to 10/31/2026

CURRENT FISCAL YEAR FEES: $307,256.00
PRIOR FISCAL YEAR(S) FEES: $0.00
TOTAL FEES DUE: $307,256.00*
DUE BY: 10/31/2025

LATE PAYMENT PENALTY

POSTMARKED:			PAY:
After 10/31/2025	through	11/30/2025	$337,981.60
After 11/30/2025	through	12/30/2025	$368,707.20
After 12/30/2025	through	01/29/2026	$491,609.60

After 2/28/2026 the Department will intercept Medi-Cal funds if available and/or take legal action against facilities operating without a current license.
*See Health and Safety Code Section 1266.5

* See page two for breakdown of total fees due.
NOTE: All outstanding fees/penalties must be paid and renewal application received by the department before a current license can be issued. To ensure new license is received prior to expiration please send payment 30 days prior to expiration date. Make payment payable to the "Department of Public Health". DO NOT SEND CASH.

If you have any questions about fees, please email RCollection@cdph.ca.gov or call at (800) 236-9747. If you have any questions about the renewal application please email CABlicensing@cdph.ca.gov or call at (916) 552-8632.

********DETACH HERE AND RETURN WITH PAYMENT********

Facility: Tri-City Medical Center (GACH)
Period of: 11/01/2025 to 10/31/2026
Expiration Date: 10/31/2025

License Number: 080000099
Invoice Number: 0000268110
Total Due: **$307,256.00**

SEND PAYMENT, INVOICE SLIP, AND RENEWAL APPLICATION TO ONE OF THE FOLLOWING:

Normal Mailing Address:	Overnight Mailing Address:
California Department of Public Health Center for Health Care Quality Licensing and Certification Program Revenue Collection Unit P.O. Box 997434, MS 3202 Sacramento, CA 95899-7434	California Department of Public Health Center for Health Care Quality Licensing and Certification Program Revenue Collection Unit MS 3202 1615 Capitol Avenue Sacramento, CA 95814

ACHD
ASSOCIATION OF CALIFORNIA HEALTHCARE DISTRICTS

Invoice

Invoice No.	**2025-0901**
Date	009/30/25
Terms	30 Days

Tri-City Healthcare District

Qty.	Description	Rate	Amount
1	Member Dues Covering 7/1/25 - 6/30/26	24,733	24,733.00
		Total	**$24,733.00**

Association of California Healthcare Districts
by check:
1127 11th St., #905
Sacramento, CA 95814

By wire:
Wells Fargo Bank
Account #: 4121-229975
ABA/Routing #: 121000248

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

August 21, 2025 – 1:30 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 1:30 p.m. on August 21, 2025.

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

Director Sheila Brown
Director Nina Chaya, M.D.
Director George W. Coulter
Director Rocky J. Chavez
Director Gigi S. Gleason
Director Adela I. Sanchez
Director Tracy M. Younger

Also present were:

Gene Ma, M.D., Chief Executive Officer
Anh Nguyen, Chief Financial Officer
Mohamad Jamshidi-Nezhad, D.O., Chief of Staff
Robert Lee, M.D., Chief of Staff Elect
Susan Bond, General Counsel
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant

1. Chairperson Younger called the meeting to order at 1:30 p.m. with attendance as listed above.

2. Approval of Agenda

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

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

   Chairperson Younger made an oral announcement of the items listed on the August 21, 2025 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Reports Involving Trade Secrets and Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees.

4. Motion to go into Closed Session

   It was moved by Director Coulter and seconded by Director Gleason to go into Closed Session at 1:34 p.m. The motion passed unanimously (7-0).

5. At 2:50 p.m., the Board returned to Open Session with attendance as previously noted.

6. Report from Board Counsel on any action taken in Closed Session.

Board Counsel Scott reported he would give a report regarding any action taken in Closed Session at the beginning to today's open session.

7. Adjournment

There being no further business, Chairperson Younger adjourned the meeting at 2:51 p.m.

Tracy M. Younger
Chairperson

ATTEST:

Adela I. Sanchez
Secretary

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

August 21, 2025 – 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 August 21, 2025.

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

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

Also present were:

Dr. Gene Ma, Chief Executive Officer
Jeremy Raimo, Chief Operating Officer
Donald Dawkins, Chief Nurse Executive
Anh Nguyen, Chief Financial Officer
Mark Albright, Chief Information Officer
Roger Cortez, Chief Compliance Officer
Jennifer Paroly, Foundation President
Mohamad Jamshidi-Nezhad, DO, Chief of Staff
Susan Bond, General Counsel
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant

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

2. Report from Closed Session

   Board Counsel Jeff Scott reported the Board in Closed Session heard reports involving Trade Secrets pursuant to Government Code 54956.87 and took no action.

   The Board also heard reports related to Quality Assurance matters and took no action.

3. Pledge of Allegiance

   Director Younger led the Pledge of Allegiance.

4. Approval of Agenda

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

5. Public Comments – Announcement

Chairperson Younger read the Public Comments section listed on the August 21, 2025 Special Board of Directors Meeting Agenda.

6. AHA Awards & Recognitions

a) STEMI – Aaron Yung, M.D./Kimberly Abrahams, RN/Cardiac Cath Lab
b) Stroke – Arthur Omuro, M.D./Ryan Raybold, Stroke Coordinator
c) Resuscitation – Cary Mells, M.D./Brian Clowe, RN, ED Manager
d) Commitment to Excellence Award – Eva England, VP/Ancillary Services

Dr. Ma reported Tri-City Medical Center was recognized with four American Heart Association awards reflecting national leadership in cardiovascular and stroke care. Dr. Aaron Yung, Dr. Arthur Omuro, Dr. Cary Mells and Stroke Coordinator Ryan Raybold commented on the respective awards and achievements. Eva England, VP/Ancillary Services commented on the Commitment to Quality Award which is a new national recognition awarded to only 158 hospitals, with Tri-City being the only hospital in San Diego to receive it. This award reflects excellence across cardiovascular care, stroke, and resuscitation, affirming Tri-City's mission to deliver safe, evidence-based, and high-quality care with better outcomes, faster recoveries, and fewer readmissions.

7. Executive Management Reports

Jeremy Raimo, Chief Operations Officer, provided updates on three key projects:

- **Psychiatric Health Facility (PHF):** Lease agreement with Exodus is nearly finalized. Exodus has applied for licensure, with review anticipated by mid-November. Pending regulatory approval, the PHF is expected to open around late November.
- **Emergency Department Expansion:** Project has faced logistical delays but reached substantial completion in mid-September. Final approvals from HCAI and CDPH are expected by late October to mid-November, after which the ED can officially open.
- **Wellness Center (South Carlsbad):** An architectural firm is currently space planning and preparing cost estimates for repurposing the former fitness facility. Proposals will be presented to the Board for discussion on phasing and funding.

Donald Dawkins, Chief Nurse Executive provided updates from the Nursing Division, Covering Clinical, Operational, People and Community categories:

- The second cohort of 11 Foreign-Educated Registered Nurses (FERN) is underway to strengthen staffing, reduce premium pay, and improve coverage for the upcoming winter season.

- We are exploring the launch of a research initiative on Guillain-Barre Syndrome, led by Dr. Mark Sadoff. It will provide us with an opportunity to expand and look into research that could improve the future of those impacted by this clinical condition.
- There is an ongoing focus on Emergency Department operational readiness.

Mark Albright, Chief Information Officer provided a report on the following:

Clinical Document Improvement (CDI) with Iodine

- Uses cognitive machine learning to analyze complete medical records in real time.
- Identifies documentation gaps and prompts CDI specialists to query physicians.
- Current review rate: 21% of admissions, generating 6% queries.
- Goal: Move to 100% review, with an expected initial 43% query rate that will increase as the system learns.
- Expected go-live by year-end.

Prompt Wrx

- Developed by former insurance company experts specializing in AI and denial prevention.
- Addresses hospital denials, currently over 11% on medical necessity claims.
- Reviews every claim before submission to flag edits, fixes, and additions to prevent denials.
- Automates appeal generation and submission if denials occur.
- Projected go-live: Approximately two weeks.

Jennifer Paroly, Foundation President shared the following:

- We are enhancing community outreach to raise awareness and share information regarding our potential affiliation with Sharp.
- The Foundation received $1.1M from the Sara Kolb estate for robotic surgical equipment and a $20K Watkins Wellness community-outreach grant.
- Upcoming events: The Gala is scheduled for November 15th at the Aviara; a Medical Staff Appreciation event is scheduled for August 29th at the Westin which will also be attended by Sharp leadership who will share their vision.

Harjit Randhawa, VP of Human Resources reported:

- The clinical ladder for eligible nurses will be fully implemented by late November and will aid in recruitment and reducing premium staffing costs.
- We are launching an employee recognition and engagement platform next week through TerryBerry which will be branded as "The Heart of Tri-City".
- Staff engagement activities include the following:
  - Summer Carnival - September 10 2025 in the MOB parking lot
  - Quarterly Town Hall – October 1, 2025

- Annual Pumpkin Carving Contest
- Holiday Week Celebration
- Annual Employee Engagement will roll out September 1 and run through the end of the month.

8. July, 2025 Financial Statements – Anh Nguyen, Chief Financial Officer

Anh Nguyen, Chief Financial Officer reported on the FYTD financials as follows (Dollars in Thousands):

Current month financials as follows (Dollars in Thousands):
- Net Operating Revenue – $27,873
- Operating Expense – $29,158
- EBITDA – $1,545
- EROE – $155

Anh presented the FYTD Key Indicators as follows:
- Average Daily Census – 117
- Average Acute Length of Stay (ALOS) – 4.80
- Adjusted Patient Days – 6,679
- Surgery Cases – 448
- ED Visits – 3,900

Anh also presented graphs including EBITDA and EROE, Average Daily Census, Average Length of Stay and Paid Full Time Equivalents per Adjusted Occupied Bed (13 Month Trend).

9. New Business – None

10. Old Business – None

11. Chief of Staff –

Consideration of August 2025 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee.

Dr. Mohamad Jamshidi-Nezhad, Chief of Staff explained the Medical Executive Committee approved the August Credentialing Actions and Reappointments Involving the Medical Staff via electronic vote. The Credentialing Actions and Reappointments are presented for the Board's approval as recommended by the Medical Executive Committee.

It was moved by Director Brown to approve the August 2025 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee via electronic vote. Director Coulter seconded the motion.

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

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

12. Consideration of Consent Calendar

It was moved by Director Chavez 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:**	**Brown, Chavez, Chaya, Coulter, Gleason, Sanchez and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

13. Discussion of items pulled from Consent Calendar

There were no items pulled from the Consent Calendar.

14. Comments by Members of the Public

There were no comments from members of the public.

15. Comments by Chief Executive Officer

Dr. Ma reported that Assembly Member Patel visited Tri-City, offering valuable insight.

Dr. Ma also reported that discussions with Sharp remain positive. An internet landing page highlighting the upcoming partnership is now live on the Tri-City website for questions and information.

16. Board Communications

Director Chavez commended the impressive reports on the awards presented and remarked on considerations for Tri-City's future name.

17. Adjournment

There being no further business, Chairperson Younger adjourned the meeting at 5:10 p.m.

_____
Tracy M. Younger
Chairperson

ATTEST:

_____
Adela Sanchez
Secretary

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending August 31, 2025

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	LeaseTerm Beginning	Ending	Services & Location	Cost Center
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	$3.59	(a)	56,415.02	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)	37,648.73	07/01/17	08/31/26	**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	06/30/30	**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)	23,026.37	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)	8,511.41	04/01/23	03/31/26	**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)	20,652.89	05/14/21	10/31/31	**Seaside Medical Group** 115 N EL Camino Real, Suite A Oceanside, CA 92058	7094
Nextmed III Owner LLC 6125 Paseo Del Norte, Suite 210 Carlsbad, CA 92011 V#83774	Approx 4,553	$4.00	(a)	25,265.13	09/01/21	08/31/33	**PCP Clinic Cairsbad** 6185 Paseo Del Norte, Suite 100 Carlsbad, CA 92011	7090
500 W Vista Way, LLC & HFT Melrose P O Box 2522 La Jolla, CA 92038 V#81028	Approx 7,374	$1.67	(a)	14,055.70	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)	34,015.00	10/01/22	09/30/29	**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)	15,079.73	05/01/23	04/30/26	**Pulmonary Specialists of NC** 3907 Waring Road, Suite 2 Oceanside, CA 92056	7088
Total				**270,145.19**				

(a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending August 2025

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6171	999050762MICHELLE LE (Summ trans)	071525	325.00	999050762	LE MICHELLE
6171	ONS/ONCC CHEMO (Summ trans)	071525 EDU	325.00	999050760	SMITH JUANITA
6171	CHEMO IMMUN (Summ trans)	062625	325.00	999050761	POFF STEPHANIE
6185	CNCER BSIC	072925 EDU	324.00	999050763	LESCH ILENE
7420	MBA HLTHCRE	072525 EDU	5,000.00	999050764	FOX KENDALL
8740	TRAUMA	81425 EDU	197.00	82938	FRIENDBERG, HILLARY
8740	TRAUMA	81825 EDU	150.00	38603	KOVAK, GRETAL
8740	TRAMUA	81425 EDU	150.00	83088	TROSTRUD, RACHEL
8740	Goods	073125 EDU	150.00	84412	TRAN TIEN

**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.