TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
January 29, 2026 – 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"

https://us02web.zoom.us/j/87139580265?pwd=ER64FRrBaglVuDnhCm3Rl82MWqApTK.1

Meeting ID: 871 3958 0265
Passcode: 548906

	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.	Board Counsel
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.	Executive Reports	5 min.	COO/CNE/CIO/ Foundation President
7	December 2025 Financial Statement Results	10 min.	CFO
8	Special Presentation: a) Recognition of Oceanside Pop Warner-Smack City National Championship	5 min.	CEO
9	New Business – a) Consideration to approve an agreement with the Center for Neurohealth,	5 min.	CNE

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

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

	Agenda Item	Time Allotted	Requestor
	Inc., dba Salma Health (Mohammed Ahmed, M.D.) for the co-medical directorship of the Outpatient Behavioral Health – Morning and Afternoon Program. b) Consideration to approve an independent physician recruitment agreement with Muhammad Madkour, M.D., Interventional Cardiology physician to practice in the communities served by the District. c) Consideration to approve market rate adjustment for employees not under contract for collective bargaining agreements.	5 min. 5 min.	COO CEO
10	Old Business – None		
11	Chief of Staff - a) Consideration of January 2026 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on January 26, 2026	5 min.	COS
12	Consent Calendar (1) Board Committee **(a) Finance, Operations & Planning Committee** **Director Younger, Committee Chair** *(January meeting cancelled)* (2) Policies & Procedures a**) Patient Care Services** 1. Cardioversion, Elective Procedure **b) Administrative 200's Finance** 1. Medi-Cal TAR Requirements 268 **c) Administrative 400's Human Resources** 1. Annual and Extended Leave Bank – 489 **d) Emergency Operations Procedure (EOP)** 1. 4028 Emergency Management Disaster Plan-Emergency Department Specific 2. Administrative Coordinators 4086 3. Communications Department Specific 4023 4. Identification of Staff and Incident Command Leaders Hospital Wide 4074 5. Information Technology Department Specific 4079 6. Medical Staff Assignments **e) Employee Health & Wellness** 1. Employee Health Infection Control Program **f) Engineering** 1. Code Green Policy 9007 2. Utility Management Plan 4003 **g) Environment of Care Manual** 1. Emergency Management Plan 2. Fire Plan (Code Red) 3005	5 min.	

	Agenda Item	Time Allotted	Requestor
	3. Hazardous Material and Waste Management and Communication Plan 6000 4. Medical Equipment Management Plan 5. Safety Management Plan 6. Security Management Plan **h) Infection Control** 1. Epidemiologic Investigation of a Suspected Outbreak **i) Mammography Women's Center** 1. Enhancing Quality using the Inspection Program (EQUIP) Policy 2. Implants Policy 3. Quality Control (QC) Policy 4. Reject Repeat Analysis Policy 5. Scheduling of Self Referring Mammography Patients Policy 6. Standardized Labeling of Mammograms Policy **j) Outpatient Behavioral Health** 1. Department Safety 2. Emergency Evacuation **k) Pulmonary Rehab** 1. Disaster Plan (3) Minutes a) Special Meeting – December 10, 2025 b) Regular Meeting – December 10, 2025 (4) Reports – (Discussion by exception only) a) Building Lease Report – (December, 2025) b) Reimbursement Disclosure Report – (December, 2025)		
13	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
14	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
15	Comments by Chief Executive Officer	5 min.	Standard
16	Board Communications	18 min.	Standard
17	Total Time Budgeted for Open Session	1 hour	
18	Adjournment		

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: January 29, 2026
PHYSICIAN GROUP AGREEMENT Co-Medical Director – Outpatient Behavioral Health Services

Type of Agreement	X	Co-Medical Directors		Panel	X	Other: Replacing Dr. Tavakoli
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Physician's Name: Center for Neurohealth, Inc., dba Salma Health (Mohammed Ahmed, M.D.)

Area of Service: Outpatient Behavioral Health-Morning and Afternoon Program

Term of Agreement: 17 months, Beginning, February 1, 2026 – Ending, June 30, 2027

Maximum Totals: Close to 70th percentile (Challenges with psychiatry recruitment and regulatory requirements)

	Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost (Not to Exceed)	Term Cost (Not to Exceed)
Medical Director Duties	$165	26	312	$4,290	$51,480	**$72,930**
Case Care Management Duties	$165	14	168	$2,310	$27,720	**$39,270**
Vacation Coverage	$165	As needed	48 max.	$660	$7,920	**$11,220**
Total:		**52**	**528**	**$7,260**	**$87,120**	**$123,420**

Co-Medical Director Responsibilities:

- Provide medical supervision and direction to the unit, including the morning and afternoon programs.
- Supervise and promote the quality of care and evaluate delivery systems.
- Oversee the development of evidence-based clinical services and provide psychiatric expertise.
- Facilitate weekly problem solving and treatment team meetings with clinical staff.
- Review all treatment plans at least monthly to determine appropriateness of problems and treatment goals.
- Evaluate and review policies and procedures and make suggestions for changes as appropriate.

Case Care Management and other Duties:

- Take on utilization management duties and respond to insurance authorization calls for IOP and communicate clinical determination of medical necessity.
- Evaluate patients at least once per month for IOP medical necessity and discharge readiness.
- Evaluate whether patients are medically stable and meet inclusion/exclusion criteria for IOP on admission and monthly thereafter.
- Prepare reports and records as requested by hospital and regulatory bodies.
- Provide professional guidance to staff Monday through Friday and evaluate risk/protective factors and recommend whether a patient needs inpatient treatment or can be managed with safety planning. Respond to calls Mondays through Fridays, 8 am-5 pm.

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: Sarah Jayyousi, Director, Outpatient Behavioral Health / Donald Dawkins, Chief Patient Care Services

Motion:
I move that the TCHD Board of Directors authorize the agreement with the Center for Neurohealth, Inc., dba Salma Health (Mohammed Ahmed, M.D.) for the co-medical directorship for a term of 17 months, beginning February 1, 2026 and ending June 30, 2027, for an hourly rate of $165, an annual cost of $87,120, and a total term cost of $123,420.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: January 29, 2026
PHYSICIAN RECRUITMENT AGREEMENT

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

Physician Name: Muhammad Madkour, M.D.

Areas of Service: Interventional Cardiology Medicine

Key Terms of Agreement:

Effective Date: October 1, 2026, or the date Dr. Madkour becomes a credentialed member in good standing of the Tri-City Healthcare District Medical Staff.

Community Need: TCHD Physician Needs Assessment shows significant community need for Cardiology.

Service Area: Area defined by the lowest number of contiguous zip codes from which the hospital draws at least 75% of its inpatients

Terms of the Engagement:	Proposal Costs:
Monthly Income Guarantee, NTE	$41,666. per month ($500,0000 a year, 2-year income guarantee with a 3-year forgiveness period)
Relocation Allowance	$10,000 (not part of the loan)
Sign-on Advance	$35,000
Total Amount of Request:	**$1,045,000**

Unique Features: Dr. Madkour will practice with Dr. Karim El-Sherief at Heart Care Associates

Requirements:

Business Pro Forma: Must submit a 24-month business pro forma for TCHD approval relating to the addition of this physician to the medical practice, including proposed incremental expenses and income. TCHD may suspend or terminate income guarantee payments if operations deviate more than 20% from the approved pro forma and are not addressed as per agreement.

Expenses: The agreement specifies categories of allowable professional expenses associated with the operation of physician's practice and approved at the sole discretion of TCHD.

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: Jeremy Raimo, Chief Operating Officer

Motion:

I move that the TCHD Board of Directors approve an expenditure, not to exceed $1,045,000, to facilitate the addition of Muhammad Madkour, M.D., Interventional Cardiology Physician to practice medicine in the communities served by the District. This will be accomplished through an independent physician recruitment agreement (not to exceed a two-year income guarantee with a three-year forgiveness period) between Tri-City Healthcare District, and Muhammad Madkour, M.D.

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT
January 14, 2026

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
CRAWFORD, Kayva MD	Otolaryngology	Provisional	1/29/2026 - 1/29/2028	
HOERIG, Alexander DO	Emergency Medicine	Provisional	1/29/2026 - 1/29/2028	
KALRA, Salil MD	Critical Care	Provisional	1/29/2026 - 1/29/2028	
ROSS, Elsie MD	Vascular Surgery	Provisional	1/29/2026 - 1/29/2028	

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
JANUARY 14, 2026

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
MOUSSAVIAN., Mehran, DO	Cardiology	Refer and Follow	01/29/2026-01/29/2028	Status change from Active to Refer and Follow, due to lack of activities.
NIKANJAM, Mina., MD	Oncology	Refer and Follow	01/29/2026-01/29/2028	Status change from Active Affiliate to Refer and Follow, due to lack of activities.
YAMANAKA, Mark K.,MD	Pulmonary	Active	01/29/2026-01/29/2028	

Department of Surgery:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
HAN, James., DPM	Podiatric Surgery	Active Affiliate	01/29/2026-01/29/2028	
KANE, Norman., MD	Orthopedic Surgery	Active	01/29/2026-01/29/2028	
MUDD, Brian D., DDS	Oral & Maxillofacial Surgery	Active	01/29/2026-01/29/2028	
TALLMAN, Garrett J., MD	Orthopedic Surgery	Refer and Follow	01/29/2026-01/29/2028	

Resignations *Medical Staff*:

Practitioner Name	Department/Specialty	Reason for Resignation
AVILA, Alfonso DO	Emergency Medicine	Resignation Documentation Received–Effective 8/26/2024
HIRASUNA, Richard MD	Anesthesiology	Resignation letter received – Effective 12/15/2025

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
JANUARY 14, 2026

Attachment B

STERN, Mark., MD	Neurological Surgery	Failure to submit Reappointment App

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

NPDB (National Practitioner Data Bank):

Practitioner Name	Department/Specialty	Comments
MUDD, Brian D., DDS	Oral & Maxillofacial Surgery	Final settlement w/payout of $550,000 for claim dated 08/01/2022

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
JANUARY 14, 2026

Modification of Staff Status

The following practitioners have requested privilege status change as noted below. Effective **January 29, 2026**

Practitioner Name	Department/Specialty	Change in Staff Status
TRACY, David J., DDS	Oral & Maxillofacial Surgery	Changing status from Refer and Follow to Active Affiliate.

Addition/Deletion of Privilege(s)

The following practitioners have requested addition/deletion of privilege(s) as noted below. Effective **January 29, 2026**

Practitioner Name	Department/Specialty	Change in Privilege/s
PHILLIPS, Jason M,. MD	Urology	Addition: **Sacral Nerve stimulation**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
January 14, 2026

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)
AGHDASI, Bayan MD	Orthopedic Surgery	• All approved privileges under Spine Category • All approved privileges under Spinal Arthrodesis Category

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE INITIALS REPORT
January 19, 2026

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
CUSSON, Jeffrey CRNA	Nurse Anesthetist	Allied Health Professional	1/29/2026 – 1/29/2028	
NOVILLA, Janell-Francine PA	PA – Emergency Medicine	Allied Health Professional	1/29/2026 – 1/29/2028	
SLOWIK, Alexandra PA	PA – Wound Care	Allied Health Professional	1/29/2026 – 1/29/2028	
SMITH, Chelsea PA	PA - Medicine	Allied Health Professional	1/29/2026 – 1/29/2028	
STALEY, Ashley PA	PA - Surgery	Allied Health Professional	1/29/2026 – 1/29/2028	

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – 1 of 1
January 19, 2026

Attachment B

Reappointments:

Any items of concern will be "red" flagged in this report. The following practitioners were presented to members of the Interdisciplinary Practice Committee for consideration for reappointment to the Allied Health Professional Staff, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance. Reappointment is for 2-years unless otherwise noted below.

Allied Health Professionals

Department of Surgery:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
BULGER, Jeffrey., PAC	Cardiothoracic Surgery	Allied Health Professional	01/29/2026-01/29/2028	
GUTHRIE, Lesli A., AuD	Audiology	Allied Health Professional	01/29/2026-01/29/2028	

Resignations - *AHP*:

Practitioner Name	Department/Specialty	Reason for Resignation
GRYSKA, Jennifer CNIM	Audiology	Resignation documentation received. Effective 11/20/2025.
THAM, Janice NP	Medicine	Resignation documentation received. Effective 11/09/2025

Professional Licensing Board: No new information reported

NPDB (National Practitioner Data Bank): No new information reported

Tri-City Medical Center

ADMINISTRATION CONSENT AGENDA
January 21, 2026

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services		
1. Cardioversion, Elective Procedure	3 year review, practice change	Forward to BOD for Approval
Administrative 200s Finance		
1. Medi-Cal TAR Requirements 268	3 year review, practice change	Forward to BOD for Approval
Administrative 400s Human Resources		
1. Annual and Extended Leave Bank - 489	3 year review, practice change	Forward to BOD for Approval
Emergency Operations Procedure (EOP)		
1. 4028 Emergency Preparedness Management Disaster Plan-Emergency Department Specific	RETIRE	Forward to BOD for Approval
2. Administrative Coordinators 4086	3 year review, practice change	Forward to BOD for Approval
3. Communications Department Specific 4023	3 year review, practice change	Forward to BOD for Approval
4. Identification of Staff and Incident Command Leaders Hospital Wide 4074	3 year review	Forward to BOD for Approval
5. Information Technology Department Specific 4079	3 year review, practice change	Forward to BOD for Approval
6. Medical Staff Assignments	3 year review	Forward to BOD for Approval
Employee Health & Wellness		
1. Employee Health Infection Control Program	3 year review, practice change	Forward to BOD for Approval
Engineering		
1. Code Green Policy 8007	3 year review, practice change	Forward to BOD for Approval
2. Utility Management Plan 4003	1 year review	Forward to BOD for Approval
Environment of Care Manual		
1. Emergency Management Plan	1 year review	Forward to BOD for Approval
2. Fire Plan (Code Red) 3005	1 year review, practice change	Forward to BOD for Approval
3. Hazardous Material and Waste Management and Communication Plan 6000	1 year review	Forward to BOD for Approval
4. Medical Equipment Management Plan	1 year review	Forward to BOD for Approval

ADMINISTRATION CONSENT AGENDA
January 21, 2026

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
5. Safety Management Plan	1 year review	Forward to BOD for Approval
6. Security Management Plan	1 year review	Forward to BOD for Approval
Infection Control		
1. Epidemiologic Investigation of a Suspected Outbreak	3 year review	Forward to BOD for Approval
Mammography Women's Center		
1. Enhancing Quality using the Inspection Program (EQUIP) Policy	3 year review	Forward to BOD for Approval
2. Implants Policy	3 year review	Forward to BOD for Approval
3. Quality Control (QC) Policy	3 year review	Forward to BOD for Approval
4. Reject Repeat Analysis Policy	3 year review	Forward to BOD for Approval
5. Scheduling of Self Referring Mammography Patients Policy	3 year review	Forward to BOD for Approval
6. Standardized Labeling of Mammograms Policy	3 year review	Forward to BOD for Approval
Outpatient Behavioral Health		
1. Department Safety	3 year review, practice change	Forward to BOD for Approval
2. Emergency Evacuation	3 year review, practice change	Forward to BOD for Approval
Pulmonary Rehab		
1. Disaster Plan	3 year review	Forward to BOD for Approval

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**CARDIOVERSION, ELECTIVE (SYNCHRONIZED CARDIOVERSION)**
Purpose:	To outline the nursing management of adult/adolescent patients undergoing an elective cardioversion
Supportive Data:	Elective cardioversion is performed by a physician only.
Equipment:	Defibrillator with functioning synchronizer Multifunction cable and pads Emergency cart Medications as ordered by physician Oral airway, manual resuscitation bag with mask, and suction equipment Automatic blood pressure cuff Infusion Pump Electrocardiogram (ECG) Electrodes End tidal carbon dioxide monitoring

A. **POLICY:**

1. Elective cardioversions will be performed in procedural areas, Intensive Care Unit (ICU), and Telemetry.
2. The Registered Nurses' (RNs) role during an elective cardioversion is to assist the physician as ordered.
3. Review the following procedures:
   a. Online Skills: Synchronized Cardioversion for detailed nursing responsibilities for pre-intra and post-procedure monitoring and assessment.
   b. Patient Care Services (PCS) Procedure: **Procedural** Sedation~~/Analgesia Used During Therapeutic or Diagnostic Procedure~~.

B. **PROCEDURE:**

1. Complete Pre-Op/Pre-Procedure Checklist.
2. Notify and request attendance for respiratory therapist for procedure.
3. Keep patient NPO as ordered.
4. Position the patient in supine position or as ordered by physician.
5. Ensure suction equipment is readily available.
6. Place automatic blood pressure cuff on patient and set for desired time intervals.
7. Administer medications as ordered.
8. Place defibrillator in synchronization mode. Select energy level as ordered by Physician.
9. Assist physician with operating equipment as necessary.
   a. Turn off oxygen flowmeter during cardioversion to decrease risk of combustion.
   b. Ensure all personnel are clear of contact with patient, bed, and equipment during actual cardioversion to prevent from being shocked.
   c. Post-cardioversion, restart oxygen after electrical discharge completed.

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

1. PCS Procedure: Sedation **Procedural**~~/Analgesia Used During Therapeutic or Diagnostic Procedure~~
2. Online Skills: Synchronized Cardioversion

D. **REFERENCE(S):**

PCS Content Expert	Clinical Policies & Procedures Committee	Nursing Leadership	Division of Cardiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
08/00, 03/03, 07/03, 03/04 03/06, 04/09, 05/19, 05/22, **10/25**	07/11, 01/16, 06/19, 06/22, **10/25**	08/11, 01/16, 06/19, 07/22	10/16, 08/19, 08/22, **12/25**	n/a	10/11, 10/16, 09/19, 09/22	10/19, 12/22	11/11, 01/17, n/a	12/11, 01/17, 10/19, 12/22

1. American Heart Association (AHA). (2016). *Advance cardiovascular life support:* Cardioversion p. 136-138.
2. Urden, L., Stacy, K., and Lough, M. (2014). *Critical care nursing: Diagnosis and treatment*. Mosby's Inc, St. Louis: MO.

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY
DISTRICT OPERATIONS

ISSUE DATE: 04/99

SUBJECT: Medi-Cal Treatment Authorization Request (TAR) Requirements

REVISION DATE~~(S)~~: 05/03, 01/06, 09/10, 01/11, 03/15, 02/18, 01/22

POLICY NUMBER: 8610-268

Administrative Policies & Procedures Content Expert:	**~~07/21~~10/25**
Administrative Policies & Procedures Committee Approval:	**~~08/21~~10/25**
Administration Approval:	**01/22**
Finance & Operations Committee Approval:	**n/a**
Board of Directors Approval:	**01/22**

A. **PURPOSE:**

1. To ensure the appropriate approved Treatment Authorization Request (TAR) has been received for all Medi-Cal admissions.

B. **DEFINITION(S):**

1. Medi-Cal Pending Patients: Patients who have applied to California Department of Public Health (CDPH) for assistance and have not been approved. These patients are considered cash paying and the hospital's deposit/payment policies apply.
2. Medi-Cal Eligible Patients: Patients who have provided valid proof of eligibility by way of a CDPH 1410 form and/or verification on the Medi-Cal Point of Service (POS) Online website (eTAR).
3. Approved TAR: A treatment authorization request, which has been submitted by the physician's office and has been approved by the field office. An approved TAR is required in advance of all elective and urgent procedures.

C. **POLICY:**

1. All Medi-Cal approved elective admissions, ~~or~~ procedures, **and ancillary services** requiring a TAR will have one obtained by the treating physician's office prior to the scheduled date of service.
2. Registration will follow the usual procedures for admission ensuring that the approved TAR has been received. ~~Case Management and~~ Registration will coordinate any questionable admissions to ~~insure~~ **ensure** TARs are appropriate and timely.
3. **Registration informs the physician's office a TAR is required prior to the services being rendered and if TAR is not received within 24 hours of the scheduled time the case will be rescheduled.** It will be the responsibility of the Registration Department to notify Surgical Services of any change. ~~Surgery Scheduling~~**Registration** ~~informs the physician's office a TAR is required prior to the services being rendered and if TAR is not received within 48~~ **24 hours of the scheduled time the case will be rescheduled.**
4. If Medi-Cal TAR is approved with a share of cost:
   a. Registration is responsible for verifying a patient's share of cost has been met. If the share of cost has not been met, Registration shall request payment in full or contact the in-house Preadmitter **or Cashier** to make appropriate payment arrangements with the patient. In accordance with hospital policy, payment arrangements ~~will not extend~~ beyond a ~~six month~~**six-month** period **need approval through billing.**~~.~~
   b. Medi-Cal pending admits will be handled as cash. The hospital policy regarding deposits and payment apply. ~~Med Assist~~**First Source** will, as needed, screen patients and continue to follow up to secure applications and/or ensure eligibility.

D. **PROCESS:**

1. Case Management will perform initial clinical review utilizing InterQual Criteria at Hospital points of entry (ED, Procedural Areas ~~etc~~**etc.**) and Case Management will contact the admitting / treating physician as needed to discuss the case to determine appropriate level of care: Inpatient or Observation level of care.
   - **a.** Case Manager's clinical reviews are documented in the electronic health record (EHR)
   - ~~1.~~**b. Registration will reach out to Utilization Management (UM) for any additional information that is needed for completion of the TAR**

~~2. Case Management - performs concurrent daily clinical review for Managed Medi-Cal – (Molina, CHG for example and APRDRG clinical review for standard Medi-Cal beneficiaries)~~
   - ~~a. Case Manager's clinical reviews are documented in the electronic health record (EHR)~~
   - ~~b. Registration Staff presents the "TAR (Medi-Cal) REVIEW" Case Management with the E-TAR~~

~~3.~~**2.** Case Management will facilitate communication with treating physician to clarify any issues surrounding appropriate level of care (Inpatient versus Observation versus 10-Bed-Call) and obtain appropriate physician orders.

3. Case Management will facilitate communication with Utilization Management (UM) Medical Director for issues regarding medical necessity and to coordinate MD to MD communication.
4. **Registration will be responsible for completing the TAR on all non-elective admissions.**

~~5. Registration is responsible for notifying Surgical Services of any changes.~~

E. **REFERENCE(S):**

1. California Code of Regulations (CCR), Title 22, the Department of Health Care Services (DHCS), Medi-Cal Form 50-1 Treatment Authorization Request (TAR) http://www.dhcs.ca.gov/provgovpart/Pages/TAR.aspx

Tri-City Medical Center
Oceanside, California

Administrative ~~Policy~~
Human Resources

ISSUE DATE: 10/17 **SUBJECT:** Annual and Extended Leave Bank

REVISION DATE(S): **POLICY NUMBER:** 8610- 489

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

A. **PURPOSE:**

1. The Annual and Extended Leave Bank program is designed to provide eligible Tri-City Healthcare District (TCHD) employees with compensated time away from their regular assignment in coordination with **Leave of Absence and~~the~~** Paid Time Off Program, in order to ensure their physical and mental well-being.

B. **POLICY:**

1. The Annual Leave Bank (ALB) and Extended Leave Bank (ELB) program provides for the accrual and utilization of leave pay. ALB and ELB may be used to supplement other payments such as State Disability Insurance (SDI) and Family **and Medical Leave~~Temporary Disability Insurance~~** (F**MLA~~TDI~~**), as well as workers' compensation payments, if the employee chooses.

C. **ANNUAL LEAVE BANK AND EXTENDED LEAVE BANK, ACCRUAL AND USE:**

1. All full-time and part-time benefited ~~and weekend professional~~ employees are eligible to accrue ALB hours each pay period in accordance with the accrual schedule below:

FULL TIME EMPLOYEES ACCRUAL RATE			80% TIME EMPLOYEES ACCRUAL RATE			60% TIME EMPLOYEES 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
All	1.85	n/a	All	1.48	n/a	all	1.11	

2. Employees accrue and may use ALB as follows:
   a. Upon completion of 90 days employment in a benefit status, employees accrue ALB each pay period in accordance with the schedule above.
   b. PTO is used for the first 16 consecutive hours of any absence. Beginning on the third consecutive day of an absence due to the employee's own illness or injury, ALB hours will be used until exhausted.
   c. Once ALB hours are exhausted, ELB hours will be used until exhausted. Once ELB hours are exhausted, remaining PTO hours will be used until exhausted.
   d. On the employee's anniversary date each year, employees with less than 120 hours in ELB will have all ALB hours automatically transferred from ALB to ELB.

e. On the employee's anniversary date each year, employees with a minimum of 120 hours in ELB who have used less than 48 hours of ALB in the preceding 12 months may choose to transfer up to 50% of ALB to PTO. The remaining 50% of ALB is forfeited.

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

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

h. ~~Employees whose~~ PTO/ALB/ELB banks **may be used to pay for benefit deductions when an employee is on an approved leave of absence.** ~~are exhausted should contact the Human Resources department Benefits section for assistance with continuation of benefits if~~**of** ~~applicable.~~

~~h.~~**i. Upon termination of employment or change from benefited to non-benefited status, an employee will be paid 50% of their accrued ALB hours provided that they have a minimum of 120 hours in ELB. If an employee has less than 120 ELB hours, all ALB will be forfeited.**

3. The Extended Leave Bank is not vested and is not paid out when the employee terminates employment.

D. **ADMINISTRATION:**

1. The **head of**~~Chief~~ Human Resources ~~Officer (CHRO)~~, with approval from the Chief Executive Officer, has authority and responsibility for administration of this policy. Practices and procedures to support the administration of this policy will be developed by the **Human Resources department**~~CHRO~~. Exceptions to this policy must be approved by the **head of Human Resources**~~CHRO~~ and Chief Executive Officer.

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

1. Administrative Policy: Paid Time Off Program 433

~~1.~~**2. Administrative Policy: Leave of Absence 435**

~~**Department Approval: 10/17**~~
~~**Administrative Policies & Procedures Committee Approval: 10/17**~~
~~**Human Resources Committee Approval: 10/17**~~
~~**Board of Directors Approval: 10/17**~~

Tri-City Medical Cen
Oceanside, California

RETIRE - see the Emergency Department – Hospital Emergency Operations Plan ED

Emergency Preparedness Management

EFFECTIVE DATE: 11/88

SUBJECT: Emergency Preparedness Management Disaster Plan: Emergency Department Specific

REVISION DATE: 3/91, 3/97, 3/99, 6/00, 1/06

POLICY NUMBER: 4028 Page 1 of 1

Department Approval: 09/24
Environmental Health and Safety Committee Approval: 12/25
Administration Approval:
Professional Affairs Committee Approval:
Board of Directors Approval:

CROSS REFERENCE:

REVIEW DATE: 4/03

APPROVAL:

~~1.0 PURPOSE:~~

~~To ensure proper management of department during an internal disaster.~~

~~2.0 PERSONNEL:~~

~~All Emergency Department personnel.~~

~~3.0 PROCEDURE:~~

~~Should a hazard (e.g. water, fire, hazardous material) threaten the Emergency Department, initiate the following:~~

~~3.1 Remove all patients to a safe place or area.~~

~~3.2 Close all doors and windows.~~

~~3.3 Report the hazard.~~

~~3.3.1 In case of fire, operate fire alarm box.~~

~~3.3.2 Call operator (66) and give location, type and extent of hazard. Keep all telephone lines open.~~

~~3.4 Shut off oxygen.~~

~~3.5 Use appropriate fire extinguisher or fire hose until relieved by Engineering or the fire department.~~

~~3.6 Turn off or unplug all involved electrical equipment.~~

~~3.7 Leave lights on.~~

~~3.8 Remove equipment from hazard area if possible without endangering lives.~~

~~4.0 EVACUATION PROCEDURE:~~

~~The Department Clinical Manager or designee will coordinate arrangements or assignments.~~

~~4.1 All Emergency Department patients will be evacuated with mode of transportation appropriate to their illness/injury, i.e., wheelchair, gurney, to an area designated by the Clinical Manager/designee. (Suggested Areas for Care are, SPRA, PACU, Mobile Tent).~~

~~4.2 Emergency Department personnel will be assigned to the evacuation initially, then to the area where the patients are located.~~

~~4.3 Family members will be directed to an area adjacent to the evacuation site by admitting clerks.~~

~~4.4 The Emergency Department will close to family and visitors upon discovery of a disaster situation until evacuation has been completed or the situation is determined to be under control by the Unit Director.~~

~~4.5 The Emergency Department unit secretary will remove all important papers and books and will be in charge of them until they are safely relocated. Medical records must be evacuated with the patient.~~

~~4.6 The MICN will:~~

~~4.6.1 Alert area hospitals of the Internal Disaster via the QA Net on the County computer in the radio room.~~

~~4.6.2 Divert incoming patients in ambulances to nearest hospitals.~~

Tri-City Medical Center
Oceanside, California

EMERGENCY OPERATIONS PROCEDURE MANUAL

ISSUE DATE: 10/05 **SUBJECT: Administrative Supervisors**

REVIEW DATE: **POLICY NUMBER: 4086**
REVISION DATE: 2/06

Department Approval Date: 02/22
Environmental Health and Safety Committee Approval: 03/22
Medical Executive Committee Approval: n/a
Administration Approval: 03/22
Professional Affairs Committee Approval: n/a
Board of Directors Approval: 03/22

A. **PURPOSE:**
1. To establish the responsibilities of the Administrative Supervisor (AS) and to ensure efficiency and proficiency setting up and supervising the command center (until relieved by an Administrator) in the event of a disaster.

B. **INTRODUCTION:**
1. Due to the varying types and magnitudes of emergency events, Tri-City Medical Center has adopted the command structure of the Hospital Incident Command System (HICS). Once the decision has been made to activate the disaster plan, the HICS becomes the standard operating procedure.

C. **NOTIFICATION:**
1. **Mobile Intensive Care Nurse (MICN)** to activate Annex D (mass casualty).
2. Emergency Department (ED) will notify the AS to activate a disaster using the appropriate code i.e., Code Orange **or Code** Yellow.

D. **DISASTER PLAN PROCEDURE:**
1. Get scenario.
2. Call the Public Broadcast Exchange (PBX) – 66
   a. Page Code Orange **or** Yellow
   b. Turn on red phones (numbers are in Chapter 2).
   c. Call Security (66) for lockdown if event is unknown.
3. Get disaster manual.
4. Go to French Room
   a. Get out box/radios
   b. Assign Recorder/Secretary role(s)
   c. Assign 5 other main roles and hand out batteries for radios as needed.
      i. Safety/Security
      ii. Logistics (Communication, Transportation, Supplies, Damage Assessment, Sanitation, Nutrition)
      iii. Planning (Labor Pool, Medical Staff)
      iv. Operations (Medical Staff Director, Surgical, Women's Children Services, Intensive Care Unit, Lab, Radiology, Cath Lab, Triage)
      v. Liaison (in communication with county/other hospitals)
   d. Tell leaders to read information sheet completely.
   e. Send Immediate Treatment Area Leader to **Emergency Department** (ED) -to open their box (given them radio for communication)

f. Gather information from messages sent from units

5. Turn over Incident Commander role to Administrator upon their arrival and return to role as AS.

E. **MISCELLANEOUS:**

1. If 6 or more contaminated patients, activate "Code Orange Decon" team via PBX (66), if 16 or greater activate "Code Orange Decon Tent" Team via PBX (66).
2. Identify resources, evaluate scenario, control situation.
3. Utilize **Special Procedure Recovery Area** (SPRA) for urgent (yellow) patients; ED Patio for 'green/walking wounded' Triage and Rehab treatment of the walking wounded, if needed. They can be blocked off.
4. Radios will be labeled with proper channels.
5. Labor Pool to gather in assembly rooms (Staff Support).
6. MD's to gather in Physician's Dining Room (extension 7424).
7. Decon Team consists of **Environmental Services** (EVS), **Patient Safety Technician**~~Lift Team~~, Security and Food/Nutrition
8. If biological event occurs, shut off Heating Ventilation and Air Condition (HVAC air intake) by Engineering.
9. Psych liaison/**C**chaplain to support as needed.
10. Disaster Call-back list in Staffing Office.

Tri-City Healthcare District
Oceanside, California

EMERGENCY OPERATIONS PROCEDURE MANUAL

ISSUE DATE: 11/88 **SUBJECT: Communications Department Specific**

REVISION DATE: 09/93, 03/97, 06/00, 01/06, 01/22 **POLICY NUMBER: 4023**

Department Approval:	**~~09/22~~12/25**
Environmental Health and Safety Committee Approval:	**~~09/22~~12/25**
~~Medical Executive Committee Approval:~~	**~~n/a~~**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**11/22**

A. PURPOSE:

1. To establish efficient Emergency Communications, and provide clear guidelines for the PBX staff to following during a disaster.

B. PROCEDURE:

1. The staff in the Communications Department will immediately assess resources available and will report to the immediate supervisor/Shift Lead Operator/designee upon notification of a disaster.
2. The Supervisor/Lead Operator will review the nature of the alert and make necessary arrangements to cover the situation. Upon review of personnel and resources, the Supervisor/Lead Operator will report his/her findings and recommendations to the Information Technology Technical Manager.
3. The Supervisor will then report to the Incident Command Center, located ~~in French Rooms 1 & 2~~**in designated area**, regarding the state of the department. At the direction of the Incident Commander, a universal page will be sent to the Emergency Call list.
4. The Supervisor/Lead Operator will provide the Supervisor with an hourly update regarding the status of the area. (Such as manpower, supplies, equipment, etc.) If additional manpower is needed, the call-back procedure will be activated.
5. In the event the disaster is located within the Communication Department, the implement the following:
   a. The Supervisor/Lead Operator will notify the Information Technology Technical Manager.
   b. All personnel will report to the Information Technology department and be accounted for.
   c. The appropriate departments will be contacted, such as Facilities, Emergency Room, Employee Health Office, and Administration
   d. At the direction of the Information Technology Technical Manager, the Supervisor/Lead Operator will begin the call backlist in the order of the employees listed. Refer to Communication call-back list.

C. EVACUATION PLAN:

1. In the event that personnel must be evacuated from any communication space due to fire, earthquake, or any other disaster, the following procedure should be observed:

2.Remain calm and do not panic.

3.Assist the injured, if possible.

4. Personnel will evacuate according to the evacuation routes. The staff will meet by the annex

building to account for all.

5. Returning to the scene of the disaster is prohibited unless instructed and deemed safe by proper authorities.
6. The Information Technology Technical Manager will be in charge and interface with proper authorities in dealing with all aspects of the disaster that occurred or related to the Communication Department.

D. COMMUNICATION DEPARTMENT RESPONSE TO CODES:

1. CODE YELLOW
   a. Announce Code Yellow three times on announcement speaker.
   b. **Call the following:**
      i. Radiation Officer
      ii. **EOC/Safety Manager**
      ~~i.~~**iii.** **Plant Engineer**
      ~~ii.~~**iv.** Administration, when closed contact the Administrative Supervisor (AS)
      ~~iii.~~**v.** Chief of Staff: (Physician)
      ~~iv.~~**vi.** Office Emergency Service
      ~~v.~~**vii.** Base Station Coordinator
      ~~vi. Admitting~~
      ~~vii.~~**viii.** Security **Lead Officer**~~: use security phone~~
      ~~viii.~~**ix.** Environmental Services:
2. CODE ORANGE
   a. Announce Code Orange and Area three times on announcement speaker.
   b. **Call** the following:
      i. Base Station Coordinator[IMJ1][WJV2]
      ~~i.~~**ii.** **EOC/Safety Manager**
      ~~ii.~~**iii.** Administration, when closed contact the AS. Security: use security phone
      ~~iii.~~**iv.** Facilities Management: (Engineering)
      ~~iv.~~**v.** Send out code orange page to ~~all Executive and Director personnel~~**designated group**.
3. DOCTOR STRONG
   a. Information to get from caller:
      ~~b.~~**i.** Location - room, station, etc.
      ~~c.~~**ii.** Callers name
      ~~d.~~**iii.** Note time call came in
   ~~e.~~**b.** Overhead page three times and announce over security radio "Doctor Strong" and the location.
4. BOMB THREAT
   a. **Call security: 66**
      ~~a.~~**i.** ~~Speed Dial: **9911**~~**Security will notify** - Oceanside Police & Fire Department
   b. FBI: **923-1122**[IMJ3][WJV4]
   ~~c. Have security call operator, do not give information out over the air.~~
   ~~d.~~**c.** **Call** Base Station Coordinator
      i. Administration when closed contact the AS.
      ~~i.~~**ii.** **EOC/Safety Manager**
      ~~ii.~~**iii.** Facilities Services: (Engineering)
   ~~iii.~~**d.** Keep person on phone as long as possible. Note sounds, accents, etc.
      ~~iv.~~**i.** Ask where bomb will explode.
      ~~v.~~**ii.** Note if they have knowledge of hospital.
5. CODE GREEN
   a. Announce Code Green and Area three times on the announcement speaker.

~~a.~~**b.** ~~Beep~~ **Call** pulmonary supervisor and lead therapist - follow notification of emergency.
~~b.~~**c.** Notification must come from Facilities Services, Pulmonary, Nursing, or other authorized personnel.
~~c.~~**d.** Code Green will always be beeped to **2222**[IMJ5][WJV6]**
~~d.~~**e.** When notified get name of person calling.

6. CODE MI[IMJ7][WJV8]
   a. Page **3100** to **8888**
   b. This will activate the following beepers:
   c. **1454** - Imaging
   d. **3152** - Laboratory
   e. **0354** - Cardiopulmonary
   f. **6524** - Cardiopulmonary
   g. The "**8888**" will represent a Code MI and signifies that a cardiac patient needs a stat procedure in the Emergency Department. These patients have TOP PRIORITY.
7. CODE BLUE
   a. Announce Code Blue and Area three times on the announcement speaker.
   b. Beeper **0066** to Room Number plus *1[IMJ9][WJV10]
   c. Speed dial **926-~~65~~-0066** – Beeper Code Blue (Be sure to enter room number)
   d. Announce Code Blue and Area three more times on the announcement speaker. Call Unit or floor to make sure everyone responded.
8. CODE PINK
   a. Announce Code Pink and Area three times on announcement speaker. Wait one minute then repeat above.
9. CODE RED
   a. When alarm rings, immediately check alarm number.
   b. Announce Code Red and Area three times on announcement speaker.
   c. Page security and give location of fire
   d. ~~Beep~~ **Call** stationary engineer: **~~0720~~760-802-2697**
   e. Repeat again in one minute.
   f. Call Administration when close contact Administrative Coordinator: **0375**. Between 4:00 p.m. and 7:00 p.m., page Administrator on-call, Monday through Friday.
   g. Wait for instructions from Facilities Services or Administration.

Tri-City Medical Center
Oceanside, California

Emergency Preparedness Management

EFFECTIVE DATE:	**6/03**	**SUBJECT:**	**Identification of Staff and Incident Command Leaders: Hospital Wide**
REVISION DATE:			
REVIEW DATE:	**10/05, 03/22**	**POLICY NUMBER:**	**4074**

Department Approval:	**~~02/22~~10/25**
Environmental Health and Safety Committee Approval:	**~~03/22~~12/25**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**03/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**03/22**

A. **PURPOSE:**
1. To identify the process for identifying Hospital Incident Command System (HICS) staff roles during an internal or external disaster.

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

C. **POLICY:**
1. HICS staff will be identified as outlined in the HICS Command Structure Hospital Wide policy.
2. Colored vest will be provided to each HICS staff, as warranted, with the following assigned titles:
   a. Incident Commander
   b. Safety and Security Officer
   c. Liaison Officer
   d. Public Information Officer
   e. Operations Chief
   f. Logistics Chief
   g. Planning Chief
   h. Finance Chief
3. Each vests will be:
   a. Issued by the Incident Commander or designee
   b. Maintained within the Incident Command Kit, located in the Incident Command Center e.g., the French Rooms
   c. Issued with the following:
      i. Job Action Sheet Package
      ii. A clipboard with its respective Job Action Sheet
      iii. Pens
      iv. Flashlight and other relevant supplies
   b. May be assigned to staff not listed above per the Incident Commander or designee
2. Identification of Employees:
   a. All employees are required to wear their photo identification (ID) badge.
   b. Workforce members without their hospital issues ID badge will be required to obtain temporary badges from Security after presenting appropriate alternative

identification and the identification is vested by department leaders or designee.

c. Hospital badges will be worn per policy.

3. Identification of Outside Agencies:
   a. Uniformed outside agencies, including police, fire and other public safety agencies in uniform will be allowed in the facility during emergencies without further identification.
      i. If there are questions, they will be requested to provide official identification (ID).
4. Outside Agency Staff Not in Uniform:
   a. Representatives of outside agencies who are not in a clearly defined uniform will be asked to provide appropriate identification, such as an official badge or ID card.
   b. They will be provided with a "Disaster ID Badge" maintained by Security.
      i. The badges will be available at the Main Entrance Security Desk.
      ii. The outside agency staff will required to check-in with Security.
5. Other Special Visitors or Authorities:
   a. Others who have an appropriate reason to be within the facility during emergency situations, will also be asked to identify themselves at the Main Entrance Security Desk, and will be issued badges as deemed appropriate by the Incident Commander, the Liaison Officer or Safety/Security Officer.

Tri-City Medical Center
Oceanside, California

EMERGENCY OPERATIONS PROCEDURE MANUAL

ISSUE~~EFFECTIVE~~ DATE: 02/03

SUBJECT: Emergency Preparedness Management Disaster Plan: Information Technology Department Specific

REVISION DATE: 11/05

POLICY NUMBER: 4079 ~~Page 1 of 2~~

Department Approval: ~~08/21~~12/25
Environmental Health and Safety Committee Approval: ~~08/21~~12/25
Medical Executive Committee Approval:
Administration Approval:
Professional Affairs Committee Approval:
Board of Directors Approval:
~~CROSS REFERENCE:REVIEW DATE:~~ **~~APPROVAL:~~**

A. **PURPOSE:**
1. To ensure efficient Information Technology services and to maintain adequate availability of personnel in the event of hospital disaster
2. Note: this Policy addresses a hospital-wide or community disaster. Separate policies and procedures are in place for an IT-specific disaster.

~~3.~~**B. PERSONNEL:**
~~4.~~**1.** The IT Department Safety Officer or designee will initial assume charge responsibility for a disaster during weekdays 7:00 Am through 5:00 PM.
~~5.~~**2.** During nights and the ~~weekends~~**weekends,** The IT director will receive the initial page of a Code orange disaster. He will then notify the appropriate staff of the Code orange status.
~~6.~~**3.** During the course of the disaster, the Manager - Application Services, Manager – Technical Services, and Director will rotate Operations manager responsibilities.

~~7.~~**C. INITIAL PROCEDURES:**
~~8.~~**1.** Due to the varying types and magnitudes of emergency events, Tri-City Medical Center has adopted the command structure of Hospital Emergency Incident Command Systems (HEICS). Once the decision has been made to activate the disaster plan, the HEICS becomes the standard operating procedure. The complete plan is located in the TCMC Safety and Disaster Plan Manual located in the shelf above the department secretary's desk.
~~9.~~**2.** Information Technology will be notified of the Disaster Plan Activation from the PBX operator announcing "CODE ORANGE" or "CODE YELLOW", using the overhead page.
~~10.~~**3.** The IT Department Safety Officer or designee will serve as Disaster Recovery Coordinator. When staff members arrive, they will check in with the Disaster Recovery Coordinator, who will log the person as available and update the Personnel Inventory Form.
~~11.~~**4.** The IT Department Safety Officer or designee will complete and send one employee with the Personnel Inventory Form to the Incident Command Center. Personnel Inventory Forms are available in the shelf above the department secretary's desk.
~~12.~~**5.** The IT Department Safety Officer or designee will assure that the Incident Command Center telephone and computer equipment are working, and that the Incident Command Center is able to communicate effectively via phone, fax, and/or Internet.
~~13.~~**6.** If the Disaster requires support from IT, the IT Department Safety Officer or designee will assure that all IT staff members are paged (if weekdays 7:00 Am through 5:00 PM) or contacted via the

on-call list (if nights or weekends). Each employee will be requested to report to the IT Department, if open, or alternatively to the to the annex if the IT Department cannot be occupied.

~~14.~~**D. ONGOING PROCEDURES:**

~~15.~~**1.** During the course of the disaster, the Manager - Application Services, Manager – Technical Services, and Director will rotate Operations manager responsibilities. These responsibilities will be focused on assuring that staff are available to man the Help Desk and provided support in each of the IT sections.

~~16.~~**2.** During the course of the disaster, the IT Department Safety Officer or designee will serve as the liaison between the IT Department and the Incident Command Center.

~~17.~~**3.** IT staff will stand ready to support TCMC departments affected by the disaster. The Help Desk will be manned on a 24/7 basis, and staff in each support section will be on site or on call during the disaster Applications Services staff will provide requested support for applications, interfaces, special reports, or special requests to reduce the effects of the disaster.

~~18.~~**4.** Customer Support staff will provide requested support for computer operations and PC hardware, software and connectivity.

~~19.~~**5.** Network Engineering staff will provide requested support for Exchange, Internet, security, server, and data communications services.

~~20.~~**6.** Communications staff will provide requested support for telephone and telecommunications services.

Tri-City Medical Center
Oceanside, California

Emergency Operations Procedure Manual
Response and Assignment of Personnel

ISSUE DATE: 06/15 **SUBJECT:** Medical Staff Assignments

REVISION DATE: 03/22

Department Approval:	~~03/22~~12/25
Environmental Health and Safety Committee Approval:	~~03/22~~12/25
Medical Executive Committee Approval:	n/a
Administration Approval:	03/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/22

A. POLICY:

1. Several teams of physicians will be needed to assist in the provision of definitive treatment and sorting. Assignments will be made after consideration of the physician's area of expertise.

B. PROCEDURE:

1. Initial responsibility for Triage and Treatment will be the responsibility of the Emergency Department (ED) Physician. As the disaster response expands, Medical Control responsibilities will be assumed by the Chief of Staff or his/her designee.
2. Upon initiation and notification of the disaster response, all available physicians in the facility will report to the Emergency Department.
3. The designated Medical Staff Unit Leader and the Chief of Staff or designee will implement a physician call-in from the Medical Staff Office after receiving a briefing on the status of the disaster situation and determining actual or potential medical care needs.
4. The designated Medical Staff Director will organize, prioritize, and assign physicians to areas where medical care is being delivered.
5. Team assignments which will be needed include:
   a. Physician coverage for Immediate, Delayed, and Minimal Treatment areas.
   b. Orthopedic Surgeons should report to the ED - ED Physician will designate assignments as necessary to cover all areas where care is delivered.
   c. Operating Room – Anesthesiologist, Surgeons - evaluate and prioritize surgical candidates and perform surgical procedures as required.
   d. Radiology – for interpretation of X-rays and other diagnostics.
   e. Intensive Care and Med/Surg units- (provide medical care to patients on units if the attending physician isn't available. Assist with and provide care for disaster patients admitted to the units.
   f. Utilization Review – make rounds with the Nursing Unit Leader and review for discharge or potential transfer.
   g. Pathology – to assist with laboratory diagnostics, forensic issues, and pathological tissue diagnosis.

Tri-City Healthcare District
Oceanside, California

EMPLOYEE HEALTH AND WELLNESS

ISSUE DATE:	**01/81**	**SUBJECT:**	**Employee Health Infection Control Program**
REVISION DATE:	**09/04; 10/07, 10/09, 10/12**		

Employee Health Department Approval:	**10/22**
Infection Control Committee Approval:	**~~12/22~~12/25**
Environmental Health and Safety Committee Approval:	**n/a**
Medical Executive Committee Approval:	**01/23**
Administration Approval:	**02/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/23**

A. **PURPOSE**:

1. Screening programs (tuberculosis [TB], latex, National Institute for Occupational Safety & Health [NIOSH] approved respirator medical evaluation and vaccine preventable diseases), pre-exposure prophylaxis, and post-exposure prophylaxis are offered through Employee Health Services (EHS) in an effort to control communicable diseases risks to both personnel and patients. However, EHS does not evaluate or treat health care personnel (HCP) for health problems or conditions that are not work-related. In conjunction with the Human Resource Department and Infection Prevention, the following specific program objective shave been developed to include:
    a. Pre-employment screening to ensure safe, appropriate placement of personnel to minimize their risk of contracting or spreading communicable disease.
    b. Personnel health and safety education.
    c. Manage bloodborne pathogen exposures, including identifying and communicating exposure risks and trends, promoting exposure prevention, and post-exposure case management.
    d. Identify health, safety and infection risks related to employment and institute preventative measures to identify and prevent injury and illness.
    e. Monitor and investigate communicable diseases, potentially harmful exposures, and outbreaks among personnel.
    f. Maintenance of employee health records.
    g. Report on the elements of the Employee Health Infection Control Program to the Infection Prevention Committee quarterly.

B. **POLICY**:

1. Immunization Program
    a. Evidence of Immunity (See Employee Health Policy: Immunization Program)
        i. All new personnel working at TCMC, including rehired personnel are required to complete an immunization screen before new employee orientation. Failure to provide proof of immunization and to complete EHS screening will prevent the HCP from working at TCMC until these requirements are met. All HCP must be immune (unless there is a medical contra-indication, as described by CDC/ACIP, or religious objection) to measles, mumps, rubella, varicella, and pertussis. All HCPs must receive influenza vaccine annually ~~and COVID-19 vaccines~~ per California Department of Public Health guidelines. Vaccine exemptions will be evaluated on an individual basis each year and must be resubmitted annually.
        ii. The following immunizations are offered at the employer's expense: Pertussis (Tdap); tetanus (Td); measles, mumps, rubella (MMR); hepatitis B; influenza, **and** varicella.~~, and COVID-19~~. Hepatitis A vaccine will be offered to any

personnel who handles or assists in food preparation or who may be exposed to raw sewage, e.g., Engineering. Live-attenuated virus vaccines (varicella, MMR) will not be given to pregnant HCP or immune-compromised persons. Other vaccines (e.g., smallpox) may be offered at the discretion of the Medical Director.

2. Employment and Annual Health Screening
   a. TCMC HCP, volunteers, and contract employees shall have initial infectious disease screening and/or immunization review. The screening will include tuberculosis screening as specified in the Infection Control Policy: Aerosol Transmissible Diseases and Tuberculosis Control Plan.
      i. Screening will be directed by EHS and will include a review of symptoms for tuberculosis as per the TB Surveillance Policy and an immunization review.
   b. All HCP will complete a respirator medical evaluation form and specific job classifications will be required to comply with respirator training and fit-testing (refer to Respiratory Protection Program Policy IC 14.1). Fit testing is not required for use of a powered air purifying respirator (PAPR) by HCP.
   c. Contract HCP who provide patient care, whether in a clinical area or in an administration office, must comply with OSHA standards and this Infection Control and Screening Program. It is the responsibility of the hiring department to assure compliance with this policy.
   d. HCP providing high-level disinfection (HLD) who may be color blind should be referred to EHS for further evaluation. In order to assess minimum effective concentrations (MEC) of HLD chemicals, HCP must be able to discern colors since chemical indicators demonstrate MEC via a color-changing strip or vial. HCP performing HLD may "color-blind", however, another HCP would be required to read the strips or vial.
3. Screening of Personnel with Infectious Diseases or Exposures to Communicable Diseases
   a. See Post-Exposure Prophylaxis for Vaccine Preventable Diseases **in the Eemployee Hhealth manual and Aerosol transmissible disease and TB control in the Infection Control manual** for specific protocols.
   b. All HCP with a potentially communicable disease (e.g., shingles, conjunctivitis, norovirus) must notify EHS. The EHS provides free medical screening for health problems encountered by HCP for the purpose of infection prevention. If necessary, EHS may order work restrictions (refer to Work Restrictions for Personnel with Infectious Diseases).
   c. Blood Exposure – Refer to Occupational Exposure to Blood/Body Fluid Secretions Policy and Bloodborne Pathogen Exposure Control Plan for management guidelines. For treatment guidelines see the Bloodborne Pathogen Exposure Protocols (HBV and HIV)

C. **RELATED DOCUMENT(S):**
1. Employee Health and Wellness Policy: Immunization
2. Employee Health and Wellness Policy: Respiratory Protection Program
3. Work Restrictions for Personnel with Infectious Diseases
4. Infection Control Policy: Aerosol Transmissible Diseases and Tuberculosis Control Plan
5. Post-Exposure Prophylaxis for Vaccine Preventable Diseases
6. Employee Health and Wellness Policy: Management of Bloodborne Pathogen Exposure
7. Bloodborne Pathogen Exposure Protocols

Tri-City Medical Center
Oceanside, California

ENGINEERING
EMERGENCY PREPAREDNESS

ISSUE DATE: 08/91

SUBJECT: Code Green Policy

POLICY NUMBER: 8007

REVIEW DATE: 08/15
REVISION DATE: 03/94, 03/97, 05/00, 05/03, 05/06, 05/09, 06/12, 10/15, 09/21, 12/22

Department Approval:	**~~04/22~~10/25**
Environmental Health and Safety Committee Approval:	**~~09/22~~12/25**
Administration Approval:	**12/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/22**

A. **PURPOSE:**
1. To establish guidelines to follow in the event of an oxygen system failure.

B. **POLICY:**
1. The responsibility of providing emergency sources of oxygen in the event of a failure of the normal oxygen supply system is coordinated between Engineering and Pulmonary Services with the support of Security, Nursing, and notification by PBX. Department Directors will be notified and further activation of the disaster call back tree will be implemented depending upon the scope of the event and the available personnel. Documentation of the emergency with all pertinent details and outcomes, including any adverse patient reactions, will be completed by the above.

C. **RESPONSIBILITY:**
1. Pulmonary Services is responsible for:
   a. Notifying the PBX operator (66) of Code Green and location.
   b. Providing patients with oxygen from portable tanks and manually ventilating them if necessary in coordination with nursing.
   c. Initially activating the emergency H-cylinder back-up system for the affected area.
   d. Coordinating action plan with Engineering.
   e. Monitoring continued use and need for more H-cylinders.
   f. Communicating the situation to the Department Director and activating the Disaster Call Back as necessary.
2. Engineering Department is responsible for:
   a. Troubleshooting and repairing the oxygen system.
   b. Determining if designated valves need closing and for the proper actuation of the appropriate valves.
   c. Coordinating action plan with Pulmonary Services.
   d. Aiding in the replenishment of H-cylinders.
   e. Notifying the oxygen supply company and arranging for additional oxygen.
   f. Communicating the situation to the Department Director and activating the Disaster Call Back as necessary.
3. Nursing Services is responsible for:
   a. Notifying PBX (66) of O2 pressure alarm and location if Facilities is unaware.
   b. Oversight of clinical issues; communicating patient oxygen needs to Respiratory Care Practitioners (RCP).

c. Assisting RCPs in providing E cylinders and/or manually bagging patients as necessary Communicating the situation to the Department Director and activating the Disaster Call Back as necessary.

4. Security is responsible for:
   a. Providing immediate response to affected area.
   b. Providing a spare walkie-talkie to the RCP Supervisor or Lead in that affected area.
   c. Assisting Engineering (back-up for night shift).
   d. Communicating the situation to the Department Director and activating the Disaster Call Back as necessary.
5. PBX Operator is responsible for:
   a. Announcing CODE GREEN and LOCATION on the overhead paging system.
   b. Notifying the Pulmonary Supervisor/Lead Therapist, Engineering, and Administrative Supervisor immediately upon notification of CODE GREEN.

D. **PROCEDURE:**

1. CODE GREEN and location is communicated by PBX Operator who notifies Engineering, Pulmonary and Administrative Supervisor.
2. Security and Pulmonary respond to affected area; Security provides walkie talkie to RCP Supervisor/Lead.
3. Once the Engineers have shut down the affected zone valves, the RCPs shall place the emergency H-cylinder connector into an available wall outlet and slowly open the cylinder valve to re-pressurize the zone.
4. RCP Supervisor/**Lead** communicates and coordinates action plan with Engineering via channel 1 on walkie talkie.
5. RCPs communicate with nursing in affected area to assure that patient oxygen needs are met.
6. H-cylinders are monitored for pressure levels; Engineering assists with additional H-cylinders and vendor ordering if needed.
7. CODE GREEN is deactivated with notification from Engineering that the system has been charged to full operating pressure utilizing normal or alternate bulk oxygen sources.

E. **LOCATIONS OF EMERGENCY CYLINDERS:**

~~1. Pavilion: Rooms 277&278 - 2 oxygen H-cylinders in each room.~~
~~2. South Tower; 1st room on left in ILU – 4 H-cylinders.~~
~~3. Center Tower: Pulmonary 2 South – 1 H-cylinder~~
~~4. NICU: 1 Air H-cylinder and 1 oxygen H-cylinder in ABG lab.~~
~~5. 1 North /Rehab: Dirty utility room – 2 oxygen H-cylinders.~~
~~6.~~**1.** Emergency Room: Dirty utility room – 3 oxygen H-cylinders.

Tri-City Healthcare District
Oceanside, California

ENGINEERING
EQUIPMENT

ISSUE DATE: 09/94

SUBJECT: Utility Management Plan

REVIEW DATE: 08/15
REVISION DATE: 02/97, 05/00, 05/03, 06/06, 05/09, 06/12, 06/15, 10/15, 01/17, 03/19, 03/22, 02/23, 02/24

Department Approval:	~~01/24~~03/25
Environmental Health & Safety Committee Approval:	~~01/24~~12/25
Administration Approval:	02/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/24

A. **EXECUTIVE SUMMARY:**

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

B. **PRINCIPLES:**

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

C. **OBJECTIVES:**

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

D. **PROGRAM MANAGEMENT STRUCTURE:**

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

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

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

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

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

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

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

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

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

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

12. Utility Systems Inventory and Initial Testing

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

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

13. Testing of Life Support Equipment

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

14. Testing of Infection Control Support Equipment

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

15. Testing of Non-Life Support Equipment

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

16. Medical Gas System Testing

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

17. Modifying / Repairing Medical Gas Systems

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

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

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

F. **ANNUAL GOALS/OBJECTIVES:**

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

G. **REFERENCE(S):**

1. The Joint Commission (2024). *Hospital Accreditation Standards*

Tri-City Healthcare District
Oceanside, California

ENVIRONMENT OF CARE MANUAL

ISSUE DATE:	**02/23**	**SUBJECT:**	**Emergency Management Plan**
REVISION DATE:	**02/23, 02/24**		

Environment of Care Content Expert Approval:	**~~01/24~~03/25**
Environmental Health and Safety Committee Approval:	**~~01/24~~12/25**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**02/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/24**

A. **EXECUTIVE SUMMARY:**

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

B. **PRINCIPLE(S):**

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

C. **OBJECTIVE(S):**

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

D. **PROGRAM MANAGEMENT STRUCTURE:**

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

issues or concerns with the Emergency Management Plan.

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

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

F. **EFFECTIVENESS:**

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

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

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

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

1. Emergency Operations Procedure Manual: Emergency Operations Plan

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE

ISSUE DATE:	**11/87**	**SUBJECT: Fire Plan (Code Red)**
REVIEW DATE:	**11/90, 11/93, 11/97, 04/06, 06/12, 08/15**	**POLICY NUMBER: 3005**
REVISION DATE:	**11/94, 03/00, 04/03, 10/11, 04/13, 10/15, 03/19, 12/21, 12/22**	

Department Approval:	**~~09/23~~10/25**
Environmental Health & Safety Committee Approval:	**~~10/23~~10/25**
Administration Approval:	**12/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/23**

A. **PURPOSE:**

1. To identify the actions Tri-City Healthcare District (TCHD) shall implement to ensure protection of patients, workforce members (WFM) employees, visitors and property from fire, smoke and other products of combustion.
2. To provide instructions on performing the following;
   a. Identifying when to report a fire
   b. Identifying when to initiate a fire alarm
   c. Smoke and fire containment
   d. Using a fire extinguisher
   e. Assisting with relocating and evacuating patients
   f. Identify fire hazards

B. **DEFINITIONS:**

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

C. **POLICY:**

1. WFM will be provided education to use the following acronyms RACE and PASS to assist with remembering the following.

2. Supervisors are responsible for showing new employees the location of extinguishers and alarm pull stations during department orientation.
3. The Code Red policy will be reviewed by all WFM during orientation.
4. Fire safety will be reviewed annually using a computer-based learning module (CBL). The following topics will be reviewed:
   a. Actions to implement in the event of a fire.
   b. How to initiate a fire pull alarm station.
   c. Instructions to identify the fire pull alarm stations, location of fire extinguishers, and evacuation map on their assigned departments.
5. AHP, Volunteers, Medical Staff, students, and non TCHD personnel do not have a defined role in the fire response plan and should remain in their current location at the time a fire alarm sounds and render assistance under the direction of the department leadership team as needed.

D. **PROCEDURE:**

1. When a fire or smoke is observed, staff will notify the public broadcast exchange (PBX) via telephone and if possible activate a fire pull alarm.
   a. The PBX operator will announce using the overhead page system "Code Red" and the location of the code red three times.
   b. If you are away from your assigned area when the alarm sounds, stay where you are and wait for further instructions from the overhead page system.
   c. The hospital's Fire Response team will consist of designated personnel in Facilities Services, Environmental Services and Security Services. Upon hearing the alarm, these WFMare to stop their work and go immediately to the area indicated by the overhead page system.
   d. An Engineer Leader will take immediate charge of the Fire Response Team. In his or her absence, the Engineer on duty will take command. This team is subject to the direction of the Administrator and/or City Fire Captain upon his or her arrival.
   e. Patients are not to be evacuated from floors without the order of the Incident Commander or designee. If it is apparent to the Department Director/or designee an evacuation is absolutely necessary for patient safety, and if it is not possible to obtain the authoritative order, he or she may elect to evacuate patients.
   f. Engineering will clear the fire alarm after the fire is secured.
   g. Clinical personnel on other units should remain at their stations. All other personnel should remain in their work areas unless their assistance is requested.
   h. The hospital Public Broadcast Exchange (PBX) Operator will announce on the overhead page system "Code Red All Clear" when fire is secure.
2. Code Red (Implementing a Code Red in Your Work Area):
   a. Remove patients and other persons from immediate danger.
   b. Go to the nearest fire alarm pull station and pull the handle to activate the alarm.
   c. Dial "66" to report "Code Red." Provide your location, size, extent and location of fire, and material burning, if known. Affiliated campus dial "911".
   d. Extinguish fire if it is safe. Use a fire extinguisher to attempt to bring fire under control using the acronyms RACE and PASS – See addendum A.
      i. If fire is out of control, close doors to room/area and shut off oxygen if possible. Move patients to the other side of the fire door away from the fire. Allow no one except the fire department to enter.
   e. Check for smoke and flames in other rooms then close all doors.
   f. Stand by to assist as needed.
3. Fire in Patient's Room:
   a. Patient's bed in flames:
      i. Remove the patient from bed to a safe place such as another bed, chair or hallway.
      ii. Depress the nurse call button in the bathroom for immediate assistance. Do not

take a smoldering bed out of the room.
iii. Close the patient's room door once the patient is out.
iv. Activate the fire alarm pull station nearest to the fire.
v. Call PBX Operator, dial "66". Provide your location, size, extent and location of fire, and material burning, if known. Affiliated campus dial "911".

4. Area Not Evacuated Secondary to the Condition of the Fire:
   a. Provide maximum protection:
      i. Instruct people to stay in their rooms with the door closed.
      ii. Reassure patients of their safety.
      iii. Place a wet blanket or linens at the base of the doors of all occupied room to prevent smoke from entering room.
   b. If safe to do so one WFM must remain in the corridor to assist fire department upon their arrival.
5. Evacuation
   a. Always use stairs, never the elevator, during a fire.
      i. If evacuation is ordered for an area, the following are methods to be used:
         1) Blanket Carry
         2) Two Person Carry
      ii. Once a room has been evacuated, it should be marked "empty" by placing a pillow in front of the door. Only firefighters may enter the room after an evacuation is completed.
      iii. Review the evacuation plans to identify the most appropriate evacuation route.
6. Types of Evacuation
   a. Horizontal Evacuation or Relocation
      i. The action taken to move patients from the immediate area of the emergency to an area of safety or an adjacent smoke compartment generally on the same floor.
      ii. Under the direction of the IC/designee leaders in the area may implement relocation.
   b. Vertical Evacuation
      i. The action taken to move patients from one floor to another for safety.
   c. Building Evacuation
      i. This involves removal of all persons from the medical center and requires a plan for implementation.
      ii. Evacuation should only be performed under the direction of the IC and/Fire Department. This would encompass moving all patients, visitors, and workforce to an alternate care site.
      iii. Refer to evacuation plan as needed.
7. Fire Hazards:
   a. Never prop open fire doors.
   b. Hallways must be kept clear at all times.
   c. Never place flammable liquids or oxygen near an ignition source.
   d. Do not use unapproved appliances - appliances brought from outside source must be cleared by Facilities Management.
   e. Do not store items to obstruct sprinkler heads, maintain an 18" minimum clearance from the items and the sprinkler heads).
   f. If you see or smell smoke, report it immediately for investigation. Early detection means prompt extinguishing of fire.
8. Duties of Personnel:
   a. Review the Fire Safety Program, evacuation routes, and your responsibilities identified policies and procedures.
   b. Participate in all fire drills and practice sessions as required.
   c. Study the fire alarm code and how to report a fire - Dial "66". Affiliated campus locations dial "911".

d. Identify the locations of and how to operate the fire alarm pull stations and fire extinguishers.
e. Observe the "No Smoking" rules.
f. Never store flammable liquids in your desk or cabinet.
g. Report any defective wiring - such as frayed cords, loose or broken plugs, blown fuses, etc.
h. Properly dispose of waste or rags used with cleaning solvents per manufacturer's instructions.
i. Do not use portable heating units.
    i. These units, particularly portable types are not permitted anywhere on the hospital premises unless approved by Engineering.
    ii. No portable heaters are allowed in patient care areas.
j. California Department of Corrections Rehabilitation Unit (CDCR) – 3 North South.
    i. If necessary, fire response will be coordinated via CDCR staff for custody patients' evacuation.
k. Switchboard personnel:
    i. If the fire is in the area of the PBX office follow the steps outlined in the general instructions section.
    ii. If the fire is not threatening the PBX office initiate the steps below:
        1) Upon receipt of a call notifying PBX of a Code Red/Fire, or when the fire alarm is activated, I immediately:
            a) Notify the Fire Department, giving the address and location of the fire in the hospital.
            b) Notify all personnel through the use of the public address system. Use the following code:
                i) "Attention, Please – CODE RED and specific location." Repeat the page three (3) times.
        2) Prepare the switchboard for emergency operations only, restricting calls.
        3) Notify:
            a) Safety Leader
            b) Administrator On-call
            c) Administrative Supervisor on duty
            d) Security Supervisor or Lead
            e) Director of Engineering
            f) Emergency Department Clinical Leader
            g) Other key personnel, as needed
        4) Implement administrative orders as directed.
        5) If PBX system is inoperative, use the RED phones system or cell phones.

E. **FIRE HAZARDS:**

1. Hazards that WFM shall recognize and correct, or cause to be corrected, or prevent from existing, are as follows:
    a. Careless Smoking – Observe all "No Smoking" rules and regulations. This includes any product containing tobacco intended to be lit, burned, or heated to produce smoke as well as any device used to smoke the tobacco, including but not limited to a pipe, cigar, or cigarette, (including electronic cigarettes and vapor devices).
    b. Exit Ways - Do not obstruct aisles, doorways, fire escapes or allow their use as storage places.
    c. Combustible Waste - All combustible waste shall be placed in all metal containers with tight fitting covers; so that any fire occurring will be kept entirely within the container.
        i. When materials capable of spontaneous ignition are stored, they shall be kept in separate containers until safely disposed.

d. Fire Doors - The proper operation of fire doors is necessary to protect or isolate one section of the building from another, thus providing protection to other areas and persons within the building. Keep all fire doors properly closed, except those equipped to close automatically. Fire doors wedged or propped open are of no value in preventing the spread of fire.

e. Flammable Liquids - (Such as acetone, alcohol, benzene, and ether) Limit the amount on hand to a minimum working supply. If possible, keep in metal container. Where safety cabinets or storage rooms are available, keep these materials in them and maintain the door to such storage in the closed position. No smoking, open flame or sparking device shall be allowed around flammable liquids or compressed gas. Oxygen and nitrous oxide shall not be stored with flammable gases, such as cyclopropane and ethylene, or with flammable liquids.

f. Electrical Hazards - Report promptly any frayed, broken or overheated electrical cords or electrical equipment. Do not operate light switches, or connect or disconnect equipment where any part of your body is in contact with metal fixtures or is in water. Specially built equipment is in use in the operating and delivery rooms to eliminate electric sparks, and to control static electricity.

g. Acids - All concentrated or corrosive acids must be handled with extreme care. Avoid storing these materials on high shelves, or in locations where they are likely to be spilled or the containers broken. Organic acids and inorganic acids shall not be stored together. Any spillage shall be immediately diluted or neutralized and cleaned up.

h. Electric Heaters - These units, particularly the portable type, are not permitted anywhere on the hospital premises unless approved by Engineering. No portable heaters are allowed in patient care areas.

i. Heat generating devices or substances such as candles, hot plates, electric blankets, heating pads, propane fueled devices, strand lights and oil lamps are not appropriate for the hospital environment and are not allowed on hospital property. Toasters, toaster ovens, microwaves and coffee machines are allowed in break rooms/offices with the approval of the Safety Officer or Director of Facilities. Devices must have an Engineering Electrical Safety sticker. Persons who do not comply with these directions will be subject to the disciplinary process.

Addendum A

What is the Fire Plan?

- **R**escue anyone in danger and close the door on your way out
- **A**larm – pull the pull-station and **dial 66**

- **C**ontain the fire by closing other doors in the area
- **E**xtinguish the fire if you can. Evacuate if necessary

How is a fire extinguisher used?

- **P**ull the pin
- **A**im at the base of the fire
- **S**queeze the handle
- **S**weep from side to side

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE MANUAL
HAZARDOUS MATERIAL MANAGEMENT

ISSUE DATE:	**11/87**	**SUBJECT:**	**Hazardous Material and Waste Management and Communication Plan**
REVISION DATE:	**09/94, 07/97, 09/00, 04/03, 12/10, 05/15, 01/17, 03/19, 12/21, 09/23**	**POLICY NUMBER:**	**6000**

Department Approval:	**~~03/23~~08/24**
Environmental Health & Safety Committee Approval:	**~~05/23~~12/25**
Administration Approval:	**09/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**09/23**

A. **PURPOSE**

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

B. **DEFINITIONS** :

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

C. **POLICY**

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

compliance with State and Federal regulations.

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

D. **GUIDELINES:**

1. Method of Identification of Hazardous Material:
   a. Material is identified as hazardous by evaluation produced by manufacturer, information disseminated from a reliable source, or by professional knowledge and experience.
   b. Directors or hospital designated leader of Engineering, Surgery, Nutrition, Laboratory, Pharmacy, and Environmental Services, will submit a list of substances determined to be hazardous by this policy to the Safety Leader or designee
      i. The list will be updated as new products determined to be hazardous are introduced to the department.
   c. Labels are required on all hazardous substances to identify the hazardous material(s) contained therein and to provide warning about the type of hazard and the type of precautions required. This includes all containers with toxic substances in a concentration greater than or equal to 1% of the total composition, or 0.1% if carcinogens; unless specifically exempted.
2. Safety Data Sheets (SDS:
   a. Request an SDS using the internet or TCMC's intranet link when assistance is needed with medical emergencies, chemical spills, and employee.
      i. Emergency Request – Immediate to 15 minutes: Poisoning, chemical exposure, chemical spill, human or environmental contamination, fire.
      ii. Immediate to 30 minutes: Regulatory Agency Request e.g., Occupational Safety and Health Administration (OSHA), Environmental Protection Agency (EPA), The Joint Commission (TJC).
      iii. Immediate to 3 hours: Employee request (non-emergency)
      iv. Standard Request – Immediate to 24 hours: Customer Request, Contractor Request.
      v. Mail Request – Rush: mailed within 24 hours – Standard: mailed within 3 business days: Request of 10 or more Safety Data Sheets.

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

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

TCHD-.

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

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

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

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

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

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

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

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

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

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

Employees will need to know the name of the chemical to tell the 3 E Company operator.

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

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

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

1) Properly trained employees may clean-up the spill using approved spill kits/supplies/equipment that meet or exceed the PPE requirements listed on the SDS notice.

2) Contact EVS who will contain the spill, and clean the chemical per SDS guidelines.

3) All collected chemicals must be handled per hazardous waste requirements and placed in an appropriate container, then labeled with the chemical name and other hazardous waste properties.

4) Contact the Safety Leader/designee with any questions.

k. Treatment of Contaminated Area:

i. Wash area immediately.

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

iii. First Aid:

1) If skin/eye/mouth area(s) have been contaminated, flush affected area with large amounts of water for at least 15 minutes.

2) Do not try to neutralize.

a) Go to the Emergency Department immediately after flushing affected area.

E. GOALS/OBJECTIVE

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

F. RELATED DOCUMENT(S):

1. TCMC Waste Disposal Guidelines.

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE MANUAL
EQUIPMENT MANAGEMENT

ISSUE DATE:	**10/94**	**SUBJECT:**	**Medical Equipment Management Plan**
REVIEW DATE:	**03/97, 07/00, 05/03, 05/08**		
REVISION DATE:	**03/97, 07/00, 05/03, 05/08, 06/15, 01/17, 03/19, 12/21, 09/23**		

Department Approval:	**~~03/23~~03/25**
Environmental Health & Safety Committee Approval:	**~~05/23~~12/25**
Administration Approval:	**09/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**09/23**

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

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

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

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

D. **ORGANIZATION AND RESPONSIBILITY:**

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

E. **PERFORMANCE ACTIVITIES:**

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

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

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

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

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

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

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

7. The hospital manages medical equipment risks

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

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

ii. Medical laser devices.

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

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

1) Records provided by the hospital's contractors.

2) Information made public by nationally recognized sources.

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

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

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

8. The hospital manages medical equipment risks -

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

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

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

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

iv. Incident history of identical or similar equipment.

v. Maintenance requirements of the equipment.

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

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

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

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

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

9. The hospital manages medical equipment risks

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

10. The hospital manages medical equipment risks

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

b. The Risk Manager is:

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

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

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

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

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

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

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

11. The hospital manages medical equipment risks

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

settings.

c. Based on the annual inventory, identify the most important alarms to manage.

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

e. Educate staff about alarm policies and procedures.

G. **INFECTION CONTROL**

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

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

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

I. **EMERGENCY PREPAREDNESS AND MANAGEMENT:**

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

J. **GOALS AND OJECTIVES:**

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

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

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

1. Engineering Policy: Equipment Management Plan

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE MANUAL

ISSUE DATE:	**11/87**	**SUBJECT: Safety Management Plan**
REVISION DATE:	**05/96, 06/97, 07/00, 06/08, 03/11, 06/12, 06/15, 12/17, 03/19, 12/21, 12/22, 02/24**	
Department Approval:		**~~01/24~~03/25**
Environmental Health & Safety Committee Approval:		**~~01/24~~12/25**
Administration Approval:		**02/24**
Professional Affairs Committee Approval:		**n/a**
Board of Directors Approval:		**02/24**

A. **PURPOSE:**

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

B. **POLICY:**

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

C. **RESPONSIBILITIES:**

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

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

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

D. **PROCEDURES:**

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

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

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

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

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

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

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

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

and use errors
8) Utility systems management problems, failures, or use errors

ii. The Manager of Risk Management coordinates the incident reporting and analysis process.

iii. The EOC/Safety Manager works with Risk Management to design appropriate processes to document and evaluate patient and visitor incidents, staff incidents, and property damage related to environmental conditions.

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

i. In addition, the Manager of Risk Management and the EOC/Safety Manager collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment or staff behaviors that require action.
1) The findings of such analysis are reported to the EHSC Committee and the Patient Safety Committee, as appropriate.
2) The EOC/Safety Manager provides summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.

ii. The EOC/Safety Manager coordinates the collection of information about environmental safety, patient safety deficiencies including identification of opportunities for improvement from all areas of TCHD.
1) The EHSC Committee and the Patient Safety Committee are responsible for identifying opportunities for improving the environment, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.

iii. The Chairperson of the EHSC Committee prepares quarterly reports to the leadership of TCHD.
1) The quarterly reports summarize key issues reported to the EHSC Committee and the Patient Safety Committee with their recommendations.
2) The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure Hospital leaders that management responsibilities have been carried out.
3) Annual reports are provided to the Board of Directors related to EC, or more often if warranted.

j. Development and Management of Policies and Procedures (LD.04.01.07 EP1)

i. The EOC/Safety Manager follows the administrative policy for the development of organization-wide and department-specific policies, procedures, and controls designed to eliminate or minimize identified risks.

ii. The EOC/Safety Manager assists department leaders with the development of department or job-specific environmental safety procedures and controls.

iii. The organization-wide policies, procedures, and controls are available to all staff members on the organizational intranet.

iv. Depart specific procedures and controls are maintained by department directors.
1) The department directors are responsible for ensuring that all staff is

familiar with organizational, departmental, and appropriate job-related policies, procedures, and controls.

2) Department directors are also responsible for ensuring implementation of these policies, procedures, and controls

3) Individual staff members are held accountable for implementing the policies, procedures, and controls related to their specific work duties and tasks

v. The policies, procedures, and controls are reviewed when significant changes occur when new technology or space is acquired, and at least every three years.

vi. The EOC/Safety Manager assists with the reviews of policies and procedures with department directors and other appropriate staff.

k. Every twelve months the hospital evaluates each environment of care management plan including a review of the plan's objectives, scope, performance, and effectiveness. (EC.04.01.01 EP15)

i. The EOC/Safety Manager coordinates the annual evaluation of the Environment of Care management plans.

ii. The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks.

1) The review also evaluates the operational results of each Environment of Care program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable.

2) The annual evaluation uses a variety of information sources. The sources include aggregate analysis of EOC rounds and incident reports, findings of external reviews, benchmarking programs or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of the EHSC Committee meetings, and analytical summaries of other activities.

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

4) Each report presents a balanced summary of an EOC program for the preceding fiscal year.

5) Each report includes an action plan to address identified gaps.

iii. The annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review (PPR). Any deficiencies identified on an annual basis are immediately addressed by a plan for improvement.

iv. Effective development and implementation of the plans for improvement will be monitored by the EOC/Safety Manager.

v. The results of the annual evaluation are presented to the EHSC Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes.

vi. The annual evaluation is distributed to the CEO, BOD, organizational leaders, the Patient Safety Committee, the Quality Assurance Performance Improvement Committee, and others as appropriate.

vii. The manager of each EOC Management Plan is responsible for implementing the recommendations in the report as part of the performance improvement process.

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

i. Identified EOC issues are communicated through the EHSC Committee and the

EHSC to senior leadership, the BOD and the CEO for analysis.

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

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

When deficiencies are identified, action is taken to improve orientation and ongoing educational materials,

methods, and retention of knowledge as appropriate.

E. **GOALS/OBJECTIVES:**

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

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

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

G. **REFERENCE(S):**

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

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE MANUAL
SECURITY MANAGEMENT

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

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

Department Approval:	~~03/23~~08/24
Environmental Health & Safety Committee Approval:	~~05/23~~12/25
Administration Approval:	09/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	09/23

A. **EXECUTIVE SUMMARY:**

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

B. **PRINCIPLES:**

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

C. **OBJECTIVES:**

1. Ensure that all applicable security personnel have received adequate training to

effectively participate in the security management plan.

2. Develop a security awareness program. The program will consist of training staff, monthly meeting and power minutes.

D. **PROGRAM MANAGEMENT STRUCTURE:**

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

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

1. Appointment of Security Leadership
   a. A Safety Officer or Security Leader is appointed to oversee the development, implementation and monitoring of the security program. The Safety Officer/Security Leader's responsibilities are defined by job description. The competency of the Safety Officer/Security Leader competency is evaluated annually by the CEO or designee.
   b. The Security Leader:
      i. Coordinates the development and implementation of the security program and assures it is integrated with the patient safety, information management, and other programs as appropriate
      ii. Maintains a current knowledge of laws, regulations, and standards of security
      iii. Continually assesses the need to make changes to procedures, controls, training, and other activities to assure that the security management program reflects the current risks present in the environment of TCHD.
2. Designation of Persons to Intervene When Immediate Threats to Life, Health, or Property are identified
   a. The Emergency Management Program includes specific response plans for TCHD to implement as appropriate whenever conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings. The response plans follow the Hospital Incident Command System (HICS) all hazards response protocol. An appropriate Incident Commander is appointed at the time any emergency response is implemented.
   b. The Immediate Threat Procedure is included in the Emergency Operations Procedure manual. The procedure lists the communications and specific actions to be initiated when situations posing an immediate threat to patients, workforce, physicians, or visitors or the threat of major damage to buildings or property.
      i. The objective of the procedure is to identify and respond to high risk situations before significant injuries, death or loss of property occurs.
      ii. The CEO has appointed the Safety Leader, the Nursing Administrative Supervisor on duty, and the Administrator on Call to exercise to assume the role

of incident command and to coordinate the mobilization of resources required to take appropriate action to quickly minimize the effects of such situations.

3. Management Plan for a Secure Environment
   a. The Security Management Program is described in this management plan. The security management plan describes the policies, procedures and controls in place to minimize the potential that any patients, workforce members, and other people coming to the facilities of TCHD experience an adverse security event.
4. Proactive Risk Assessment
   a. The Security Leader coordinates proactive risk assessments to identify risks that create the potential for personal injury of staff or others or adverse outcomes of patient care. The purpose of the risk assessments is to gather information that can be used to develop procedures and controls to minimize the potential of adverse events affecting workforce members, patients, and others.
   b. The Security Leader works with department directors, managers, the Patient Safety Officer, Risk Manager and others as appropriate.
   c. The Security Department is responsible for enacting proactive security measures as follows:
      i. Scheduling patrolling of the Medical Center and parking lots to help prevent work place violence/incidents.
      ii. Locking/unlocking of exterior doors, departments, and associated rooms; and on-going inspections of all sensitive areas throughout the Medical Center.
      iii. Ensuring all workforce members and physicians properly display their photographic identification badges at all times.
      iv. Submitting reports to the Director of Engineering or designee pertaining to security and safety violations, including but not limited to: defective lighting, damaged equipment, unsafe situations or conditions that may present a danger to others.
      v. Maintaining unrestricted locations for the timely loading and unloading of persons seeking medical treatment in the Emergency Department (ED) and Women's Center.
      vi. Security will also ensure a location for long-term vehicle parking.
      vii. Monitoring the Security Department Closed Circuit Television (CCTV)
      viii. Providing campus escort services 24 hours per day as needed for employees and visitors.
5. The hospital takes action to minimize or eliminate identified security risks in the physical environment
   a. The results of the risk assessment process are used to create new or revise existing procedures and controls. They are also used to guide the modification of the environment or the procurement of equipment that can eliminate or significantly reduce identified risks. The procedures, controls, environmental design changes, and equipment are designed to effectively manage the level of security in a planned and systematic manner.
   b. In response to Cal/OSHA, Workplace Violence Prevention in Healthcare, Title 8, Chapter 4, § 3342 regulations, TCHD has created new environmental risk assessment tools and general employee education programs.
   c. TCHD has implemented the Non-Violent Crisis Intervention Program (NVCI) for the mandated training of workforce members working in high-risk areas per h the California Health and Safety Code Section 1247.7 and 1257.8. The training includes, but is not limited to the following:
      i. General safety measures.
      ii. Personal safety measures.
      iii. The assault cycle.
      iv. Aggression and violence predicting factors.

v. Characteristics of aggressive and violent patients and victims.
vi. Verbal and physical maneuvers to diffuse and avoid violent behavior.
vii. Strategies to avoid physical harm.
viii. Restraining techniques.
ix. Resources available to employees coping with violence (stress debriefing, employee assistance programs, etc.).

d. The NVCI program will be offered to ancillary staff routinely assigned to the Emergency Department. Ancillary department managers will be responsible for determining staff appropriate for this training.

6. Development and Management of Policies and Procedures
   a. The Security Leader follows the administrative policy for the development of organization-wide and department specific policies, procedures, and controls designed to eliminate or minimize the identified risks. Security assists department leaders with the development of department or job specific environmental safety procedures and controls.
   b. The organization-wide policies, procedures and controls are available to all departments and services on the organizational intranet. Departmental policies, procedures and controls are maintained by department directors who are responsible for ensuring their workforce are familiar with organizational, departmental, and appropriate job related policies, and procedures.. Department directors are also responsible for monitoring appropriate implementation of the policies, procedures and controls in their area(s) of responsibility. Each workforce member is responsible for implementing the policies, procedures and controls related to her/his work processes.
   c. The policies, procedures and controls are reviewed when significant changes in services occur, when new technology or space is acquired, and at least every three years. The Security Leader coordinates the reviews of procedures with department leaders and other appropriate workforce members.
7. Identification of Patients, Staff, and Others Entering the Facility
   a. The identification (ID) of workforce members is an interdisciplinary function. Several Directors share responsibility for designing identification systems and establishing procedures and controls to maintain the effectiveness of the systems.
   b. The current systems in place include photographic ID badges for all workforce, volunteers, students, contracted staff and members of the medical staff; password systems to limit access to authorized users of information system applications, physical security systems to limit access to departments and areas of the hospital, and distinctive clothing/badges to facilitate rapid visual recognition of critical groups of the workforce.
   c. The ID of patients is also an interdisciplinary function. The current system includes personal identification of patients in medical records and by use of various arm band systems.
   d. The identification of others entering TCHD is managed by the Security and Materials Management Departments. The Security Leader in collaboration with the CEO or designee and other appropriate workforce members provides a secure environment that requires identification of all contractors/vendors and the badging of visitors to the various areas of the facility. The Director of Materials Management manages the procedures for identification of vendors. The Security Leader takes appropriate action to remove unauthorized persons form areas and to prevent unwanted individuals from gaining access to TCHD.
8. Identification and Management of Security Sensitive Areas
   a. The following areas have been designated as sensitive areas:
      i. Emergency Department
      ii. Maternal Child Health
      iii. Neonatal Intensive Care Unit
      iv. Pharmacy Department.

v. Human Resources Department
vi. Adult Critical Care Unit
vii. Information Technology
viii. Administration
ix. Progressive Care Unit
x. Medical Records Office and Storage areas
xi. Nuclear Medicine Hot Lab

b. Workforce members in each sensitive area participates in training addressing the unique risks of the area and the procedures and controls in place to manage them. Key personnel and security staff receive specialized training related to processes in high risk security areas.

c. The Security Plan has a program for the inspection, preventative maintenance and testing of the following security equipment:

i. Emergency Department:
1) Electronic access control.
2) Panic buttons.
3) Closed Circuit Television (CCTV) cameras.
4) Security Officer Station – Posted 24 hours per day.

ii. Women and Newborn Services Units:
1) Electronic access control.
2) Access Control System CCTV.
3) Department policy in place for identifying visitors.
4) Department procedure for uniquely identifying mother-infants.
5) Teaching program to educate parents or guardians to explain the security processes.
6) Unique identification for staff members.
7) Unique visitor badge identification for visitors.

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

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

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

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

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

viii. Case Management:
1) Panic buttons

9. Management of Security Incidents Including an Infant or Pediatric Abduction

a. The Security Leader has developed procedures for rapid response to breaches of security. On-duty Security Officers and local police have the manpower and technological resources to respond to a wide variety of incidents. The Security Leader or

a designee is responsible for assessing breaches of security and determining what resources are required to respond effectively.

b. The Security Leader, Safety Leader and Director of Women's and Children's Services are responsible for the design and management of systems to reduce the threat of abduction of infants or children and to respond to any threats of or actual abductions.

c. A Code Adam is announced over the paging system, as well as selected radios when a potential or actual abduction has occurred.
   i. All available workforce responds per the Patient Care Services Code Adam.
   ii. The Code Adam plan is tested at least annually and the responses are documented, evaluated, critiqued and as appropriate corrective activity, additional training, or program improvements are made.

d. The Security Leader and Director of Women and Newborn Services are required to conduct at least one abduction drill annually.
   i. Activations of the abduction alert system and all attempted or actual abductions of infants or children are treated as security incidents and reported and analyzed appropriately.

10. The hospital monitors conditions in the environment
    a. Risk Management coordinates the design and implementation of the incident reporting and analysis process.
    b. The Security Leaders works with Risk Management to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.
    c. Incident reports are completed by the staff member or witness to whom a patient or visitor incident is reported. The completed reports are forwarded to Risk Management. Risk Management works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.
    d. Risk Management and the Security Leader collaborate to conduct an aggregate analysis of incident reports generated to determine if there are patterns of deficiencies in the environment or workforce members behaviors that require action. The findings of such analysis are reported to the Environmental Health and Safety Committee (EHSC) and the Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Committee Chairpersons provide summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.
    e. The Security Leader works with the EHSC to collect information about security deficiencies and opportunities for improvement from all areas of TCHD. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the six environments of care functions use the information to analyze safety and environmental issues and to develop recommendations for addressing them.
    f. The EHSC and the Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the Environment of Care Management Programs.
    g. The Safety Leader and the Patient Safety Committee prepare a quarterly report to the leadership of TCHD. The quarterly report summarizes key issues reported to the Committees and the recommendations of them. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to ensure leaders of management responsibilities have been carried out.

11. Annually the hospital evaluates each environment of care management plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.
    a. The Safety Leader coordinates the annual evaluation of the management plans associated with each of the Environment of Care functions.

b. The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care (EC) program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources.
   i. The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews, benchmarking programs or assessments by regulators, accrediting bodies, insurers, consultants, minutes from appropriate committees, and analytical summaries of other activities.
   ii. The findings of the annual review are presented to the EHSC by the end of the first quarter of the fiscal year.
   iii. Each report presents a balanced summary of the EHSC program for the preceding fiscal year.
   iv. Each report includes an action plan to address identified risks.

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

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

e. The results of the annual evaluation are presented to the EHSC. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the CEO, the Board of Directors, organizational leaders, the Patient Safety Committee, and others as appropriate. The manager of each Environment of Care Program is responsible for implementing the recommendations in the report as part of the performance improvement process.

12. Analysis and actions regarding identified environmental issues
   a. The EHSC receives reports of activities related to the environmental "EOC Rounding" program at least quarterly.
   b. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital and the Patient Safety Committee as indicated.

13. Improving the Environment
   a. When the leadership of the hospital, quality improvement, or patient safety concurs with the EHSC recommendations for improvements to the environment of care management programs, a team of appropriate workforce is appointed to manage the improvement project. The EHSC works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.
   b. The EHSC establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital, quality improvement, and patient safety leadership.

14. Orientation and Ongoing Education and Training
   a. Orientation and training addressing the environment of care and workplace safety is provided to each workforce member, contract staff and volunteer. All Licensed Independent Practitioners (LIP) receive orientation to the Environment of Care and workplace safety in accordance with the Medical Staff policies and bylaws.
   b. Annual EOC and workplace safety training is provided and documented via learning management system.
   c. The Human Resources Department with assistance from the Education Department coordinates the general New Employee Orientation (NEO) program per HR and the Education Department policies and procedures

d. The Safety Leader collaborates with the EOC leaders, the manager of Quality Improvement, Infection Control, Patient Safety Officer and others as appropriate to develop content materials for general and job-related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each EOC program and revised as necessary.

e. The Safety Leader gathers data during environment of care rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job-related physical risks are to be managed or eliminated as part of daily work. The environment of care rounds (tours) evaluates the degree to which workforce members and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

f. Information about the workforce and LIPs knowledge and technical skills related to managing or eliminating environment of care risks is reported to the EHSC. When deficiencies are identified action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

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

1. Patient Care Services: Code Adam Policy

G. **REFERENCE(S):**

1. The Joint Commission Environmental of Care Standards
2. Cal/OSHA Workplace Violence Prevention in Healthcare, Title 8, Chapter 4, § 3342 regulations

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL

ISSUE DATE:	**09/00**	**SUBJECT:**	**Epidemiologic Investigation of a Suspected Outbreak**
REVISION DATE:	**03/02, 03/05, 07/11, 08/14, 07/17 06/20**		

Infection Control Department Approval:	**12/22**
Infection Control Committee Approval:	**~~04/23~~12/25**
Pharmacy and Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**04/23**
Administration Approval:	**05/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/23**

A. **PURPOSE:**

1. To provide guidelines for uniform and complete investigation of suspected outbreaks of Healthcare Associated Infections (HAI) or community acquired infections seen in the hospital.

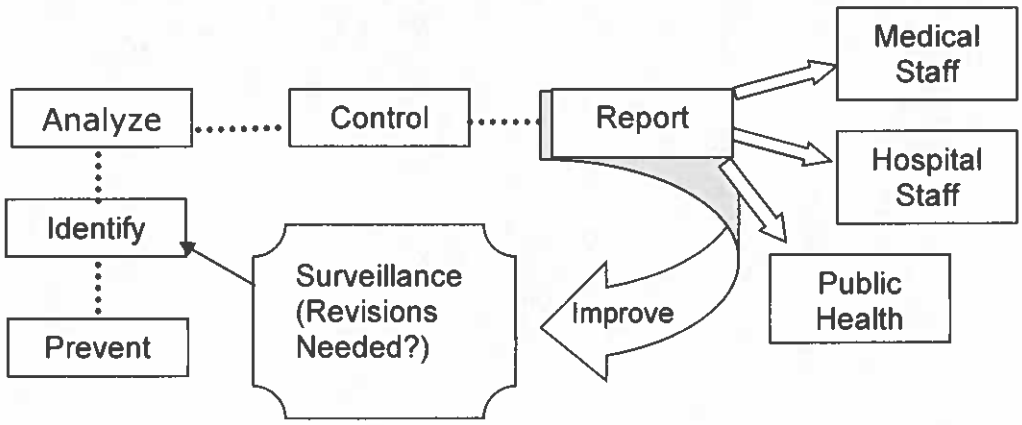
B. **POLICY:**

1. The Infection Control Committee shall have ultimate responsibility for investigating outbreaks and developing policies aimed at prevention and control of Healthcare Associated Infections (HAI). If an outbreak is suspected, the hospital epidemiologist or their designee will direct the investigation. The aim of the process is to identify the source of the organism and the mode of spread so that infection control measures can be instituted to halt an outbreak.
2. An outbreak is defined as an increase over the expected occurrence of an event.

C. **PROCEDURE:**

1. The Medical Director of Infection Control along with the Infection Preventionist(s) will determine whether a situation is a probable outbreak that poses a threat to the health of patients, employees or visitors and warrant further investigation. Early identification of a suspected outbreak is important. The Infection Control department will take the following investigative steps:
   a. Confirm that an outbreak exists. Determine of the number of "cases" exceeds the background rate, ie: Any increase in infection incidence found during routine surveillance.
   b. Identify all individuals who meet the case definition (patients and staff) and develop a line listing of cases. (See Data Collection Tool)
   c. Confirm laboratory findings with Lab department.
   d. Ask Lab to collect appropriate clinical specimens and save all outbreak specific isolates from potential cases.
   e. Compare exposure of identified cases to understand the route of transmission and potential risk factors.
   f. Appropriately isolate all individuals who meet the case definition.
   g. Implement immediate control measures as needed.
   h. Report suspected outbreak to local San Diego Public Health (SDPH) Epidemiology department and California Department of Public Health (CDPH) and follow guidance provided.
   i. Local & state agencies will assist with case identification, development of investigative approach, prevention and control measures and assist with specimens.

j. Communicate with department heads, microbiology director, administrators, and employee health as appropriate.
k. Implement guidance from local and state agencies.
l. Perform ongoing surveillance for any continued signs of the outbreak.
m. Evaluate efficacy of control measures implemented.
n. When the control measures have terminated transmission, declare outbreak is over.
o. Change policies and procedures if necessary.
p. Report findings to Infection Control Committee and other Committees as needed.



D. **RELATED DOCUMENT(S):**
1. Data Collection Tool - Sample

~~E.~~ **REFERENCE(S):**

E.

~~1.~~ **Campbell, E. (2021). Chapter 12 outbreak investigation. In APIC text of infection control and epidemiology (6th ed.). APIC. (Accessed 11/24/25)**~~Campbell, E. (2021). Chapter 12 Outbreak Investigation. APIC Text of Infection Control and Epidemiology. Washington DC: APIC, 6th Edition.~~

Centers for Disease Control and Prevention. (n.d.). About outbreak investigations in healthcare settings. https://www.cdc.gov/hai/outbreaks/ (Accessed 11/25/25)~~CDC Principles of Epidemiology: Lesson 6 Investigating an Outbreak~~

1.

~~2. CDC: Outbreak Investigations in Healthcare Settings https://www.cdc.gov/hai/outbreaks/ (Reviewed 11/22)~~

California Department of Public Health. (2017). AFL 23-08 CDPH: Outbreaks and unusual infection occurrences. (Accessed 11/24/25)~~CDPH: Outbreaks and Unusual Infection Occurrences 2017~~

2.

3. California Code of Regulations. (n.d.). Title 17, sections 2500-2502. https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=IA47A62205A2011EC8227000D3A7C4BC3&transitionType=Default&contextData=%28sc.Default%29#I01D4328129FA11EDA5B6DDCDF7AC13B6 (Accessed 11/24/25)

Data Collection Tool - Sample

MR #	Patient's Name	Admit Date	Date of Onset of S & S	Culture Date	Culture Results	Invasive Device or Procedure	Device / Procedure Date	Unit	Comments

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE:	**08/18**	**SUBJECT:**	**Enhancing Quality using the Inspection Program (EQUIP)**
REVISION DATE:	**09/18**		

Department Approval:	**~~04/21~~10/25**
Department of Radiology Approval:	**~~12/22~~12/25**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**01/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/23**

A. **PURPOSE:**

1. To Enhance facilities to continue providing Quality mammography using the Inspection Process Purpose:
2. To promote clinical image quality as a primary goal of the Mammography Quality Standards Act (MQSA) required by FDA policy:
   a. 900.12(i)Clinical images produced by any certified facility must continue to comply with the standards for clinical image quality established by that facility's accreditation body.
   b. 900.12(d)(1)(ii)(A)All interpreting physicians shall follow the facility procedures corrective action when the images they are asked to interpret are of poor quality.
   c. 900.12(d)(2) Quality assurance records. The lead interpreting physician... shall ensure that records concerning mammography technique and procedures, quality control (including monitoring data, problems detected by analysis of that data, corrective actions, and the effectiveness of the corrective actions), safety, protection and employee qualifications to meet assigned quality assurance tasks are properly maintained and updated.

B. **PROCEDURE:**

1. Quality Assurance- Clinical Image Corrective Action:
   a. To comply with MQSA requirements, mammography department has established a mechanism to continue providing quality images indicating that interpreting physicians (IPs) are required to follow department's procedures for corrective action when the images they are reviewed by IPs, are of poor quality.
   b. Mammography facility's interpreting physicians (IPs) randomly auditing mammography technologists' performances on positioning, quality of images, techniques and other necessary requirements for quality assurance (QA) purposes. Mammography department has displayed a review comment sheets for IPs to document their comments for each individual mammography technologist. IPs will document their comments on designated areas for positioning, compression, exposure level, contrast, sharpness, noise, artifacts, and exam identification. If an area of inefficiency is located, steps to correct the deficiency will be taken. In addition, recommendations on how to improve problem/problems will be discussed with technologists in order to enhance clinical image quality as well as increasing expertise of staff.
   c. Additional Recommendations" and "Additional Comments" on the second page that is followed by technologist's signature indicating that corrective action will be followed by IP reviewer and technologist. Patient will be called back for repeating the exam if there are any technical errors or poor quality. Please see the attachment.

2. Quality Assurance- Review of a sample of IP interpretation by other Interpreting MD reviewers:
   a. To assess whether the IP accepted images which meet the image quality standards of the American Board of Radiology (ABR), our mammography facility has arranged a mechanism to audit IP peer reviews by other IPs in order to ensure of reliability, clarity, and accuracy of the interpretation of mammograms by each IP.
   b. Women's Diagnostic Center's lead interpreting physician (LIP) randomly selects sample image dictated reports from other IPs who read mammograms in our facility. LIP will fill out a designated Peer IP Reviewers' form by reflecting patient's MRN and the Date that the mammogram has been performed and dictated. LIP will send the forms to other radiologists who read mammograms in our Women's Diagnostic Center in order to audit and review sample images and dictate reports from other IPs. IP reviewers will review and completing the form by marking as Concordant interpretation or Discordant Interpretation. Review results will be discussed with IP reviewer and IP performer; the form will be signed and dated by Primary interpreting MD performer and interpreting MD reviewer.
   c. Women's Center supervisor will collect all forms in a designated EQUIO folder and all data will be reviewed quarterly by LIP. Please see the attachment.
3. Quality Control- Facility QC Review
   a. To comply with MQSA, EQUIP standards, our mammography facility has stablished a procedure to assure facility's LIP is responsible for providing oversight of the QA/QC records, including a review of the frequency of performance of all required tests, and review of any corrective action. LIP will review and sign facility's QC charts for all of the mammography exam rooms as well as printer and radiologists' reading monitors. Quarterly, facility's supervisor and QC technologist presenting daily/monthly/quarterly/semi-annually/annually QC file to LIP for review. LIP correlates information with QC charts to assure that QC tests whether or not are comply with MQSA standards within accurate range. LIP signs and dates on the approved QC review sheet along with QC technologist's and Supervisor's signature. Please see the attached form.
   b. Facilities will be cited for violations if they have not complied with MQSA/EQUIP standards. Facility's state inspector will review all the above requirement during annual MQSA inspections.

C. **RELATED DOCUMENT(S):**
1. Clinical Image Quality Assurance Program Regular Review of a Sample of Images
2. Daily Operation of Quality Assurance – Clinical Image Corrective Action by IPs to RTs in Women's Diagnostic Center
3. Equip Facility QC Review_Quarterly
4. Facility QC Review
5. Quality Assurance Review by Interpreting Physician

D. **REFERENCE(S):**
1. MQSA Clinical Image Quality-Related Regulations:
2. http://www.fda.gov/Radiation-EmittingProducts/mammoraphyQualityStandardActandprocedures
3. EQUIP: Enhancing Quality Using the Inspection Program
4. U.S Department of Health and Human Services
5. Food and Drug Administration (FDA)

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE: **SUBJECT: Implants**

REVISION DATE: **08/11, 08/18**

Department Approval:	**~~04/21~~10/25**
Department of Radiology Approval:	**~~12/22~~12/25**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**01/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/23**

A. **AUTHORIZED TO PERFORM:**

1. Licensed Radiologic Technologist possessing certification from the American Registry of Radiology Technologists (ARRT) and California Certified Radiologic Technologist (CRT) in Mammography. Must have performed 200 mammograms in a 24-month period as per Mammography Quality Standard Act (MQSA) regulations.

B. **PURPOSE:**

1. To provide consistent guidelines for imaging patients with implants.

C. **POLICY:**

1. Implant Mammography is categorized as a Diagnostic Mammogram in accordance with American College of Radiology (ACR) guidelines. Implant displacement views to be done in addition to implant views on all patients with implants unless encapsulated.

D. **PROCEDURE:**

1. Consent signed by the patient.
2. Views to be done are:
   a. Craniocaudal views with displacement views (cc).
   b. Mediolateral Oblique views with displacement views (mlo).
3. If breast is encapsulated and unable to do displacement views, do the following views:
   a. Craniocaudal views (cc)
   b. Mediolateral Oblique views (mlo)
   c. Mediolateral views (ml)

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

1. Mammography Quality Standards Act (MQSA) of 1998 https://www.fda.gov/downloads/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/Regulations/UCM110849.pdf

F. **REFERENCE(S):**

1. Mammography Quality Standards Reauthorization Act, Pub. L., Title XLII § 263b. (1998).

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE: 08/07 **SUBJECT: Quality Control (QC) Policy**

REVISION DATE: 08/11, 08/18

Department Approval:	**~~04/21~~10/25**
Department of Radiology Approval:	**~~12/22~~12/25**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**01/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/23**

A. **AUTHORIZED TO PERFORM:**
1. Licensed Mammography technologists who are scheduled in mammographic room and have demonstrated competency in Quality Control (QC) procedures.

B. **PURPOSE:**
1. To ensure compliance by consistent performance and documentation of QC procedures and adherence to Mammography Quality Standard Act (MQSA) and manufacturers guidelines.

C. **POLICY:**
1. TCMC will provide QC in compliance with state and federal standards. QC tech or, in their absence, licensed mammography tech who is competent in QC will be responsible for all daily/weekly QC on equipment. Any QC problem will be immediately addressed with supervisor and Operations Manager. Semi-annual meetings between the Mammography supervisor, Lead Interpreting Radiologist and Imaging Director will review and sustain quality program.

D. **PROCEDURE:**
1. Daily Secondary Eraser·:
   a. To ensure that imaging plates are clean, clear and ready for exposure. Once completed, place the "completion" signage on cassettes.
2. Daily monitor SEMPTE:
   a. To ensure that the interpretation monitors are clear and calibrated prior to reading images.
3. Weekly Phantom:
   a. Phantom exposed per manufacturers (Fuji) guide- lines, results posted in QC manual.
4. Weekly Contrast to Noise Ratio (CNR):
   a. To confirm that CNR remains consistent over time at the same exposure settings. Document in QC manual.
5. Weekly Printer Dry Pix 4000
   a. Perform at beginning of workweek prior to processing any clinical images. Document in QC manual

E. **EXTERNAL LINK(S):**
1. The Mammography Quality Standards Act Final Regulations: Preparing for MQSA Inspections; Final Guidance for Industry and FDA (2001) https://www.fda.gov/downloads/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm094441.pdf

F. **REFERENCE(S):**

1. U.S. Food & Drug Administration (2017, November 16) Mammography Quality Standards Act and Program. Retrieved from https://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/default.htm

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE: 05/99 **SUBJECT: Reject/Repeat Analysis**

REVISION DATE: 08/11, 08/18

Department Approval:	**~~04/21~~10/25**
Department of Radiology Approval:	**~~12/22~~12/25**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**01/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/23**

A. **AUTHORIZED TO PERFORM:**
1. Licensed Mammography Technologist.

B. **PURPOSE:**
1. To determine the number and cause of repeated mammograms and rejected films.

C. **POLICY:**
1. To be done monthly.

D. **PROCEDURE:**
1. Each technologist will enter any repeat film done and why repeated in the diagnostic radiology () EMR computer system when completing the exam.
2. Monthly, the supervisor will pull statistics from the EMR system and review the repeat rate percentage.
3. If the repeat or reject rate changes from the previously determined rate (3.0% or less) by more than 2.0%, the reason for the change shall be determined. Any additional teaching or education of technologists will be done. Any corrective actions will be documented by supervisor and placed in repeat analysis statistics binder.

E. **REFERENCE(S):**
1. U.S. Food & Drug Administration (2017, November 16) Mammography Quality Standards Act and Program. Retrieved from https://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/default.htm

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE: 01/00

SUBJECT: Scheduling of Self-Referring Mammography Patients

REVISION DATE: 08/11, 01/19

Mammography Department Approval:	~~09/21~~10/25
Department of Radiology Approval:	~~10/21~~12/25
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/23

A. **DEFINITION(S):**
1. Self-Referred: comes for a mammogram but has no personal health care provider or the provider declines responsibility.
2. Self-Requesting: has taken the initiative to come for a mammogram, can name health care provider, but does not have a referral.

B. **PURPOSE:**
1. To clarify the Women's' Center self-referral process for screening versus diagnostic exams.
2. To clarify follow up for the self-requesting and self-referring patients.

C. **POLICY:**
1. The Women's Center will perform self-referral exams for screening only. Self-referring patients with breast symptoms must have a physical exam by a physician prior to mammogram scheduling.
2. The Women's Center will ensure that follow up for self-referring and self-requesting patients meet MQSA standards.

D. **PROCEDURE:**
1. Scheduling:
   a. The scheduler will confirm whether the exam is for screening or diagnostic purposes.
   b. The scheduler will ask for referring physician for all patients.
   c. The scheduler will inform the self-referring patient with breast symptoms of this Policy (Diagnostic Exam) and provide the Breast Help Line number, 940-5100 for physician referral information.
2. Interpretation:
   a. Self-referred: The interpreting physician will assume responsibility for women's breast care; including education and physical exam, communication of results (see Mammography Policy: Communication of Results).
   b. Self-requesting: The Women's Center will document that the designated provider accepts responsibility for follow up, or the interpreting physician will assume responsibility for women's breast care, if physician declines.

E. **RELATED DOCUMENT(S):**
1. Mammography Policy: Communication of Results

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE:	**11/99**	**SUBJECT:**	**Standardized Labeling of Mammograms**
REVISION DATE:	**08/18**		

Department Approval:	**~~04/21~~10/25**
Department of Radiology Approval:	**~~12/22~~12/25**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**01/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/23**

A. **AUTHORIZED TO PERFORM:**
1. Licensed Mammography Technologist

B. **PURPOSE:**
1. To ensure that ~~films~~ images are not lost or misinterpreted.

C. **POLICY:**
1. Each mammographic image shall have permanent and complete, legible information appropriately placed so as not to obscure anatomic structures.
   a. Name of patient, DOB, and MRN number.
   b. Date of exam.
   c. View and laterality. This information should be placed on the image near the axilla.
   d. Facility name and location.
   e. Technologist identification (initials).
   f. ~~Cassette/~~screen identification.
   g. Mammography unit identification.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

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

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

Department Approval:	~~07/20~~05/24
Environmental Health and Safety Committee Approval:	12/25
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	10/21
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	10/21

A. **PURPOSE:**
1. To provide general guidelines for maintaining a safe environment.

B. **POLICY:**
1. All program staff are responsible for the maintenance of a safe environment for patients, staff and visitors.

C. **PROCEDURE**
1. Who may perform/responsible: Outpatient Behavioral Health Services (OPBHS) Staff.
2. Program grounds are maintained in a manner that is designed to provide safe access to and a safe environment for patients, staff and visitors.
3. Emergency services are readily identifiable and easily accessible. Evacuation plans are posted throughout the facility.
4. Policies pertaining to safety issues are reviewed during orientation and annually with the program staff.
5. Any flammable, poisonous, sharp or potentially dangerous items are stored in a locked cabinet.
6. The nurse's station is closed when it is left unattended.
7. All exterior doors are to remain unlocked during program hours.
8. All corridors are to remain clear of furniture and equipment.
9. All building contents, including furniture, appliances and program materials must be kept in good condition.
10. All safety hazards are reported to the Operations Manager and are documented on an incident report if appropriate.
11. The Operations Manager or designee is responsible for the regular monthly visual safety inspection of the OPBHS.
12. The Operations Manager, Safety Representative, or designee will be responsible for completion of the Environment of Care/Patient Safety Rounds at least quarterly.
13. Safety Check List:
    a. Cords under desk - out of walk paths.
    b. All windows and doors locked at the end of the day.
    c. Corridor doors are not to be propped open.
    d. All lights out at the end of the day.
    e. Nurses' station and chart cabinet locked at the end of the day.
    f. All appropriate appliances/machines turned off at the end of the day.

g. No water left running;
h. All furniture and equipment placed out of walkway;
i. First Aid Kit remains fully stocked at all times.
j. Fire extinguishers are checked monthly and serviced annually.
k. Fire and evacuation drills are conducted ~~quarterly~~**annually**.
l. Smoke detectors are checked ~~monthly~~**quarterly**.
m. Emergency equipment checklist is completed ~~monthly~~**quarterly**.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

ISSUE DATE:	**08/96**	**SUBJECT:**	**Emergency Evacuation**
REVISION DATE:	**05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 07/17, 10/21**		

Department Approval:	**~~08/20~~06/24**
Environmental Health and Safety Committee Approval:	**12/25**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**10/21**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**10/21**

A. **PURPOSE:**

1. Provide safe evacuation from the Outpatient Behavioral Health Services (OPBHS).

B. **POLICY**

1. In the case of an emergency, the program staff will evacuate all patients and visitors in a safe and orderly manner.

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

~~1. Who may perform/responsible: OPBHS Staff~~

2. The evacuation plan **shall be** ~~for the Program is~~ prominently posted throughout the facility.
3. When a patient is admitted to the Program, the patient will be given a tour of the facility. ~~This~~**The tour shall include, but is not limited to the following:**
   - **a.** ~~tour includes the l~~**L**ocation of all exits
   - ~~3.~~**b. Review of the** ~~. The~~ evacuation plan ~~will be reviewed~~ as part of the orientation process.
4. ~~A quarterly~~**An annual** fire/emergency evacuation drill shall be conducted with ~~the~~ patients in accordance with the hospital evacuation plan.
5. **During an evacuation of the location or the building,** ~~A~~all patients, visitors and staff are to be evacuated to a designated place.
6. ~~4.~~ The Operations Manager, or designee~~,~~ will conduct a count of all patients, visitors and staff (see Environment of Care: Fire Plan – Code Red Policy).

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

1. Environment of Care: Fire Plan – Code Red Policy

Tri-City Medical Center
Oceanside, California

PULMONARY REHABILITATION SERVICES

ISSUE DATE: 10/88 **SUBJECT: Disaster Plan**

REVISION DATE: 09/93, 03/97, 06/00, 03/03, 12/12 05/22

Department Approval:	~~02/20~~07/25
Division of Pulmonary Approval:	n/a
Environmental Health and Safety Committee Approval:	12/25
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	05/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/22

A. **PURPOSE:**

1. To ensure efficient Pulmonary Rehabilitation Center Services and to maintain adequate availability of personnel in the event of disaster, to establish, supervise, and maintain safety of the patients we serve.

B. **INTRODUCTION:**

1. Due to the varying types and magnitudes of emergency events, Tri-City Medical Center has adopted the command structure of Hospital Emergency Incident Command Systems (HEICS). Once the decision has been made to activate the disaster plan, the HEICS becomes the standard operating procedure. The complete plan is located on the TCMC intranet.

C. **NOTIFICATION:**

1. The Pulmonary Rehabilitation Center shall be notified of the Disaster Plan Activation from the PBX operator announcing "CODE ORANGE" or "CODE YELLOW" using the overhead page.
2. Charge Responsibilities:
   a. Read the Unit Leader Responsibilities found in the Department Disaster packet (This is kept in the Safety and Disaster Manual). Charge duty shall transfer to the Manager/Director after one arrives.
   b. Complete and send one employee with the Personnel Inventory Form to the Incident Command Center.
      i. Personnel Inventory Forms are found on the TCMC intranet. The Incident Command Center is located in the French Rooms. If the Incident Command Center is not set up, contact the Emergency Department.
   c. Recall staff from breaks for standby to report to disaster priority areas.
      i. Staff shall return immediately if they hear the overhead page activating the disaster plan.
   d. Contact Manager/Director and begin call-in procedure. Relay as much information as you can to the Incident Command Center.
   e. Upon direction of Incident Commander or Department Director, begin call-in procedure.
   f. Every hour, or more frequently as directed, send status reports to Incident Command Center.

D. **STAFF RESPONSIBILITIES:**

1. Assist in evacuating patients from the Pulmonary Rehabilitation Center to their private vehicles, ensuring safety of patients at all times. Patients shall be sent to their homes via private transportation.

2. Facilitate flow of patients out of unit.
3. Facilitate the call-in procedure.
4. Man the telephones for incoming requests.
5. Assists in preparing the Pulmonary Rehabilitation Center for use by other department's personnel as necessary.

E. **EVACUATION OF UNIT:**

1. The decision to evacuate the Pulmonary Rehabilitation Center rests with the Incident Commander after an evaluation by Facilities Management.
2. Complete Evacuation:
   a. All patients shall be evacuated to their private homes unless situation prohibits them from leaving hospital premises.
   b. Patients shall be assisted to their private vehicles via ambulation; wheelchair assistance or other appropriate "carries" as necessary.
3. All staff shall report to Command Center to assist hospital in appropriate capacity.

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

December 11, 2025 – 2:30 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 2:30 p.m. on December 3, 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 Adela I. Sanchez
Director Tracy M. Younger

Director Gleason participated telephonically pursuant to the Brown Act "just cause" provision due to illness.

Also present were:

Gene Ma, M.D., Chief Executive Officer
Jeremy Raimo, Chief Operations Officer
Anh Nguyen, Chief Financial Officer
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant

1. Chairperson Younger called the meeting to order at 2:30 p.m. with attendance as listed above.

2. Approval of Agenda

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

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

   Chairperson Younger made an oral announcement of the items listed on the December 11, 2025 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included two matters of Existing Litigation and Reports Involving Trade Secrets.

4. Motion to go into Closed Session

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

5. At 3:30 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 of today's open session.

7. Adjournment

There being no further business, Chairperson Younger adjourned the meeting at 3:32 p.m.

_____
Tracy M. Younger
Chairperson

ATTEST:

_____
Adela I. Sanchez
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
December 11, 2025 – 3:30 o'clock p.m.

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held at 3:30 p.m. on December 11, 2025.

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

Director Sheila D. Brown
Director Rocky Chavez
Director Nina Chaya, M.D.
Director George W. Coulter
Director Adela Sanchez
Director Tracy M. Younger

Also present were:

Dr. Gene Ma, Chief Executive Officer
Donald Dawkins, Chief Nurse Executive
Jeremy Raimo, Chief Operating Officer
Anh Nguyen, Chief Financial Officer
Mark Albright, Chief Information Officer
Roger Cortez, Chief Compliance Officer
Jennifer Paroly, President, Foundation
Susan Bond, General Counsel
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant

Chairperson Younger called the meeting to order at 3:30 p.m. with attendance as listed above. Director Gleason was attending remotely in accordance with Government Code Section 54953 (2)(A)(i).

Director Gleason notified the Board that for "just cause" she would be attending remotely due to her recent surgery. The Board unanimously approved the request.

1. Report from Closed Session

In accordance with the minutes of the December 3, 2025 Special Board meeting, the Board met in closed session and discussed reports regarding Trade Secrets pursuant to Health & Safety Code Section 32106 and took no action.

The Board also discussed the Public Employee Evaluation of the CEO pursuant to Government Code Section 54957 (b) (4) for the evaluation of the Chief Executive Officer. The Board voted 4-3 with Directors Gleason, Sanchez and Brown in opposition to direct Board Counsel to bring back an amendment to the CEO's Employment Agreement which provides for a 10% increase in his base salary, retroaction to July 15, 2025.

Today, the Board met in Closed Session to discuss two Exiting Litigation matters pursuant to Government Code Section 54956(d)(4). The first case involved Northcutt

vs. TCMC, Case No. 37-2023-00021374. The Board heard a status report and voted unanimously to direct outside counsel to take appropriate action to settle the case.

The second case involved Lea vs. Bonjindasup, M.D., Case No. 37-2023-00005032. The board voted unanimously to direct outside counsel to take appropriate action to settle the case.

Lastly, the Board met in Closed Session and discussed reports regarding Trade Secrets pursuant to Health & Safety Code Section 32106 and took no action.

3. Pledge of Allegiance

Director Brown led the Pledge of Allegiance.

4. Approval of Agenda

It was moved by Director Chavez and seconded by Director Brown 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 December 11, 2025 Regular Board of Directors Meeting Agenda.

6. Presentation and consideration of the approval of the VMG Fair Market Value Appraisal in accordance with Health & Safety Code 32121(p)(2)(A)(vi).

Dr. Ma reported the District engaged VMG, a national healthcare advisory firm and one of the largest providers of enterprise valuations for hospitals, to conduct the analysis in accordance with widely accepted fair market value standards. VMG applied the three most common valuation approaches—income approach, cost approach, and market (enterprise sales) approach—and has rendered an opinion based on those methodologies. The summary of their opinion begins on page 3 of the report with the full valuation analysis included in the agenda packet materials before you today for consideration.

There were no questions or comments.

It was moved by Director Chaya to approve the VMG Fair Market Value Appraisal in accordance with Health & Safety Code 32121(p)(2)(A)(vi). 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**

7. A presentation and discussion of Affiliation, Transfer and Lease Agreements between the Tri-City Healthcare District and Sharp Healthcare District

Jeff Scott, Board Counsel presented the details of the Affiliation Agreement, Transfer Agreement and Hospital Lease Agreement between Tri-City Healthcare District and Sharp Healthcare. Mr. Scott stated the information was also presented at six 6) Community Forums (including today) in the cities of Oceanside, Vista and Carlsbad. If approved by the Board today, a measure will be placed on the ballot for June 2, 2026 Primary Election.

Mr. Scott opened the meeting for public comments. There were no further comments.

8. Board Consideration of Resolution No. 829 Approving the Affiliation, Transfer and Lease Agreements between the Tri-City Healthcare District and Sharp Healthcare District

It was moved by Director Chavez to approve Resolution No. 829 Approving the Affiliation, Transfer and Lease Agreements between the Tri-City Healthcare District and Sharp Healthcare District. 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**

9. Special Presentation –

a) Stroke Survey Results

Tri-City Medical Center successfully completed its Joint Commission survey for recertification as an Advanced Thrombectomy-Capable Stroke Center on November 24–25 and was officially recertified on November 25 for a two-year period. The survey, led by a neurosurgery-trained nurse practitioner, rigorously assessed our commitment to the highest standards of quality and safety for patients, staff, and the community.

Improvement efforts already underway include strengthening physician collaboration and documentation, expanding stroke education for patients prior to discharge, and enhancing nursing documentation and assessment practices. Notable strengths highlighted by the surveyor included: robust stroke education for pre-hospital and EMS providers across the Tri-City Healthcare District; planned community stroke education in partnership with the Tri-City Hospital Foundation; industry-leading stroke treatment times among San Diego County hospitals; the fastest CTA turnaround times in the county (from CT initiation to radiology interpretation); a highly collaborative "stroke pit stop" process in the emergency department; and effective use of VIS AI technology to coordinate interdisciplinary communication and support excellent patient outcomes. The surveyor also recognized the high level of annual stroke education required for the stroke care team, extending even to frontline staff such as security officers, who are trained to recognize stroke signs and symptoms.

10. October, 2025 Financial Statements – Anh Nguyen, Chief Financial Officer

Anh Nguyen, CFO reported on the current and fiscal year to date financials as follows (Dollars in Thousands):

- Net Operating Revenue – $30,686
- Operating Expense – $31,533
- Total Non-operating Revenue (Expenses) $2,108
- EBITDA – $2,847
- EROE – $1,260

Anh reported on the fiscal year to date financials as follows (Dollars in Thousands):

- Net Operating Revenue – $114,235
- Operating Expense – $130,461
- Total Non-Operating Revenue (Expenses) $9,765
- EBITDA – $9,425
- EROE – $3,539

Key Indicators – FYTD include:

- Average Daily Census – 119.5
- Average Acute Length of Stay (ALOS) – 4.89
- Adjusted Patient Days – 26,977
- Surgery Cases – 1,717
- ED Visits -16,234

Anh also presented graphs including Average Daily Census, Acute Average Length of Stay and Paid Full Time Equivalents per Adjusted Occupied Bed.

11. New Business

a) Consideration to approve Resolution No. 830, a Resolution of the Tri-City Healthcare District Board of Directors to approve the Title VI Program and Policies including a Language and Assistance Plan and Public Participation Plan

Sarah Jayousi, Manager for Outpatient Behavioral Health presented the District's Title VI Program, required in connection with a SANDAG grant supporting patient translation services.

The program affirms non-discrimination in translation services, includes a language assistance plan for individuals with limited English proficiency, and outlines notice and complaint procedures.

Sarah noted with the Board's approval a signed copy of the Title VI Program will be posted on the District's website.

It was moved by Director Chaya to approve Resolution No. 830, a Resolution of the Tri-City Healthcare District Board of Directors to approve the Title VI Program and Policies including a Language and Assistance Plan and Public Participation Plan. Director Chavez 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**

b) Consideration to approve the Office Lease Agreement with Sycamore Ave II, LLC for a sixty-four (64) month term beginning on February 1, 2026 and ending May 31, 2031, for a maximum total expense for the term not to exceed $749,719.

Jeremy Raimo, COO presented a proposed office lease for space in Vista (Sycamore) to establish a 1206(b) OB/GYN clinic targeted to open February 1, 2026, in alignment with the strategic initiative with Sharp and to increase access to women's services.

It was moved by Director Sanchez to approve the Office Lease Agreement with Sycamore Ave II, LLC for a sixty-four (64) month term beginning on February 1, 2026 and ending May 31, 2031, for a maximum total expense for the term not to exceed $749,719. 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**

c) Consideration to approve an Office Lease Agreement between Tri-City Healthcare District and Tri-City Healthcare Cardiology and Arrythmia Services Inc., at 6260 El Camino Real, Suite 105 for a 12-month term.

Jeremy Raimo, COO presented a proposed timeshare arrangement at the existing Wellness Center suite in South Carlsbad for cardiologist Dr. Mohammad Pashforoush to increase access to cardiology services in that market. Under the arrangements, the District will provide exam space and support (ECG, echocardiography, front office staff, and medical assistant) for designated half-day blocks.

It was moved by Director Chavez to approve an Office Lease Agreement between Tri-City Healthcare District and Tri-City Healthcare Cardiology and Arrythmia Services Inc., at 6260 El Camino Real, Suite 105 for a 12-month term. 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**

d) Consideration to approve an Office Lease Agreement between Tri-City Healthcare District and Abinav Sharma, M.D., at 6260 El Camino Real, Suite 105 for a 12-month term

Jeremy Raimo, COO presented a proposed timeshare arrangement at the existing Wellness Center suite in South Carlsbad for cardiologist Dr. Abhinav Sharma to increase access to cardiology services in that market. Under the arrangements, the District will provide exam space and support (ECG, echocardiography, front office staff, and medical assistant) for designated half-day blocks.

It was moved by Director Chavez to approve an Office Lease Agreement between Tri-City Healthcare District and Abinav Sharma, M.D., at 6260 El Camino Real, Suite 105 for a 12-month term. 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**

e) Consideration to approve Professional Services Agreement between Richard Smith, M.D. Inc., and Tri-City Healthcare District for a 1206(b) Infectious Disease Clinic

Jeremy Raimo, COO presented a proposal to establish a 1206(b) Infectious Disease clinic, centered on Dr. Richard Smith, the current infectious disease specialist at Tri-City, to ensure continued inpatient coverage and expanded ambulatory care services through infectious disease in South Carlsbad at the request of community primary care providers.

It was moved by Director Chavez to approve an Office Lease Agreement between Tri-City Healthcare District and Richard Smith, M.D., Inc., for a 1206(b) Infectious Disease Clinic. 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**

f) Consideration to approve Professional Services Agreements between Paul W. Hinshaw, D.O., Inc; Natalia Babkina M.D. Ph.D., Inc., and Brano Cizmar, M.D., Inc and Tri-City Healthcare District for a 1206(b) OB/GYN clinic.

Jeremy Raimo, COO presented three proposed professional service agreements for OB/GYN providers to practice at the new Sycamore 1206(b) clinic: Drs. Brano

Cizmar, Natalia Balkina, and Paul Henshaw, all established providers in the community.

It was moved by Director Sanchez approve Professional Services Agreements between Paul W. Hinshaw, D.O., Inc; Natalia Babkina M.D. Ph.D., Inc., and B. Cizmar, M.D., Inc and Tri-City Healthcare District for a 1206(b) OB/GYN clinic. Director Brown 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**

g) Consideration and possible action to elect Board of Directors Officers for calendar year 2026.

Board Counsel, Jeff Scott reviewed the process for electing Board officers for 2026 and opened the floor to nominations for Chairperson.

After discussion,

It was moved by Director Chavez for the Board to retain their existing positions for calendar year 2026, citing the importance of continuity during the Sharp transaction. Director Chaya seconded the motion.

After confirming no additional nominations,

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**

Board Officers for 2026 include the following:

- Chairperson – Director Younger
- Vice Chairperson – Director Chaya
- Secretary – Director Sanchez
- Treasurer – Director Chavez
- Assistant Secretary – Director Gleason
- Assistant Treasurer – Director Coulter
- Board Member at Large – Director Brown

h) Consideration of proposed 2026 Board Meeting Schedule

Chairperson Younger presented the 2026 Board Meeting Schedule for consideration, noting July is "dark" as well as October. She also commented that Special Meetings will be held throughout the year as necessary.

It was moved by Director Chaya to approve the proposed 2026 Board Meeting Schedule. 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**

i) Consideration to award a Board Scholarship to the Tri-City Hospital Auxiliary in the amount of $10,000.

Auxiliary President Bunny McElliott presented the annual request to fund the Auxiliary Nursing Scholarship event scheduled for Tuesday, April 14, 2026, highlighting the program's impact on nursing education and long-term workforce development.

It was moved by Director Sanchez to award a Board Scholarship to the Tri-City Hospital Auxiliary in the amount of $10,000. Director Brown 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**

9. Old Business - None

10. Chief of Staff

a. Consideration to approve the November 2025 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on November 24, 2025 as well as the General Vascular Surgery Privilege Form.

It was moved by Director Chavez to approve the November 2025 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee and the General Vascular Surgery Privilege Form on November 24, 2025. Director Brown 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

11. Consideration of Consent Calendar

It was moved by Director Brown 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 provided an update on the Sharp transaction and organizational performance. He noted that, following six public meetings and community input, the definitive agreements with Sharp had been refined and received overwhelmingly positive feedback. The transaction consideration from Sharp is anticipated to be one of the largest of its kind and reflects the strategic importance of North County. He clarified that although the definitive agreements with Sharp will be executed, final closing remains contingent on public approval at the June 2, 2026 election. A signing ceremony to celebrate execution of the agreements will be scheduled.

Dr. Ma highlighted a $35M year-over-year financial improvement in FY25, with continued progress expected in the current fiscal year. He emphasized improvements in quality and patient experience, including the 4P medical-surgical unit achieving 99th percentile HCAHPS performance in California, exceeding national benchmarks.

Dr. Ma also reported the partnership with the County of San Diego and Exodus has resulted in state approvals to open the Psychiatric Health Facility (PHF), with an anticipated opening date of December 18.

Finally, Dr. Ma recognized Susan Bond and Harjit Randhawa who will be departing the organization, and he formally thanked them for their significant contributions to financial stewardship and organizational discipline.

16. Board Communications

Directors expressed appreciation to leadership, staff, and community partners for their work throughout the transaction process and for continued service to the community.

17. Adjournment

There being no further business Chairperson Younger adjourned the meeting at 4:25 p.m.

_____
Tracy M. Younger
Chairperson

ATTEST:

_____
Adela I. Sanchez
Secretary

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending December 31, 2025

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	Lease Term Beginning	Lease Term 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)	41,021.32	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)	16,914.69	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)	28,454.82	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)	34,420.00	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)	15,786.75	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)	11,556.77	05/01/23	04/30/26	**Pulmonary Specialists of NC** 3907 Waring Road, Suite 2 Oceanside, CA 92056	7088
Total				**270,757.54**				

(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 December 2025

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6171	CPXP EXAM FEE	111325 EXP	475.00	84098	JOSHUA SMILEY
7095	DEA RENEWAL	120525 EXP	888.00	84334	JOHNSON RYAN
8740	ACCP PHARMACY	120225 EDU	200.00	84582	SCOTT ASHLEY

**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.