TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
September 24, 2015 – 1:30 o'clock p.m.
Classroom 6 - Eugene L. Geil Pavilion
Open Session – Assembly Rooms 1, 2, 3
4002 Vista Way, Oceanside, CA 92056

The Board may take action on any of the items listed below, unless the item is specifically labeled "Informational Only"

	Agenda Item	Time Allotted	Requestor
1	Call to Order	3 min.	Standard
2	Approval of agenda		
3	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Closed Session portion of the Agenda. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors.	3 min.	Standard
4	Oral Announcement of Items to be Discussed During Closed Session (Authority: Government Code Section 54957.7)		
5	Motion to go into Closed Session		
6	Closed Session	**2 Hours**	
	a. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: October 31, 2015		
	b. Conference with Labor Negotiators (Authority: Government Code Section 54957.6) Agency Negotiator: Tim Moran Employee organization: SEIU		
	c. Conference with Legal Counsel – Potential Litigation (Authority Government Code Section 54956.9(d) (1 Matter)		
	d. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	e. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: October 31, 2015		
	f. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: December 31, 2015		

Note: Any writings or documents provided to a majority of the members of Tri-City Healthcare District regarding any item on this Agenda will be made available for public inspection in the Administration Department located at 4002 Vista Way, Oceanside, CA 92056 during normal business hours.

Note: If you have a disablility, please notify us at 760-940-3347 at least 48 hours prior to the meeting so that we may provide reasonable accommodations.

	Agenda Item	Time Allotted	Requestor
	g. Conference with Legal Counsel – Existing Litigation (Authority Government Code Section 54956.9(d)1, (d)4 (1) Steven D. Stein v. Tri-City Healthcare District Case No. 12-cv-02524BTM BGS (2) Medical Acquisitions Company vs. TCHD Case No: 2014-00009108 Case No. 2014-00022523		
	h. Approval of prior Closed Session Minutes		
7	Motion to go into Open Session		
8	Open Session		
	Open Session – Assembly Room 3 – Eugene L. Geil Pavilion (Lower Level) and Facilities Conference Room – 3:30 p.m.		
9	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)		
10	Roll Call / Pledge of Allegiance	3 min.	Standard
11	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 14-018, 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
12	Special Recognitions – 1) Lucky 13 Triple Crown Presentation – Mrs. Tina Knight	10 min.	Chair
13	Community Update 1) Emergency Preparedness Update – Kevin McQueen	20 min.	K. Conley
14	Report from TCHD Auxiliary	5 min.	Standard
15	Report from Chief Executive Officer	10 min.	Standard
16	Report from Chief Financial Officer	10 min.	Standard
17	New Business		
	a. Consideration of the FY2015 Fiscal Year Audit – Presentation by Devon Wiens/Moss Adams	15 min.	Audit Comm./CFO
	b. Consideration to appoint Mr. Jack Cumming to an additional two-year term on the Audit, Compliance & Ethics Committee	5 min.	Audit Comm.
18	Old Business - None		
19	Chief of Staff a. Consideration of August 2015 Credentialing Actions Involving the Medical Staff – New Appointments Only	5 min.	Standard

	Agenda Item	Time Allotted	Requestor
	b. Medical Staff Credentials for August, 2015 – Reappointments		
20	Consideration of Consent Calendar (1) Board Committees ***(1) All Committee Chairs will make an oral report to the Board regarding items being recommended if listed as New Business or pulled from Consent Calendar.*** ***(2) All items listed were recommended by the Committee.*** ***(3) Requested items to be pulled require a second.*** **A. Human Resources Committee** Director Kellett, Committee Chair Open Community Seats – 0 *No meeting held in August, 2015* **B. Employee Fiduciary Retirement Subcommittee** Director Kellett, Subcommittee Chair Open Community Seats – 0 *No meeting held in August, 2015* **C. Community Healthcare Alliance Committee** Director Nygaard, Committee Chair Open Community Seats – 1 (Committee minutes included in Board Agenda packets for informational purposes **D. Finance, Operations & Planning Committee** Director Dagostino, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes) 1) Approval of an agreement with ABC-10/KGTV for a monthly cost of $12,508 for a term of 12 months beginning July 1, 2015 through June 30, 205 for an annual cost of $150,000. 2) Approval of an agreement with the San Diego Business Journal for a monthly cost of $8,333 for a term of 12 months beginning July 1, 2015 through June 30, 2016 for an annual cost of $100,000. 3) Approval of Administration Policy #8610-278 – Contract Review. 4) Approval of an agreement with Rady Children's Hospital for a term of 12 months, beginning September 1, 2015 through August 31, 2016 at $175 per hour, not to exceed eight (8) hours per month, for a monthly amount of $1,400 and a total expense for the Term of $16,800. 5) Approval of an Emergency Department On-Call Coverage Agreement for Neurology with The Neurology Center of Southern California physicians namely Drs. Andrew Blumenfeld, Bilal Choudry, Laura DeSadier, Benjamin Frishberg, Michael Lobatz, Amy Nielsen, Irene Oh, Remia	5 min.	Standard HR Comm. Emp. Fid. Subcomm. CHAC Comm. FO&P Comm.

	Agenda Item	Time Allotted	Requestor
	Paduga, Jay Rosenberg, Mark Sadoff, Gregory Sahagian, Jack Schim, Leslie Aguilar Tabora, Anchi Wang, Chunyang Wang and Michael Zupancic for a term of 12 months beginning July 1, 2015 through June 30, 2016 at a daily rate of 740 for an annual cost of $20,840 and a total cost for the term of $270,840.		
	6) Approval of an agreement with Anshu Gupta, M.D. as the Plastics Coverage Physician for a term of 24 months beginning October 1, 2015 through September 30, 2017 at an estimated annual cost of $78,000 and a total cost for the term of $156,000.		
	7) Approval of a Lease Agreement for Suite 105 in the Wellness Center MOB located at 6260 El Camino Real, Carlsbad, CA 92009, with the Well Being Clinic, Inc. for a five-year term beginning March 1, 2016 through February 28, 2021, at the rate of $7,469 per month for the first year, increasing 3% yearly thereafter.		
	8. Approval of an agreement with Federal Heath Sign Company for the construction of an Electronic Digital Media Display Pylon Sign for a total cost not to exceed $380,000, contingent upon final approval by the City of Oceanside.		
	9. Approval of an agreement with Kristin Preiser, Nurse Practitioner to provide coverage for a term of 10 months, beginning September 3, 2015 through June 30, 2016, not to exceed an average of 40 hours per month, at an hourly rate of $60 for an annual cost of approximately $24,000.		
	E. Professional Affairs Committee Director Dagostino, Committee Chair (Committee minutes included in Board Agenda packets for informational purposes.)		PAC
	1) **Formulary** Abilify Maintena		
	2) **Unit Specific** **A. Engineering Department:** 1. Interim Life Safety Program 2. System Failure Report		
	B. Infection Control: 1. Cleaning, Disinfection and Sterilization 2. Philosophy- IC 1 3. Standard and Transmission- Based Precautions- IC 5		
	C. NICU 1. Criteria for Case Referrals to Morbidity and Mortality (M&M) Meetings 2. Lumbar Puncture, Assisting with (DELETE) 3. Nasojejunal Transpyloric (NJ) Tube Insertion, Maintenance, and Removal of 4. Urinary Catheter, Insertion and Removal of (DELETE)		

	Agenda Item	Time Allotted	Requestor
	D. Pharmacy 1. Automatic Dose Rounding 2. Decreasing Medication Errors 3. Drug Compounding for Medication Not Commercially Available 4. Drug Distribution 5. Inventory Control 6. Labeling Standards 7. Medication Management Program 8. Receiving and Tracking Narcotic Pump Refills 9. Prepared by Outside Vendors 10. Unit Dose Distribution System (DELETE) **E. Pulmonary** 1. Incentive Spirometry Instruct and Follow-Up (DELETE) **F. Rehabilitation Services** 1. Discipline-Specific Staff Meetings – 201 2. Maintaining Current Licenses, Registrations and Certifications- 301 (DELETE) 3. Mission Statement, Goals and Objectives- 100 4. Physical Plant- 105 5. Productivity Reporting System- 203 6. Staff Rotations- 615 7. Statement of Accountability- 102 **G. Security Manual** **Section 2 – Security Operations** 1. Aero Medical Transport Responsibilities- 223 2. BHS STAT Response- 215 3. Emergency Department Patient Parking- 225 4. Exterior Door Security- 222 5. Lost and Found Procedure for Security Department – 230 6. Media Relations – 229 7. Patient Valuables Collection and Return- 237 8. Patrol of Areas Under Construction- 226 9. Property Custody- 232 10. Psychiatric Patient Escorts – 216 11. Safety and Security Incident Investigation- 233 12. Security Alarm Systems Response- 220 13. Security Department VIP Policy- 235 14. Security Incident Notification- 208 15. Security Officer Documentation- 238 16. Security Panic Alarm System Response- 221 17. Vehicle Jumpstart- 234 **Section 3- Security Personnel** 1. Departmental Personnel Issues – 307 2. Hair and Grooming Standards for Security Officers- 302 3. New Officer Training- 301 4. Outside Employment- 306 (DELETE) 5. Payroll Timecard- 305		

	Agenda Item	Time Allotted	Requestor
	6. Scheduled Time Off- 303 7. Unplanned Time Off (Unscheduled Absence/ Tardy) **Section 4 – Security Equipment** 1. Authorized Security Department Uniforms & Safety Equipment- 401 2. Chemical Agent- 402 (DELETE) 3. Security Department Key Rings and Department Key Control – 406 4. Security vehicles- 405 5. Use of Handcuffs- 403 (DELETE) 6. Use of Impact Weapon/ Tactical Baton- 404 (DELETE) 7. Use of recording device- 408 **Section 5 – Security Safety** 1. After Action Incident Review and Debriefing- 511 2. Conflict Resolution- 510 3. Disposal of Drugs or Drug Paraphernalia- 506 4, High Risk Patient or Visitor- 509 5. Personal Safety escort for Visitors and Staff- 514 6. Security Sensitive Areas- 502 **Section 8 – Emergency Preparedness** 1. Disaster Manual- 802 2. Disaster Plan for the Security department- 801 3. Emergency Situation Officer Recall- 803 4. Medical center Power Outage- 804 **H. Women and Newborn Services** 1. Balloon Cervical Ripening Catheter 2. Breast Milk Misadministration 3. Breast Milk Pumping, Handling and Storage of 3) **Medical Staff** 1. Peer Review Process OPPE and FPPE **F. Governance & Legislative Committee** Director Schallock, Committee Chair Open Community Seats - 0 (Committee minutes included in Board Agenda packets for informational purposes.) 1) **Rules & Regulations** a. Department of Pathology 2) Approval of Board Policy 15-027 – Prohibition on Political Activities, Solicitation, Distribution of Literature and Goods on District Properties. 3) Recommendation to reject Medical Staff Bylaws		Gov. & Leg. Comm.

	Agenda Item	Time Allotted	Requestor
	G. Audit & Compliance Committee Director Finnila, Committee Chair Open Community Seats – 0 (Minutes to be available at meeting due to reschedule of meeting to September 22nd). 1) **Approval of Administrative Policies & Procedures**: a. 8610-531 – Sanctions to Comply with Privacy and Security Policies & Procedures b. 8610-592 – Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment and Healthcare Operations (TPO) c. 8610-525 – Use and Disclosure of Protected Health Information (PHI) for Fundraising (2) Minutes – Approval of a) August 27, 2015 – Regular Board of Directors Meeting (3) Meetings and Conferences – None (4) Dues and Memberships		Audit, Comp. & Ethics Comm. Standard Standard Standard
21	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
22	Reports (Discussion by exception only) (a) Dashboard - Included (b) Construction Report – None (c) Lease Report – (August 2015) (d) Reimbursement Disclosure Report – (August, 2015) (e) Seminar/Conference Reports - None	0-5 min.	Standard
23	Legislative Update	5 min.	Standard
24	Comments by Members of the Public NOTE: Per Board Policy 14-018, members of the public may have three (3) minutes, individually, to address the Board.	5-10 minutes	Standard
25	Additional Comments by Chief Executive Officer	5 min.	Standard
26	Board Communications (three minutes per Board member)	18 min.	Standard
27	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session **(Includes 10 minutes for recess to accommodate KOCT tape change)**	**2 hours/ 45 min.**	
28	Oral Announcement of Items to be Discussed During Closed Session (If Needed)		
29	Motion to Return to Closed Session (If Needed)		
30	Open Session		
31	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
32	Adjournment		

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
September 9, 2015

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 09/25/2015– 08/31/2017)

Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 09-25-15 through 08-31-2017:

- **AMINLARI, Ardalan E., MD/Ophthalmology**
- **CARDENAS, Carrie L., MD/Family Medicine**
- **DENSERT, Ruchira S., MD/Psychiatry**
- **MALHOTRA, Arati, MD/Pediatrics**
- **MOZAYAN-ISFAHANI, Arash, MD/Ophthalmology**
- **POSADAS, Emerito D., MD/Pediatrics**
- **SMITH, Angela N., MD/Anesthesiology**
- **TASWELL, Carl, MD/Psychiatry**

INITIAL APPLICATION WITHDRAWAL: (Voluntary unless otherwise specified)

Medical Staff:

- **NGUYEN, James T., MD – Anesthesiology**
- **TAYLOR, William R., MD – Neurosurgery**

TEMPORARY MEDICAL STAFF MEMBERSHIP: Medical Staff:

None

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
September 9, 2015

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 10/01/2015 – 09/30/2017)

The following application was recommended for reappointment to the medical staff office effective 10/1/2015 through 9/30/17, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- AMORY, David W., M.D./Orthopedic Surgery/Active
- BARRON JR., ROBERT H., M.D./Family Medicine/Affiliate
- BURRUSS JR., Richard P., M.D./Emergency Medicine/Active
- CALHOUN, Chanelle R., M.D./Pediatrics/Active
- COLL, Jonathan P., M.D./Teleradiology/Associate
- DZINDZIO, Barry S., M.D./Cardiology/Active
- GEORGY, Bassem A., M.D./Interventional Radiology/Active
- GUERIN, Chris K., M.D./Endocrinology/Active.
- MURPHY, Carmel, M.D./Pediatrics/Provisional
- NIELSEN, Martin M., M.D./Pulmonary Medicine/Active
- ROSENBURG, Jeffrey M., M.D./Cardiothoracic Surgery/Active
- SADOFF, Mark N., M.D./Neurology/Active
- SCHIM, Jack D., M.D./Neurology/Active
- SCHWENDENMANN, Wade D., M.D./Maternal & Fetal Medicine/Provisional
- SIDDIQUI, Fareeha, M.D./Oncology/Active
- SIGNER, Stephen F., M.D./Psychiatry/Consulting
- TITH, Tevy, M.D./Maternal & Fetal Medicine/Provisional
- VOIGT, Michelle R., M.D./Emergency Medicine/Active

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
September 9, 2015

Attachment B

REINSTATEMENT: (Effective date 09/25/2015 to 8/31/2017)

- FRASIER, Bradley, M.D./Urology
- ORR, Robert, M.D./Cardiology

UPDATE TO PREVIOUS REAPPOINTMENT RECOMMENDATIONS: (Time Period of 09/01/2015 – 08-31/2017) The information in purple is what changed.

- CASTREJON, Joseph, M.D./Family Medicine/Courtesy
- GARG, Aruna K., M.D./ Pediatric Hematology/Active
- LIU, Alice Y., M.D./Dermatology/Consulting
- MENDOZA, Jorge A., M.D./Teleradiography/Provisional
- OLSON, Scott, M.D./Interventional Neuroradiology/Consulting

RESIGNATIONS: (Effective date 09/30/2015 unless otherwise noted)

Voluntary:

- PRINCE, Adam F., PA-C/Allied Health Professional
- THAPER, Mohinderpal S., MD – Internal Medicine

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS (Effective Date: 09/25/2015, unless specified otherwise)

PRIVILEGE RELATED CHANGES

- Hanna, Karen, MD/General-Vascular Surgery/Provisional
- McQueen, Paula, CNM/Allied Health Professional

STAFF STATUS CHANGES

- Wang, Vanessa PA-C/Allied Health Professional

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 3 of 3
September 9, 2015

Attachment C

PROCTORING RECOMMENDATIONS (Effective 09/25/2015, unless otherwise specified)

- **Allen, Danielle, AUD** — **Allied Health Professional**
  Release from proctoring: Neurophysiological Intraoperative Monitoring

  Sponsoring Physician: Neville Alleyne, MD

- **Allen, Matthew PA-C** — **Allied Health Professional**
  Release from proctoring: Central IV Line Access and Reduction of Major Joints

  Sponsoring Physician: Neil Tomaneng, MD

- **Chase, Nicole PA-C** — **Allied Health Professional**
  Release from proctoring: Repair of Complex Lacerations

  Sponsoring Physician: Neil Tomaneng, MD

- **Choi, James M.D.** — **Anesthesiology**
  Release from proctoring: Regional Anesthesiology

- **Desadier, Jason D.O.** — **Emergency Medicine**
  Release from proctoring: General Patient Care

- **Han, James, DPM** — **Podiatry**
  Release from proctoring: Podiatric H&P, Minor Procedures and Major Procedures

- **Hanna, Karen, M.D.** — **General/Vascular Surgery**
  Release from proctoring: Bariatric Surgery

- **McDonald, April, NP** — **Allied Health Professional**
  Release from proctoring: NP-Neonatal Privileges

  Sponsoring Physician: Hamid Movahhedian, MD

- **Zaveri, Maulik, M.D.** — **Ophthalmology**
  Release from proctoring: General Ophthalmology Category

Human Resources Committee
(No meeting held in September, 2015)

Employee Fiduciary Subcommittee
(No meeting held in September, 2015)

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
September 10, 2015 Assembly Room 1

MEMBERS PRESENT: Board of Directors Chairman Larry Schallock; Director/CHAC Chairperson Julie Nygaard, Director James Dagostino, Dr. Victor Souza, Bret Schanzenbach, Carol Herrera, Don Reedy, Gigi Gleason, Guy Roney, Linda Ledesma, Marilyn Anderson, Marge Coon, Mary Lou Clift, Rosemary Eshelman

NON-VOTING MEMBERS: Tim Moran, CEO; David Bennett, Sr. VP & CMO; Kapua Conley, COO; Audry Lopez, Roma Ferriter, Fernando Sanudo

OTHERS PRESENT: Cheryle Bernard Shaw, CCO; Susan McDowell, CHAC Coordinator; Celia Garcia, CHAC Coordinator

MEMBERS ABSENT: Barbara Perez, Carol Brooks, Darryl Hebert, Gina McBride, Jack Nelson, Laura Vines, Linda Allington, Marilou de la Rosa Hruby, Xiomara Arroyo

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CALL TO ORDER	The September 10, 2015 Community Healthcare Alliance Committee meeting was called to order at 12:36pm by Director and CHAC Chair Julie Nygaard.		
APPROVAL OF MEETING AGENDA	Director Jim Dagostino motioned to approve the September 10, 2015 agenda. The motion was seconded by Gigi Gleason and unanimously approved.		
PUBLIC COMMENTS & ANNOUNCEMENTS	No public comments were made.		
RATIFICATION OF MINUTES	Director Larry Schallock motioned to approve the August 13, 2015 meeting minutes. The motion was seconded by Director Jim Dagostino and unanimously approved with no corrections.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
September 10, 2015 Assembly Room 1

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
PRESENTATION	*"Hospitalists' Work at TCMC"* By Dr. Victor Souza, MD Dr. Victor Souza provided his presentation, "*Hospitalists' Work at TCMC*" to explain the benefits of Hospitalists to TCMC and to patients admitted to the hospital. **ADVANTAGES OF HOSPITALISTS**: 1. Able to assist hospitalized patients quickly rather than the patient having to wait for their Primary Care Physicians to arrive. 2. Can help increase patient satisfaction scores. 3. Patient needs are met skillfully and efficiently. 4. Often contributes to shorter length of stay. 5. Quality communication provided to patient's PCP at regular intervals. 6. Can improve patient outcomes and provide for a better work environment for the staff. 7. Hospitalists are knowledgeable about the facility, services and staff members since their offices are located within the hospital itself.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
September 10, 2015 Assembly Room 1

TOPIC		ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
PRESENTATION	Presentation highlights included: 1) The organization of medical care when the patient arrives at the hospital. 2) Enhanced performance in Health Care. 3) Benefits to the patients and hospital staff. 4) Future expectations. Dr. Souza entertained questions by the audience. The group thanked Dr. Souza for his insightful presentation. Fernando Sanudo noted that years ago, when he and Dr. Souza both worked for the VCC, Dr. Souza was a wonderful doctor to the patients and great person to work with.		
DATE & TIME OF NEXT CHAC MEETING	The next CHAC meeting is scheduled for Thursday, October 8, 2015.		
COMMITTEE COMMUNICATIONS	No Committee Reports.		
PUBLIC COMMENTS	Committee member Marilyn Anderson relayed that a recent visit by a relative to the TCMC emergency room was made worse by noise issues during their stay. While the care was excellent, the noise by another patient in the area caused the event to be more stressful than necessary. Julie Nygaard noted that noise is a problem with the current ER design, and that TCMC is addressing these concerns with the ER redesign.		

TOPIC		ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
PUBLIC COMMENTS (Con't)	Julie Nygaard introduced and welcomed new TCMC CCO, Cheryle Bernard Shaw, to the meeting. Fernando Sanudo notified the group that the Oceanside VCC has made some improvements with the recent addition of dental care and 3 new exam rooms. Carol Herrera asked why the Mental Health Committee has not had any reports lately. Gigi Gleason noted that there have been some staffing issues combined with County delays, and that the Committee will report as soon as information becomes available. Linda Ledesma reported that the Carlsbad Fire Department will be having a Fundraiser at LEGOLAND on Saturday, September 12th. Don Reedy stated that the Oceanside Harbor Days are scheduled for the 26th and 27th. Roma Ferriter reported that NCHS will be hosting an Oceanside Chamber Mixer on September 17th. Gwen Sanders of the North County Chapter of the NAACP noted that the NAACP Blue & Gold Gala will be held on October 10th. Gwen requested that a flyer with details concerning the event be forwarded to members of the CHAC committee. David Bennett recognized Celia Garcia, Brand Management Specialist at Tri-City Medical Center, for her excellent work with the ads and graphics for the hospital.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
September 10, 2015 Assembly Room 1

TOPIC		ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
PUBLIC COMMENTS (Con't)	Jamie Johnson, Marketing Manager, provided details about the Flu Shot clinics scheduled for the Fall season. A list of dates will be emailed to the CHAC committee members.		
ADJOURNMENT	The meeting was adjourned at 1:39pm.		

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
September 15, 2015

Members Present	Dr. James Dagostino, Director Cyril Kellett, Director Julie Nygaard, Dr. John Kroener, Dr. Frank Corona, Kathleen Mendez, Steve Harrington, Wayne Lingenfelter, Tim Keane
Non-Voting Members Present:	Tim Moran, CEO, Steve Dietlin, CFO, Kapua Conley, COO, Cheryle Bernard-Shaw, CCO, Wayne Knight, Sr. VP, Medical Services
Others Present	Kevin Stotmeister, (Federal Heath), Leif Olson, (Federal Heath), David Bennett, Charlene Carty, Scott Livingstone, Daniel Martinez, Colleen Thompson, Tom Moore, Scott Worman, M.D., Joy Melhado, Mary Diamond, Andrea Benton, Jody Root, (Procopio)
Members Absent:	Carlo Marcuzzi, Dr. Marcus Contardo

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Dagostino called the meeting to order at 12:33 pm.		
2. Approval of Agenda		**MOTION** **It was moved by Director Nygaard, Director Kellett seconded, and it was unanimously approved to accept the agenda of September 15, 2015**	
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Dagostino read the paragraph regarding comments from members of the public.		Director Dagostino
4. Ratification of minutes of August 18, 2015		Minutes were ratified, with the following corrections. Legal representative Jody Root from Procopio is to be added to those in the attendance at the August 18th	

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		meeting, as well as correcting that he, not Chairman Dagostino, made the Closed Session announcement. **MOTION** **It was moved by Dr Kroener, Dr. Corona seconded, that the minutes of August 18, 2015, be approved with the modifications requested.** **Dr. Corona abstained.**	
5. Old Business			
a. ABC-10 / KGTV Television Advertising Proposal	David Bennett explained this agreement for advertising with ABC-10 / KGTV is being resubmitted. It was previously presented at the August 18th, 2015 meeting, but due to the discovery of errors on the original write-up, it was not included on the August BOD agenda. The corrected write-up is now being resubmitted. Director Dagostino also noted that this write-up does not currently reflect approval by the Chief Compliance Officer. Approval by the CCO was received after FOP packet distribution, and this write-up would be amended to reflect this information.	**MOTION** **Director Nygaard moved, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with ABC-10 / KGTV for a monthly cost of $12,508 for a term of 12 months, beginning July 1, 2015 and ending June 30, 2016 for an annual / term cost of $150,100.** Write-up to be amended by Barbara Hainsworth	David Bennett
b. San Diego Business Journal Print Advertising Proposal	David Bennett explained that this media agreement for print advertising with the San Diego Business Journal is being resubmitted. It was previously presented at the August 18th, 2015 meeting, but due to the discovery	**MOTION** **Mr. Lingenfelter moved, Dr. Corona seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with the San**	David Bennett

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	of errors on the original write-up, it was not included on the August BOD agenda. The corrected write-up is now being resubmitted. Director Dagostino also noted that this write-up does not currently reflect approval by the Chief Compliance Officer. Approval by the CCO was received after FOP packet distribution, and this write-up would be amended to reflect this information.	**Diego Business Journal for a monthly cost of $8,333 for a term of 12 months, beginning July 1, 2015 and ending June 30, 2016, for an annual/term cost of $100,000.** **Write-up to be amended by Barbara Hainsworth**	
6. New Business			
a. Policy Review • Contract Review	This policy was presented in red-line version by Cheryle Bernard-Shaw. Discussion ensued, with clarification requested on specific edits made to this policy.	**MOTION** **Mr. Keane moved, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors approve the Contract Review Policy, as written/revised.**	Cheryle Bernard-Shaw
b. Rady Children's Hospital Agreement Proposal	Mary Diamond explained this proposal would permit Rady Children's Hospital of San Diego to provide information regarding State guidelines for Newborn Screening testing and program certification, as well as training for staff, as requested. This service would also provide review of newborn hearing screening policies / procedures, as well as information / education needed, to obtain referrals for additional testing, to include Brainstem	**MOTION** **Director Nygaard moved, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the Agreement with Rady Children's Hospital for a term of 12 months, beginning September 1, 2015 and ending on August 31, 2016 at $175 per hour, not to**	Mary Diamond

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	Evoked Response, Otoacoustic Emission and Tympanometry.	**exceed 8 hours per month, for a monthly amount of $1,400 and a total expense for the Term of $16,800.**	
c. Neurology Physician On-Call Coverage Agreement	Kapua Conley presented the proposal for Emergency Department On-Call Neurology. He emphasized this would provide 24/7 patient coverage for all neurology specialty services, in accordance with Medical Staff Policy #8710-520. Discussion ensued.	**MOTION** **Dr. Corona moved, Dr. Kroener seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the above-mentioned physicians of The Neurology Center of Southern California as the Coverage Physicians for a term of 12 months beginning July 1, 2015 and ending June 30, 2016, at a daily rate of $740, for an annual cost of $270,840 and a total cost for the term of $270,840.**	Kapua Conley
d. Physician Agreement for Plastic Surgery Coverage Inpatient • Anshu Gupta, M.D.	Kapua Conley presented the proposal for the Physician Agreement for Inpatient Plastic Surgery coverage. He explained that the physician would provide plastic surgery services, both Consultative and Procedural for registered TCMC patients, to include inpatients and observation patients. Discussion ensued.	**MOTION** **Director Kellett moved, Dr. Kroener seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Anshu Gupta, M.D. as the Plastics Coverage Physician for a term of 24 months beginning October 01, 2015 and ending September 30, 2017.**	Kapua Conley
e. Wellness Center Medical MOB Lease Agreement Proposal	Wayne Knight presented the proposal for the Wellness Center Medical Office Building Lease Agreement with Drs. Yoo Jin Chong and Maribeth Chong, as personal guarantors. Discussion ensued, during which	**MOTION** **Director Nygaard moved, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors the Lease**	Wayne Knight

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	Director Nygaard suggested that future, revenue generating write-up documents to be submitted, possess a specific area where this information can be easily recognized.	**Agreement for Suite 105 in the Wellness Center MOB located at 6260 El Camino Real, Carlsbad, CA 92009, with Well Being Medical Clinic, Inc., for a five-year term (March 1, 2016 through February 28, 2021), at the rate of $7,469 per month for the first year, increasing 3% yearly thereafter.**	
f. Federal Heath Sign Company Proposal	David Bennett introduced Kevin Stotmeister and Leif Olson from Federal Heath Sign Company. Collectively, they presented the proposal to provide an electronic, digital media display, pylon sign, for TCMC. This sign would electronically display messaging content, and would be the property of Tri-City Medical Center. Discussion ensued. Director Dagostino also noted that this write-up does not currently reflect approval by the Chief Compliance Officer. Approval by the CCO was received after FOP packet distribution, and the write-up would be amended to reflect this information.	**MOTION** **Mr. Lingenfelter moved, Ms. Mendez seconded, and it was approved with Director Nygaard opposed, that the Finance, Operations and Planning Committee recommend, that the TCHD Board of Directors authorize the agreement with Federal Heath Sign Company for the construction of an Electronic Digital Media Display Pylon Sign for a total cost not to exceed $380,000, contingent upon final approval by the City of Oceanside.** **Write-up to be amended by Barbara Hainsworth**	David Bennett
g. Nurse Practitioner Agreement – Behavioral Health Unit	Joy Melhado and Sharon Schultz presented the proposal for the Behavioral Health Unit Nurse Practitioner Agreement. The responsibilities of the nurse practitioner would include assessment, evaluation and treatment of mental health	**MOTION** **Director Kellett moved, Dr. Corona seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Kristin Preiser, NP to provide coverage for a term of 10 months,**	Joy Melhado / Sharon Schultz

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	patients, 5150 Holds and consultation. Discussion ensued.	**beginning September 3, 2015 and ending June 30, 2016. Not to exceed an average of 40 hours per month, at an hourly rate of $ 60.00, for an annual cost of approximately $24,000, and a total cost for the term of approximately $ 24,000.**	
h. Financials	Steve Dietlin presented the financials ending August 31, 2015 (dollars in thousands) **Fiscal Year to Date** Operating Revenue $ 56,242 Operating Expense $ 55,521 EROE $ 1,474 EBITDA $ 3,863 **TCMC –Key Indicators – FYTD** Avg. Daily Census 184 Adjusted Patient Days 18,663 Surgery Cases (IP) 636 Surgery Cases (OP) 512 Deliveries 429 ED Visits 11,532 **Current Month** Operating Revenue $ 27,829 Operating Expense $ 27,557 EROE $ 1,817 EBITDA $ 612 **Net Patient A/R & Days in Net A/R By Fiscal Year** FY Avg. Net Patient A/R (in millions) $ 41.6 FY Avg. Days in Net A/R 46.2 **Graphs:** • TCMC-Net Days in Patient		Steve Dietlin

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	Accounts Receivable • TCMC-Average Daily Census-Total Hospital-Excluding Newborns • TCMC-Adjusted Patient Days • TCMC-Emergency Department Visits • TCHD-EROE and EBITDA		
i. Work Plan – Information Only • Meaningful Use (semi-annual)	Director Dagostino reported that these agenda items were for review only, but Committee members were welcome to ask questions. Dan Martinez gave a brief PowerPoint presentation, on the anticipated challenges of integrating ICD-10 and Meaningful Use. Regarding ICD-10, he explained that numerous systems have required updating and testing, as well as modifying existing reports. Cerner has conveyed they plan to be available 24/7, for support. For Meaningful Use it was emphasized that there are risks, challenged by meeting the newer criteria for Meaningful Use. Cerner conveyed they plan to have a Meaningful Use consultant on-site at TCMC.		Dan Martinez

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
• Dashboard (monthly)	Steve Dietlin briefly reviewed the Dashboard financials.		Steve Dietlin
j. Update / Progress Report • Vivify / Airstrip / Sotera / CureMetrix	Dr. Scott Worman, Kapua Conley, Dan Martinez, and Scott Livingstone collectively gave a brief PowerPoint presentation, updating the committee on the system integration, data aggregation, and the overall impact these systems are having on patient care. Dan Martinez also shared that there have been some challenges with the wireless connectivity infrastructure. Dr. Worman disclosed that he possesses such confidence in CureMetrix, that he has become an investor in the company.		Scott Worman, M.D / Kapua Conley / Dan Martinez / Scott Livingstone
7. Comments by Committee Members		None	Chair
8. Date of next meeting	October 20, 2015		Chair
9. Community Openings (none)			
10. Oral Announcement of items to be discussed during closed session (Government Code Section 54957.7)			Jody Root

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
11. Motion to go into Closed Session		**MOTION** **Director Kellett moved, Dr. Corona seconded, and it was unanimously approved to go into Closed Session at 2:18 pm**	
16. Open Session		**MOTION** **Director Kellett moved, Mr. Keane seconded, and it was unanimously approved to go into Open Session at 2:23 pm**	
17. Report from Chairperson of any action taken in Closed Session (Authority: Government code, section 54957.1)	No report made.		
18. Adjournment	Meeting adjourned 2:24 pm		

AMENDED

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: SEPTEMBER 15, 2015
ABC-10 / KGTV - Television Advertising Proposal

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

Vendor Name: ABC-10 / KGTV – Television Advertising

Area of Service: Marketing

Term of Agreement: 12 months, Beginning, July 1, 2015 – Ending, June 30, 2016

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost	Cost Difference from Previous FY
$12,508	$150,100	$150,100	$ 0

Description of Services/Supplies:

- Televised Advertising on ABC-10 / KGTV in Pre-Approved Targeted Market Spots

Document Submitted to Legal:	X	Yes		No		Not Applicable
Approved by Chief Compliance Officer:	X	Yes		No		Not Applicable
Is Agreement a Regulatory Requirement:		Yes		No	X	Not Applicable

Person responsible for oversight of agreement: David Bennett, Sr. VP, CMO

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with ABC-10 / KGTV for a monthly cost of $12,508 for a term of 12 months, beginning July 1, 2015 and ending June 30, 2016 for an annual/term cost of $150,100.

AMENDED

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: SEPTEMBER 15, 2015
San Diego Business Journal Print Advertising Proposal

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

Vendor Name: San Diego Business Journal

Area of Service: Marketing

Term of Agreement: 12 months, Beginning, July 1, 2015 – Ending, June 30, 2016

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost	Cost Difference from Previous FY
$ 8,333	$ 100,000	$ 100,000	($ 20,000)

Description of Services/Supplies:

- Print advertising in the San Diego Business Journal

Document Submitted to Legal:	X	Yes		No		Not Applicable
Approved by Chief Compliance Officer:	X	Yes		No		Not Applicable
Is Agreement a Regulatory Requirement:		Yes		No	X	Not Applicable

Person responsible for oversight of agreement: David Bennett, Sr. VP / CMO

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with the San Diego Business Journal for a monthly cost of $8,333 for a term of 12 months, beginning July 1, 2015 and ending June 30, 2016, for an annual/term cost of $100,000.

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: 11/02 **SUBJECT:** CONTRACT REVIEW

REVISION DATE: 05/03; 04/06; 01/11; 07/11; 04/12 **POLICY NUMBER:** 8610-278

Administrative Policies & Procedures Committee Approval:	~~06/11~~-05/15
Finance & Operations Committee Approval:	07/11
Board of Directors Approval:	07/11

A. **PURPOSE:**

To ensure all agreements executed by or on behalf of Tri-City Healthcare District or its operating units ("TCHD") have received appropriate administrative review and approval, are legally sufficient, minimize risk to TCHD and comply with legal, accreditation and TCHD requirements.

B. **POLICY:**

1. **General Policy**. Agreements between TCHD and other parties must be in writing, submitted by the contract requestor for appropriate administrative and/or legal review and approval and signed by the CEO or his/her authorized designee as set forth in Administrative Policy #8610-232, Signature Authority.
2. **Competitive Bidding. ~~TCHD~~ and Other Procurement Procedures. TCHD has adopted policies and procedures, ~~as a public entity, is subject to~~ including** competitive bidding **~~requirements for certain types of transactions and agreements~~regulations, governing the purchase of materials, supplies, equipment, services including professional services and public works, as set forth in Board Policy #10-013.** Contract requestors must comply with TCHD **procurement policies and procedures, including** competitive bidding requirements when applicable, as set forth in Board Policy ~~#07-013~~**10-013**.
3. **Fair Market Value.** Compensation under an agreement, and any changes in compensation, shall compensate the contractor for the services under the agreement for the reasonable fair market value of such services.
4. **TCHD Standard Form Agreements. A contractor must utilize TCHD standard form agreements when possible. The list of TCHD standard form agreements is attached as Exhibit A, and such lists may be amended periodically by the Contract Manager. The ~~and~~ TCHD standard agreements may not be altered, modified, changes or amended, unless the proposed changes are approved by the Contract Manager or the Contract Manager's designee (i.e. Board counsel, or other outside legal counsel retained by TCHD.)**
5. **Legal Review**. Review and approval by TCHD's **legal counsel** ("Legal ~~Affairs~~ **Counsel"**) is required for some agreements, based on agreement type and dollar amount as set forth below.
6. **Agreements with Physicians**. All agreements between TCHD and a referring physician (and/or physician's immediate family members) require review and approval by Legal ~~Affairs~~ **Counsel** to ensure compliance with the federal Stark and Anti-kickback statutes and similar California laws **unless conforming fully to an approved form agreement.** Agreements with physicians also must be approved or ratified ~~by the Board~~**as provided in Administrative Policy #8610-232, Signature Authority.**
7. **Independent Contractor and Consulting Services Agreements**. All consulting services agreements must be approved by the CEO and comply with IRS guidelines with respect to the status of independent contractors. **All Consulting Services Agreements shall be reviewed in accordance with ~~B.7, B.8 and~~ B.9, B.10 and B.11 of this policy, whichever is applicable depending on the dollar amount of the expenditure.**

~~**Compliance with Policy.** It is the responsibility of the TCHD manager, director or other executive or~~

~~employee requesting a contract to ensure compliance with the contract approval process, and to ensure that a fully executed agreement is obtained prior to initiating any contracted service or payment for such service.~~

~~**TCHD Standard Form Agreements:** A contractor must utilize TCHD standard form agreements when possible. The list TCHD standard form agreements is attachment as Exhibit A, and may be amended periodically by Legal Affairs and may not be altered, modified, changes or amended, unless the proposed changes are approved by Legal Affairs or its designee (i.e. Board counsel, or outside legal counsel retained by Legal Affairs.)~~

8. **Materials, Supply and Equipment** - All requests to purchase or lease materials, items, equipment and supplies must be submitted by the contract requestor to Supply Chain Management. Supply Chain Management may use form agreements, or the vendor's terms and conditions, if they terms comply with the Contract ~~Checklist Guidelines developed by Legal Affairs~~**Legal Term** ~~**Checklist attached as Exhibit C to the TCHD Handbook for Contracting ("Contract Checklist").**~~ Supply Chain Management will submit all equipment lease requests to Finance to ensure appropriate accounting treatment of capital and/or operating leases. **All materials, supplies and equipment agreements shall be reviewed in accordance with ~~B.7, B.8 and~~ B.9, B.10 and B.11 of this policy, whichever is applicable depending on the dollar amount of the expenditure.**

9. **Real Property Agreements**-All requests to enter Real Property Agreements, whether via lease, acquisition, broker, or otherwise, must be submitted to ~~Legal Affairs or its designee~~**the Contract Manager. The Contract Manager shall then forward the request to Legal Counsel for review and approval. All Real Property Agreements, regardless of the amount of the expenditure, shall be reviewed and approved by Legal Counsel**. The contract requestor also must submit the proposal to Finance to ensure appropriate accounting treatment of capital and/or operating leases.

10. ~~**Agreements for less the $25,000 not within the above categories**: The responsible TCHD Director, Vice President, or C-Level Executive (CEO, COO, CFO, CCO, CHR, CNE)~~ **involving expenditures less than $25,0001. Unless otherwise expressly provided in this policy, the responsible C-Level Executive, as set forth in Administrative Policy #8610-232 Signature Authority,** may approve the language in non-standard agreements without review by Legal ~~Affairs~~Counsel, so long as the material terms comply with the ~~Legal Affairs~~ Contract Check-List ~~Guidelines~~, ~~ad~~ as may be amended from time-to-time by Legal ~~Affairs~~Counsel.

11. **Agreements involving expenditures between $25,001 and $100,000 ~~not within the above categories~~**: ~~The~~. Unless otherwise expressly provided in this policy, the Contracts Manager ~~and Paralegal~~ may approve the language in non-standard agreements and/or modifications to TCHD standard form agreements that comply with ~~Legal Affairs contract~~ **the Contract** Check-List ~~Guidelines~~ or other contracting guidelines developed by Legal ~~Affairs~~**Counsel**.

~~**Contract Management System Compliance**. All duly approved and fully executed contracts must be scanned by the contract requestor into Meditract, TCHD's contract management system. TCHD will not make payment on any contract unless and until Finance/Accounts Payable confirm that a fully executed contract has been scanned into Meditract.~~

12. Agreements involving an expenditure in excess of $100,000. Unless otherwise expressly provided in this policy, all agreements involving an expenditure in excess of $100,000 shall be reviewed and approved by Legal Counsel.

C. **PROCEDURE:**

1. ~~**Procedures Applicable to all Agreements: The contract formation and review process should follow the guidelines as**~~ **Contract Review and Approval**. **The contract review and approval process shall comply with this policy, Board Policy #~~10~~-013 ~~and the guidelines set forth in the TCHD Contract Procedure Handbook; see the intranet for handbook~~**.

2. **Procedure for Legal Review. If legal review is required, the contract requestor shall submit a request for legal review to TCHD's Contract Manager. The Contract Manager will then forward the request to Legal Counsel.**

3. **Contract Execution**. The contract requestor is responsible for obtaining all appropriate

signatures for approved contracts in accordance with Administrative Policy #8610-232 Signature Authority.

4. **Electronic Signatures.** Contracts may be accepted in electronic form (e.g., by scanned copy of a signed document, or with an electronic or digital signature) provided that:
   a. A copy of the signature is on file with the Contract Manager so that it can be determined the person to which electronic signature is attributable and
   b. The contract includes a provision pursuant to which the parties agree that
      i. An electronic signature by either party shall be deemed binding on that party.
      ii. The parties will not contest the validity or enforceability of the contract, including under any applicable stature of frauds, because it was accepted or signed in electronic form, and
      iii. The parties will not contest the validity or enforceability of a signed facsimile copy of the contact on the basis that it lacks original handwritten signature.

5. **Contract Management System Compliance. All duly approved and fully executed contracts must be scanned into TCHD's contract management system, as soon as reasonably practicable following the execution of the contract, as failure to do so may result in delays in the payment process. The contract requestor shall be responsible to confirm with the Contract Manager that the executed contract has been scanned into TCHD's contract management system.**

6. **Approval of Invoices. The contract requestor and/or a TCHD-authorized approver will also be responsible for approving any invoices as valid and consistent with the approved contract before Accounts Payable can pay the invoice.**

7. **Monitoring Contract Renewal and Termination. The contract requestor for each contract as noted in TCHD's contract management system shall monitor timelines for the renewals and/or terminations of their contracts, and shall notify the Contract Manager when any change in contract terms are required.**

D. **PROHIBITED CONFLICTS OF INTEREST. Any practices which might result in unlawful activity including, but not limited to, rebates, kickbacks, or other unlawful consideration are prohibited. No employee may participate in the contract process, including but not limited to the bid or other procurement process, contractor selection, negotiation, review or approval of a contract, when the employee has a relationship with a person or business entity seeking the contract that requires disqualification of the employee under the Political Reform Act or other provisions of law.**

E. **COMPLIANCE WITH POLICY. It is the responsibility of the TCHD manager, director or other executive or employee requesting a contract to ensure compliance with Board Policy #10-013, the contract approval process as stated in this policy and the TCHD Handbook for Contracting, and to ensure that a fully executed agreement is obtained prior to initiating any contracted service or payment for such service.**

~~terms prior~~

~~Legal will review the final draft, acquire CEO signature and enter into Contract~~

F. **~~FORM REFERENCED WHICH IS~~ DOCUMENTS REFERENCED IN THIS POLICY AND LOCATED ON THE TCHD INTRANET:**

1. Contract Request Form (CRF) – for contracts greater than $25,000
2. Contract Legal Terms Checklist – for contracts less than $25,0010
3. ~~Contract Procedure **TCHD** Handbook **for Contracting**~~

EXHIBIT A

Standard Form Agreements

The following is a list of types of Standard Form Agreements available from ~~Legal Affairs~~the Contract Manager:

~~a. Independent Contractor/Consulting Services Co-Management Agreement[Non-Physician]~~
a. Clinical Trial Agreements (device and drug)
b. Co-Management Agreement
~~b.~~ c. Confidentiality ~~Physician Consulting Services~~ Agreement
~~Medical Director Agreement~~
~~Physician Recruitment Agreement and associated forms.~~
~~On-Call and Coverage Agreements for Clinical Services~~
~~Educational affiliation agreements~~
~~Transfer agreements~~
~~Purchase Order Terms and Conditions~~

~~c.~~ d. Education Affiliation Agreements
~~d.~~ e. ~~GPO~~ Group Purchasing Organization ("GPO") Agreements are deemed to comply with TCHD requirements when reviewed and completed by the Director of Supply Chain Management in compliance with ~~Legal Affairs~~ Contract Check ~~L~~list ~~Guidelines~~
~~e.~~ f. Independent Contractor/Consulting Services Agreement [Non-Physician]
~~f.~~ g. Joint Marketing Agreements
~~g.~~ h. HIPAA Business Associate ~~Agreements~~Agreement and Addendum
~~h.~~ i. Hospice Services Agreement
~~i. Medical Director Agreement~~
j. Medical Office Lease and Sublease
~~k. Medical Staff Leadership Agreement~~
~~l. On-Call Coverage Agreement and Guidelines~~
~~j.~~ k. Patient Transfer Agreement
l. Physician ~~Consulting Services~~ Agreements
i. Medical Director Agreement
ii. Medical Staff Leadership Agreement
iii. On-Call Coverage Agreement and Guidelines
iv. Physician Consulting Services Agreement
~~n.~~
~~o.~~v. Physician Recruitment Agreement and associated forms.
~~k.~~ m. Professional Services Agreement [Non-Physician]
~~l.~~ n. Purchase Order Terms and Conditions
~~m.~~ o. Registry Agreement
~~n.~~ p. Request for Bids and associated forms for public works projects
~~o.~~ q. Secured Promissory Note
~~p.~~ r. Security Agreement
~~q.~~ s. Travel Agency Agreement

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: SEPTEMBER 15, 2015
Rady Children's Hospital Agreement Proposal

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

Vendor Name: Rady Children's Hospital San Diego

Area of Service/Dept: Women's and Newborn Services

Term of Agreement: 12 months, Beginning, September 1, 2015 – Ending, August 31, 2016

Maximum Monthly Total:

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 month (Term) Cost
$175	8 hrs.	96	$1,400	$16,800	$16,800

Description of Services/Supplies:

- Provide information regarding state guidelines for Newborn Screening testing and Program Certification
- Training for staff as requested
- Newborn Hearing Screening Policy/Procedure Review
- Information/Education as needed for referrals for additional testing, including Brainstem Evoked Response, Otoacoustic Emission, Tympanometry
- Email/telephone/onsite support as requested
- Not to exceed 8 hours per month

Document Submitted to Legal:	X	Yes		No		Not Applicable
Approved Chief Compliance Officer:	X	Yes		No		Not Applicable
Is Agreement a Regulatory Requirement:	X	Yes		No		Not Applicable

Person responsible for oversight of agreement: Mary Diamond, R.N., Sharon Schultz, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the Agreement with Rady Children's Hospital for a term of 12 months, beginning September 1, 2015 and ending on August 31, 2016 at $175 per hour, not to exceed 8 hours per month, for a monthly amount of $1,400 and a total expense for the Term of $16,800.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 15, 2015
Neurology Physician On-Call Coverage Agreement

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

Physicians Name: The Neurology Center of Southern California (Andrew Blumenfeld, M.D.; Bilal Choudry, M.D.; Laura DeSadier, M.D.; Benjamin Frishberg, M.D.; Michael Lobatz, M.D.; Amy Nielsen, D.O.; Irene Oh, M.D.; Remia Paduga, M.D.; Jay Rosenberg, M.D.; Mark Sadoff, M.D.; Gregory Sahagian, M.D.; Jack Schim, M.D.; Leslie Aguilar Tabora, M.D. ; Anchi Wang, M.D.; Chunyang Wang, M.D.; Michael Zupancic, M.D.)

Area of Service: Emergency Department On-Call: Neurology

Term of Agreement: 12 months, Beginning, July 1, 2015 – Ending, June 30, 2016

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

Rate/Day	Days per Year	Annual Cost	12 Month Term Cost
$740	366	$270,840	$270,840

Position Responsibilities:

- Provide 24/7 patient coverage for all neurology specialty services in accordance with Medical Staff Policy #8710-520 (Emergency Room Call: Duties of the On-Call Physician)
- Complete related medical records in accordance with all Medical Staff, accreditation, and regulatory requirements.
- The previous contract for Neurology ED Call was $500 per day, a difference of $87,840 for the period beginning July 1, 2015 and, ending June 30, 2016.

Board Approved Physician Contract Template:	X	Yes		No		Not Applicable
Approved by Chief Compliance Officer:	X	Yes		No		Not Applicable
Is Agreement a Regulatory Requirement:	X	Yes		No		Not Applicable

Person responsible for oversight of agreement: Kapua Conley, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the above-mentioned physicians of The Neurology Center of Southern California as the Coverage Physicians for a term of 12 months beginning July 1, 2015 and ending June 30, 2016, at a daily rate of $740, for an annual cost of $270,840 and a total cost for the term of $270,840.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 15, 2015
PHYSICIAN AGREEMENT for Plastic Surgery Coverage - Inpatient

Type of Agreement		Medical Directors		Panel	X	Other: Plastic Surgery Coverage - Inpatient
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Physician's Name: Anshu Gupta, M.D.

Area of Service: Hospital Inpatient Units

Term of Agreement: 24 months, Beginning, October 01, 2015 – Ending, September 30, 2017

Maximum Totals: Will be reflected in projected annual cost savings based on decreased protracted hospital stays at Tri-City Medical Center, and/or transfers to UCSD of our patients requiring Plastic Surgery Service that is currently unavailable.

Within Hourly and/or Annualized Fair Market Value: YES

Rate/Case (Patient)	Potential Savings per Case (Patient)	Potential Savings per Year	Estimated per patient Cost	Estimated Annual Cost	24 month (Term) Cost
125% Medicare Rates	$80,382.60	$886,591.20	$6,500	$78,000	$156,000

Position Responsibilities:

- On a case-case-basis, Physician to provide Plastic Surgery Services (Consultative and Procedural) for registered TCMC Hospital patients (both inpatient & observation patients)
- MD to provide TCMC with detailed EOB to include procedure codes
- An average of one case per month or 12 cases annually, at a per case rate of 125% of Medicare Rate for an estimated annual cost of $78,000 per year. Potential Saving of $886K annually, (UCSD currently charges TCMC 100% of total charges)

Board Approved Physician Contract Template:	X	Yes		No		Not Applicable
Approved by Chief Compliance Officer:	X	Yes		No		Not Applicable
Is Agreement a Regulatory Requirement:	X	Yes		No		Not Applicable

Person responsible for oversight of agreement: Kirkpatrick (Kapua) Conley, COO

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Anshu Gupta, M.D. as the Plastics Coverage Physician for a term of 24 months beginning October 01, 2015 and ending September 30, 2017.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 15, 2015
Wellness Center MOB Lease Agreement Proposal

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

Physician's Name: Well Being Medical Clinic, Inc.
(Yoo Jin Chong, M.D., and Maribeth Chong, M.D. – personal guarantors)

Term: Five Year Lease (March 1, 2016 through February 28, 2021)
3% Year Rent Escalator
Option for an additional 5-year extension

Premises: 6260 El Camino Real, Suite 105, Carlsbad, CA 92009 (2,716 sq. ft.)
District will replace carpet and perform minimal paint touch up; there will be no additional Tenant Improvements

Rental Rate: $7,469 per month ($2.75 NNN per square foot)

Within Fair Market Value: YES (FMV was determined by Lease Comparables)

Document Submitted to Legal:	X	Yes		No		Not Applicable
Approved by Chief Compliance Officer:	X	Yes		No		Not Applicable
Is Agreement a Regulatory Requirement:		Yes		No	X	Not Applicable

Person responsible for oversight of agreement: Wayne Knight, Sr. Vice President, Medical Services

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the Lease Agreement for Suite 105 in the Wellness Center MOB located at 6260 El Camino Real, Carlsbad, CA 92009, with Well Being Medical Clinic, Inc., for a five-year term (March 1, 2016 through February 28, 2021), at the rate of $7,469 per month for the first year, increasing 3% yearly thereafter.

AMENDED

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 15, 2015
Federal Heath Sign Company Proposal

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

Vendor Name: Federal Heath Sign Company

Area of Service: Marketing

Term of Agreement: One time construction project; Start and Completion Dates, TBD.

Maximum Totals:

Cost Not to Exceed:
$380,000

Description of Services/Supplies:

- Electronic Digital Media Display Pylon Sign
- 41.8' Proposed Height
- Digital Display Sign Will Be 10' Wide x 18' High
- Electronically Display Messaging Content
- TCMC Will Own Pylon Sign
- Once operational, will offset traditional billboard signage fees

Document Submitted to Legal:		Yes	X	No		Not Applicable
Approved by Chief Compliance Officer:	X	Yes		No		Not Applicable
Is Agreement a Regulatory Requirement:		Yes	X	No		Not Applicable

Person responsible for oversight of agreement: David Bennett, Sr. VP/CMO

Motion:

I move that the Finance Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Federal Heath Sign Company for the construction of an Electronic Digital Media Display Pylon Sign for a total cost not to exceed $380,000, contingent upon final approval by the City of Oceanside.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 15, 2015
Nurse Practitioner Agreement - Behavior Health Unit

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

Nurse Practitioner's Name: Kristin Preiser, Nurse Practitioner

Area of Service: Behavioral Health Unit

Term of Agreement: For 10 months: Beginning, September 3, 2015 - Ending, June 30, 2016

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

Rate/Hour	Average Hours per Month	Hours per Year	Monthly Cost	Annual Cost	10 month (Term) Cost
$ 60	Approximately 40	Approximately 400	$ 2,400	$ 24,000	Approximately $ 24,000

Position Responsibilities:

- Assessment, evaluation and treatment of mental health patients
- 5150 Holds
- Consultations

Board Approved Physician Contract Template:	X	Yes		No		Not Applicable
Approved by Chief Compliance Officer:	X	Yes		No		Not Applicable
Is Agreement a Regulatory Requirement:	X	Yes		No		Not Applicable

Person responsible for oversight of agreement: Joy Melhado, Manager / Sharon Schultz CNE

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Kristin Preiser, NP to provide coverage for a term of 10 months, beginning September 3, 2015 and ending June 30, 2016. Not to exceed an average of 40 hours per month, at an hourly rate of $ 60.00, for an annual cost of approximately $24,000, and a total cost for the term of approximately $ 24,000.

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
September 17, 2015

Members Present: Director Laura Mitchell (Acting Chair), Director Ramona Finnila, Dr. Gene Ma, Dr. Scott Worman and Dr. Marcus Contardo.

Non-Voting Members Present: Tim Moran, CEO, Kapua Conley, COO/ Exec. VP and Sharon Schultz, CNE/Sr. VP.

Others present: Jody Root, General Counsel, Marcia Cavanaugh, Director of Quality and Security and Risk Management, Chris Miechowski, Kerry Moriarty-Homsy, Nancy Myers, Andrea Hanson, Priya Joshi, Michael Parent, Kevin McQueen, Sharon Davies, Sherry Miller and Karren Hertz.

Members absent: Board Chair Director Dagostino, Dr. James Johnson, Cheryle Bernard-Shaw, Chief Compliance Officer, Jami Piearson, Director of Quality and Regulatory.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Mitchell, who is filling in for Chair Dagostino, called the meeting to order at 12:05 p.m. in Assembly Room 1.		Director Mitchell
2. Approval of Agenda	The group reviewed the agenda and there were no additions or modifications.	Motion to approve the agenda was made by Director Finnila and seconded by Dr. Worman.	Director Mitchell
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Mitchell read the paragraph regarding comments from members of the public.		Director Mitchell

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Ratification of minutes of August 2015.	Director Mitchell called for a motion to approve the minutes of the August 20, 2015.	Minutes ratified. Director Finnila moved and Dr. Contardo seconded the motion to approve the minutes from August.	Karren Hertz
5. New Business a. Quality Outcomes Dashboard	The committee reviewed the dashboard for Core Measures data. As previously requested by the Board members, the line graphs were used for this month showing the upper and lower control limit of each indicator. It was identified that the flu season for the hospital starts in October.	Informational.	Sharon Schultz
Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures:** **<u>Unit Specific</u>** **Engineering Department** 1. Interim Life Safety Program	The section on smoking not prohibited in campus needs to include parking lot and construction areas. The Interim Life Safety assessment tool also needs to include alternate routes with signage if deemed necessary.	**ACTION:** The Engineering Department unit-specific policies and procedures were approved with the exception of some minor edits. Director Finnila moved and Dr. Contardo seconded the motion to approve these policies.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
2. System Failure Report	Tri-City Medical Center should be replaced with Tri-City Healthcare District.		
Infection Control			
1. Cleaning, Disinfection and Sterilization	Dr. Contardo added that heightened education and awareness should be exercised by the staff as we have recent challenges with resistant bacteria resulting for HAI. Sterilization of scopes was briefly discussed. Director Mitchell asked for more recent references.	**ACTION:** The unit-specific policies and procedures for Infection Control were approved as moved by Dr. Worman and seconded by Dr. Contardo.	Patricia Guerra
2. Philosophy- IC 1	No discussion on this policy.		
3. Standard and Transmission- Based Precautions- IC 5	Director Finnila asked for clarification if the Lift team staff is aware of the isolation precautions for patients. Sharon mentioned that they undergo the same training that staff does so they are aware of what they need to do in ceratin cases.		
NICU			
1. Criteria for Case Referrals to Morbidity and Mortality (M&M) Meetings	Director Mitchell asked for the addition of the word "respiratory" on the description of neonatal depression.	**ACTION:** The unit-specific policies and procedures for NICU were approved with the exception of some minor edits. Dr. Contardo moved and Dr. Worman seconded the motion to approve these policies.	Patricia Guerra
2. Lumbar Puncture , Assisting with	Policy deletion.		
3. Nasojejunal Transpyloric (NJ) Tube Insertion, Maintenance, and Removal of	LIP clarification was made on this policy.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Urinary Catheter, Insertion and Removal of	Policy deletion.		
Pharmacy			
1. Automatic Dose Rounding	Andrea Hanson clarified further the process of automatic dose rounding on some drugs.	**ACTION:** The Pharmacy unit-specific policies and procedures with the exception of the policy on pharmaceutical vendors were approved as moved by Dr. Worman and seconded by Director Finnila.	Patricia Guerra
2. Decreasing Medication Errors	The policy number for medication event reporting was requested to be added to this policy as mentioned in the second page.		
3. Drug Compounding for Medication Not Commercially Available	Dr. Contardo had asked for clarification on drug compounding. It was noted that the hospital has no license to compound non-sterile drugs. An accredited outside company does it and they adhere to the hospital's safety standards.		
4. Medication Dispensing/ Distribution	No discussion on this policy.		
5. Drug Product Procurement and Inventory Management	No discussion on this policy.		
6. Labeling Standards	No discussion on this policy.		
7. Medication Management Program	No discussion on this policy.		
8. Pharmaceutical Vendors	The issue of pharmaceutical vendors was discussed; all kinds of gifts regardless of value is prohibited. However, this might be duplicated in the AP & P Manual.	**ACTION:** This policy is being pulled out as it needs to be compared to the Board Policy for possible duplication and further	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
9. Receiving and Tracking Narcotic Pump Refills Prepared by Outside Vendors	No discussion on this policy.	clarification.	
10. Unit Dose Distribution System	No discussion on this policy.		
Pulmonary			
1. Incentive Spirometry Instruct and Follow-Up	Policy deletion.	**ACTION:** The unit-specific policy and procedure for Pulmonary Department was approved to be deleted. Director Finnila approved and Dr. Worman seconded.	Patricia Guerra
Rehabilitation Services			
1. Discipline-Specific Staff Meetings – 201	No discussion on this policy.	**ACTION: T**he unit-specific policies and procedures for Rehab Services were approved with the exception of some minor edits. Dr. Worman moved and Director Finnila seconded the motion to approve these policies.	Patricia Guerra
2. Maintaining Current Licenses, Registrations and Certifications- 301	No discussion on this policy.		
3. Mission Statement, Goals and Objectives- 100	The word TCMC was requested to be changed to TCHD on this policy.		
4. Physical Plant- 105	This policy only reflects the address change for the physical plant.		
5. Productivity Reporting System- 203	No discussion on this policy.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
6. Registry/ Contract Therapy Services- 107	This policy might have some similarities with the staffing policy.	**ACTION:** This policy is being pulled so that it can be compared with the registry services information in the staffing policy.	Patricia Guerra
7. Staff Rotations- 615	No discussion on this policy.		
8. Statement of Accountability- 102	This policy embodies the leadership structure that is contained in the hospital's organizational chart.		
Security Manual			
Section 2- Security Operation			
1. Aero Medical Transport Responsibilities- 223	A clarification was made on the person (Security Officer) who will shut down the air handlers once helicopter is onsite. Discussion also centered on which site near the hospital can be considered once an emergency landing is needed.	**ACTION:** The unit specific policies for Security Operations were approved and are going forward for Board approval as moved by Dr. Contardo and seconded by Director Finnila.	Patricia Guerra
2. BHS STAT Response- 215	It was clarified on what constitutes a BHS Stat response as indicated in this policy.		
3. Computer Usage Policy- 228	This policy needs to be checked for duplication with the AP&P policy.	**ACTION**: This policy is being pulled out so that it can be compared side by side with the computer usage policy in the AP&P.	Patricia Guerra
4. Emergency Department Patient Parking- 225	A minor editorial change was made on the purpose of this policy. Also, the Women's Resource Center is now known as Women's Center.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
5. Exterior Door Security- 222	No discussion on this policy.		
6. Forensic Services- 218	The distinction between law enforcement officer and correctional was noted. Local peace officer is now known as law enforcement officer and custodial officer is currently called correctional officer.	**ACTION**: This policy needs to be pulled out as most of the terms concerning law enforcement and custodial need to be changed accordingly.	Patricia Guerra
7. Lost and Found Procedure for Security Department – 230	No discussion on this policy.		
8. Media Relations – 229	No discussion on this policy.		
9. Patient Valuables Collection and Return- 237	No discussion on this policy.		
10. Patrol of Areas Under Construction- 226	No discussion on this policy.		
11. Property Custody- 232	No discussion on this policy.		
12. Psychiatric Patient Escorts – 216	This policy is intended for psychiatric patients who are attempting to elope the facility.		
13. Safety and Security Incident Investigation- 233	Marcia Cavanaugh emphasized that the Security Dept. staff do not put in reports in the RL system but they do have their own reporting system.		
14. Security Alarm Systems Response- 220	It was specified that the grid in this policy reflects the number of alarms per location.		
15. Security Department VIP	Director Finnila clarified who is considered a		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Policy- 235	VIP; it was noted that the Foundation identifies if a donor/ VIP request a visit from the Administration.		
16. Security Incident Notification- 208	No discussion on this policy.		
17. Security Officer Documentation- 238	Marcia reiterated that if necessary, the report from the Security Dept. gets attached to the RL if further information is need in certain cases.		
18. Security Panic Alarm System Response- 221	This policy is similar to the Security Alarm Systems Response policy.		
19. Seized Contraband or Evidence- 231	There was a discussion on the chain of custody form that needs to be enforced for seized contraband.	**ACTION:** This policy is being pulled as the hospital needs to develop a chain of custody procedure when it comes to seized contraband.	Patricia Guerra
20. Solicitation and Union Activity on Medical Center Campus- 236	It was identified that the union activity needs to have HR's permission while solicitors go to the Materials Mgt. Dept. for permission. This needs to be separated out for clarification purposes.	**ACTION:** This policy needs to be separated out---one goes to HRC and the other one goes to AP&P for review and approval.	Patricia Guerra
21. Vehicle Jumpstart- 234	The term mobile patrols should be added to this policy as Security staff cannot leave their designated assignment to do a vehicle jumpstart.		
Section 3- Security Personnel			

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Departmental Personnel Issues – 307	No discussion on this policy.	**ACTION:** The Security Personnel policies were approved and are going forward for Board approval as moved by Director Finnila and seconded by Dr. Ma.	Patricia Guerra
2. Hair and Grooming Standards for Security Officers- 302	No discussion on this policy.		
3. New Officer Training- 301	Director Finnila clarified that the new Security officers also get a manual for training purposes.		
4. Outside Employment- 306	No discussion on this policy.		
5. Payroll Timecard- 305	The term 'Genie" will be taken out on the procedure part of this policy.		
6. Scheduled Time Off- 303	No discussion on this policy.		
7. Unplanned Time Off (Unscheduled Absence/ Tardy)	Kevin McQueen differentiated that hospital staff should have two hours to call in while the Security Dept. staff gets three hours.		
Section 4- Security Equipment			
1. Authorized Security Department Uniforms & Safety Equipment- 401	No discussion on this policy.	**ACTION:** The Security Equipment policies were approved and are going forward for Board approval as moved by Dr. Contardo and seconded by Director Finnila.	Patricia Guerra
2. Chemical Agent- 402	It was noted that the Security staff do not use pepper spray any longer.		
3. Security Department Key Rings and Department Key Control – 406	No discussion on this policy.		
4. Security vehicles- 405	Security staff currently uses golf carts		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	around the hospital.		
5. Use of Handcuffs- 403	No discussion on this policy.		
6. Use of Impact Weapon/ Tactical Baton- 404	No discussion on this policy.		
7. Use of recording device- 408	No discussion on this policy.		
Section 5- Security Safety			
1. After Action Incident Review and Debriefing- 511	No discussion on this policy.	**ACTION:** The Security Safety policies were approved with the exception of the policy on patient specific information and are going forward for Board approval as moved by Dr. Contardo and seconded by Director Finnila	Patricia Guerra
2. Conflict Resolution- 510	No discussion on this policy.		
3. Disposal of Drugs or Drug Paraphernalia- 506	It was stated that confiscated drugs or paraphernalia is not given to the Police Dept. not unless a patient gets admitted.		
4. High Risk Patient or Visitor- 509	No discussion made on this policy.		
5. Personal Safety escort for Visitors and Staff- 514	No discussion made on this policy.		
6. Security Sensitive Areas- 502	Closed patient areas need to be added on the list of security sensitive areas for this policy.		
Section 8- Emergency Preparedness			
1. Disaster Manual- 802	No discussion on this policy.	**ACTION:** The Security Preparedness policies were	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
2. Disaster Plan for the Security department- 801	No discussion on this policy. No discussion on this policy.	approved and are going forward for Board approval as moved by Dr. Ma and seconded by Dr. Worman.	
3. Emergency Situation Officer Recall- 803	The word "response" should be added to the title of this policy.		
4. Medical center Power Outage- 804	Director Mitchell asked for a clarification on the term "unfavorable cervix".		
Women and Newborn Services			
1. Balloon Cervical Ripening Catheter	The JCAHO term should be taken out and replaced with Joint Commission.	**ACTION:** The unit specific policies for WNS were approved and are going forward for Board approval as moved by Director Finnila and seconded by Dr. Ma.	Patricia Guerra
2. Breast Milk Misadministration	There was a brief discussion on the breast milk storage (freezer or refrigerator) and also, clarification was made on the milk given to infants as donated by another party.		
3. Breast Milk Pumping, Handling and Storage of	The approving committee of this policy was changed from Governance to PAC. The grid for criteria for peer review was modified and the last page for the policy which states the stipend schedule was taken out.		
Medical Staff 1. Peer Review Process OPPE and FPPE		**ACTION:** This Medical Staff policy was approved with specific information and is going forward for Board approval as moved by Dr. Worman and seconded by Dr. Contardo.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Dr. Contardo moved and Dr. Ma seconded and it was unanimously approved to go into closed session at 1:10 PM.	Director Mitchell
8. Return to Open Session	The Committee return to Open Session at 2:43 PM.		Director Mitchell
9. Reports of the Chairperson of Any Action Taken in Closed Session	There were no actions taken.		Director Mitchell
10. Comments from Members of the Committee	No Comments.		Director Mitchell
11. Adjournment	Meeting adjourned at 2:45 PM		Director Mitchell

TRI-CITY MEDICAL CENTER
PHARMACY AND THERAPEUTICS COMMITTEE

Request for Formulary Status Evaluation:

Admission { X } **Deletion { }**

Date: May 27, 2015

Requestor: Christina Lam, Nurse Practitioner

Trade Name: aripiprazole for prolonged release injectable suspension

Generic Name: Abilify Maintena

Dosage form(s): Vials: 300 mg and 400 mg

Indication:
Maintenance treatment of schizophrenia in stabilized adult patients

Efficacy:
Treatment of schizophrenia
Aripiprazole Once-Monthly for Treatment of Schizophrenia: Double-Blind, Randomized, Non-inferiority Study[3]

38-week, randomized, double-blind, active-controlled trial consisting of three treatment phases: a conversion phase, oral stabilization phase and double-blind, active-controlled phase. 662 patients were randomized (2:2:1) to aripiprazole once-monthly 400 mg, oral aripiprazole (10-30 mg/day) or aripiprazole once-monthly 50 mg.

Kaplan-Meier estimated impending relapse rates at week 26 were 7.12% for aripiprazole once-monthly 400 mg, 7.76% for oral aripiprazole and 21.80% for 50mg once-monthly aripiprazole. Both 400 mg once-monthly aripiprazole and oral aripiprazole were superior to 50mg once-monthly aripiprazole ($P<0.001$). Non-inferiority was confirmed for 400mg once-monthly aripiprazole compared to oral aripiprazole.

Aripiprazole Intramuscular Depot as Maintenance Treatment in Patients with Schizophrenia: A 52-Week, Multicenter, Randomized, Double-Blind, Placebo-Controlled Study[4]

52-week, randomized-withdrawal, double-blind, placebo-controlled trial conducted in adult patients with a current diagnosis of schizophrenia. This trial consisted of a screening phase and 4 treatment phases: open-label, oral conversion phase, open-label, oral aripiprazole stabilization phase, 12-week uncontrolled, single-blind ABILIFY MAINTENA™ stabilization phase and double-blind, placebo-controlled randomized-withdrawal phase to observe for relapse.

710 patients entered stabilization, 576 progressed to IM-depot stabilization and 403 were randomly assigned to double-blind treatment. Time to impending relapse was significantly delayed in aripiprazole IM-depot treatment compared with placebo ($P<0.0001$). The hazard ratio (placebo/aripiprazole IM-depot) at final analysis was 5.03(95% CI, 3.15-8.02). The rate of impending relapse was significantly lower with aripiprazole IM-depot than placebo (10% vs 39.6%). Most common adverse effects were insomnia, tremor and headache.

Aripiprazole Once-Monthly in the Acute Treatment of Schizophrenia: Findings From a 12-Week, Randomized, Double-Blind, Placebo-Controlled Study[5]

12-week, randomized, double-blind, placebo-controlled study with primary efficacy outcome being a change from baseline to endpoint in Positive and Negative Syndrome Scale (PANSS) total score. Secondary outcome was the change from baseline in Clinical Global Impressions-Severity of Illness scale (CGI-S).

340 patients enrolled and randomized to aripiprazole once-monthly and placebo. Least squares mean change form baseline to endpoint favored aripiprazole versus placebo in PANSS total (-15.1, 95%CI -19.4 to -10.8; p<0.0001) and CGI-S (-0.8, 95%CI -1.1 to -0.6; P<0.0001) scores. Common adverse effects were increased weight (16.8% vs. 7.0%), headache (14.4% vs. 16.3 %) and akathesia (11.4% vs 3.5%).

Safety:

Propensity for medication error: moderate; look-alike, sound-alike issues: may be confused with Ambien, Abelcet, and proton pump inhibitors (dexlansoprazole, esomeprazole, pantoprazole); Beers Criteria medication: this medication may be potentially inappropriate for use in geriatric patients; there are two formulations available for IM administration: Abilify is available in an immediate release short-acting formulation and an extended-release formulation. These products are not interchangeable

Abuse potential: low

Sentinel event potential: low

Black box warning: Antidepressants increase the risk of suicidal thinking and behavior in children, adolescents, and young adults (10 to 24 years of age) with major depressive disorder (MDD) and other psychiatric disorders; Elderly patients with dementia-related psychosis treated with antipsychotics are at increased risk of death compared to placebo

Cost comparison with similar Formulary products:
Drug **Cost**

Atypical Anti-Psychotic Long-acting Depot injections	Dosage Form	Dosing Frequency	Initial Cost/Unit	Cost/Month
Abilify Maintena (aripiprazole)	Pre-filled dual chamber syringe kits: 300mg, 400mg Single use vials: 300mg, 400mg	300mg-400mg once monthly	300mg: $865-$1125 400mg: $802-$1500	300mg: $865-$1125 400mg: $802-$1500
Invega Sustenna (paliperidone palmitate)	Pre-filled syringe: 39mg, 78mg, 117mg, 156mg, 234mg	Initial: 234mg on day 1 followed by 156mg 1 week later, then 78mg-234mg dose once monthly	234mg: Inpt: $1100-$1795 + 156mg: Inpt: $733-$1197	Maintenance: 39mg:$189-$300 78mg: $379-$599 117mg: $570-$799 156mg: $733-$1197 234mg: $1100-$1795

Risperidal Consta (risperidone)	kit: 12.5mg, 25mg, 37.5mg, 50mg	Initial: 25mg every 2 weeks, if unresponsive, some may benefit from larger doses (37.5mg to 50mg). A lower initial dose of 12.5mg may be appropriate for some patients	12.5mg: $95-$158 25mg: $200-$316	12.5mg x2: $190-$316 25mg x2: $400-$630 37.5mg x2: $600-$950 50mg x2: $800-$1268
Zyprexa Relprevv (olanzapine pamoate monohydrate)	Kit: 210mg, 300mg, 405mg	Initial: 210mg every 2 weeks for 4 doses or 405mg every 4 weeks for 2 doses or 300mg every 2 weeks for 4 doses	210mg: $453-$590 300mg: $647-$843 405mg: $874-$1137	210mg x2: $906-$1180 300mg: $647-$843 405mg: 874-$1137

Other considerations:

Contraindications[1]:

Geriatrics (>65 years of age) with dementia
Pediatrics (< 18 years of age)
Patients with known hypersensitivity to aripiprazole

Warnings and Precautions[1]:

Boxed Warning: increase mortality in elderly patients with dementia
Cerebrovascular Adverse Reactions in Elderly Patients with Dementia-Related Psychosis: Increased incidence of cerebrovascular adverse reactions (e.g., stroke, transient ischemic attack, including fatalities)
Neuroleptic Malignant Syndrome: Manage with immediate discontinuation and close monitoring
Tardive Dyskinesia: Discontinue if clinically appropriate
M etabolic Changes: Atypical antipsychotic drugs have been associated with metabolic changes that may increase cardiovascular/cerebrovascular risk. These metabolic changes include hyperglycemia, dyslipidemia, and weight gain
Hyperglycemia and Diabetes Mellitus: Monitor patients for symptoms of hyperglycemia including polydipsia, polyuria, polyphagia, and weakness. Monitor glucose regularly in patients with and at risk for diabetes
Dyslipidemia: Undesirable alterations have been observed in patients treated with atypical antipsychotics
Weight Gain: Gain in body weight has been observed; clinical monitoring of weight is recommended
Orthostatic Hypotension: Use with caution in patients with known cardiovascular or cerebrovascular disease
Leukopenia, Neutropenia, and Agranulocytosis: Perform complete blood counts in patients with a history of a clinically significant low white blood cell count (WBC)/absolute neutrophil count (ANC). Consider discontinuation if clinically significant decline in WBC/ANC in the absence of other causative factors
Seizures: Use cautiously in patients with a history of seizures or with conditions that lower the seizure threshold
Potential for Cognitive and Motor Impairment: Use caution when operating machinery

Recommendation:

The initial and usual maintenance dose of aripiprazole is 400 mg once a month. The dose can be reduced to 300 mg or 200 mg monthly based on drug interactions or tolerability. Patients should have established tolerability to aripiprazole before receipt of Abilify Maintena. Oral aripiprazole, 10-30 mg/day, or another oral antipsychotic must be continued for 2-weeks after the initial dose, and then discontinued.

We recommend adding this medication to the TCMC formulary with *restriction to use only by psychiatry clinical service for treatment of schizophrenia in stabilized adult patients* and with requirement that patient's ability to have *OUTPATIENT access to therapy with ABILIFY MAINTENA™ is established*

prior to drug initiation.

Process/Plan to monitor Patient Responses:
No significant monitoring required

References:

1. Otsuka Pharmaceutical Co.,Ltd ABILIFY MAINTENA™ Package Insert. December, 2013
2. Clinical Pharmacology Online http://www.clinicalpharmacology-ip.com/
3. Fleischhacker WW, Sanchez R, Perry PP et al. Aripiprazole once-monthly for the treatment of schizophrenia: a double-blind, randomized, non-inferiority study vs. oral aripiprazole. BritJPsych 2014; 205:135-144
4. Kane JM, Sanchez R, Perry PP et al. Aripiprazole intramuscular depot as maintenance treatment in patients with schizophrenia: a 52-week, multicenter, randomized, double-blind, placebo-controlled study. J Clin Psychiatry. 2012; 73(5):617-24
5. Kane JM, Peters-Strickland T, Baker RA et al. Aripiprazole once-monthly in the acute treatment of schizophrenia: findings from a 12-week, randomized, double-blind, placebo-controlled study. J Clin Psychiatry 2014; 75(11): 1254-1260
6. Schwartz AG, Targan SR, Saxon A, Weinstein WM. Sulfasalazine-induced exacerbation of ulcerative colitis. N Engl J Med 1982; 306:409.

PROFESSIONAL AFFAIRS COMMITTEE
September 17th, 2015

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Unit Specific		
Engineering		
1. Interim Life Safety Program	3 year review, practice change	Forward to BOD for approval with revisions
2. System Failure Report	3 year review, practice change	Forward to BOD for approval with revisions
Infection Control		
1. Cleaning and Disinfection	3 year review, practice change	Forward to BOD for approval
2. Philosophy – IC 1	3 year review, practice change	Forward to BOD for approval with revisions
3. Standard and Transmission – Based Precautions – IC 5	3 year review, practice change	Forward to BOD for approval with revisions
Neonatal Intensive Care (NICU		
1. Criteria for Case Referrals to Morbidity and Mortality	3 year review, practice change	Forward to BOD for approval with revisions
2. Lumbar Puncture, Assisting with	**DELETE**	Forward to BOD for approval
3. Nasojejunal (NJ Tube Insertion, Maintenance, and Removal of	3 year review, practice change	Forward to BOD for approval with revisions
4. Urinary Catheter, Insertion and Removal of	**DELETE**	Forward to BOD for approval
Pharmacy		
1. Automatic Dose Rounding	3 year review, practice change	Forward to BOD for approval
2. Decreasing Medication Errors	3 year review, practice change	Forward to BOD for approval with revisions
3. Drug Compounding for Medication Not Commercially Available	3 year review, practice change	Forward to BOD for approval
4. Drug Distribution	3 year review, practice change	Forward to BOD for approval
5. Inventory Control	3 year review, practice change	Forward to BOD for approval
6. Labeling Standards	3 year review, practice change	Forward to BOD for approval
7. Medication Management Program	Practice change	Forward to BOD for approval
8. Pharmaceutical Vendors	3 year review, practice change	Pulled for further review
9. Receiving and Tracking Narcotic Pump Refills Prepared by Outside Vendors	3 year review	Forward to BOD for approval
10. Unit Dose Distribution System	**DELETE**	Forward to BOD for approval

PROFESSIONAL AFFAIRS COMMITTEE
September 17th, 2015

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Pulmonary		
1. Incentive Spirometry Instruct and Follow-up	DELETE	Forward to BOD for approval
Rehabilitation Services		
1. Discipline-Specific Staff Meetings - 201	3 year review, practice change	Forward to BOD for approval
2. Maintaining Current Licenses, Registrations and Certifications - 301	DELETE	Forward to BOD for approval
3. Mission Statement - 100	3 year review, practice change	Forward to BOD for approval with revisions
4. Physical Plant - 105	3 year review, practice change	Forward to BOD for approval
5. Productivity Reporting System - 203	3 year review, practice change	Forward to BOD for approval
6. Registry Therapy Services - 107	3 year review, practice change	Pulled for further review
7. Staff Rotations - 615	3 year review, practice change	Forward to BOD for approval
8. Statement of Accountability - 102	3 year review, practice change	Forward to BOD for approval
Security Manual		
Section 2 – Security Operation		
1. Aero Medical Transport 223	3 year review	Forward to BOD for approval
2. BHS STAT Response 215	3 year review	Forward to BOD for approval
3. Computer Usage Policy 228	3 year review	Pulled for further review
4. Emergency Department Patient Parking 225	3 year review	Forward to BOD for approval with revisions
5. Exterior Door Security 222	3 year review	Forward to BOD for approval
6. Forensic Services 218	3 year review	Pulled for further review
7. Lost and Found Procedure for Security Department 230	3 year review	Forward to BOD for approval
8. Media Relations 229	3 year review	Forward to BOD for approval
9. Patient Valuables Collection and Return 237	3 year review	Forward to BOD for approval
10. Patrol of Areas Under Construction 226	3 year review	Forward to BOD for approval
11. Property Custody 232	3 year review, practice change	Forward to BOD for approval
12. Psychiatric Patient Escorts 216	3 year review, practice change	Forward to BOD for approval with revisions
13. Safety and Security Incident Investigation 233	3 year review	Forward to BOD for approval
14. Security Alarm Systems Response 220	3 year review	Forward to BOD for approval with revisions
15. Security Department VIP Policy 235	3 year review	Forward to BOD for approval

PROFESSIONAL AFFAIRS COMMITTEE
September 17th, 2015

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
16. Security Incident Notification 208	3 year review	Forward to BOD for approval
17. Security Officer Documentation 238	3 year review	Forward to BOD for approval
18. Security Panic Alarm System Response 221	3 year review	Forward to BOD for approval with revisions
19. Seized Contraband or Evidence 231	3 year review	Pulled for further review
20. Solicitation and Union Activity on Medical Center Campus 236	3 year review, practice change	Pulled for further review
21. Vehicle Jumpstart 234	3 year review	Forward to BOD for approval with revisions
Section 3 – Security Personnel		
1. Departmental Personnel Issues 307	3 year review	Forward to BOD for approval
2. Hair and Grooming Standards for Security Officers 302	3 year review	Forward to BOD for approval
3. New Officer Training 301	3 year review	Forward to BOD for approval
4. Outside Employment 306	**DELETE**	Forward to BOD for approval
5. Payroll Timecard 305	3 year review	Forward to BOD for approval with revisions
6. Scheduled Time Off 303	3 year review	Forward to BOD for approval
7. Unplanned Time Off (Unscheduled Absence/Tardy)	3 year review	Forward to BOD for approval
Section 4 – Security Equipment		
1. Authorized Security Department Uniforms and Safety Equipment 401	3 year review	Forward to BOD for approval
2. Chemical Agent 402	**DELETE**	Forward to BOD for approval
3. Security Department Key Rings and Department Key Control 406	3 year review	Forward to BOD for approval
4. Security Vehicles 405	3 year review	Forward to BOD for approval
5. Use of Handcuffs 403	**DELETE**	Forward to BOD for approval
6. Use of Impact Weapon/Tactical Baton 404	**DELETE**	Forward to BOD for approval
7. Use of Recording Device 408	3 year review, practice change	Forward to BOD for approval with revisions
Section 5 - Security Safety		
1. After Action Incident Review and Debriefing 511	3 year review	Forward to BOD for approval with revisions
2. Conflict Resolution 510	3 year review	Forward to BOD for approval
3. Disposal of Drugs or Drug Paraphernalia 506	3 year review	Forward to BOD for approval
4. High Risk Patient or Visitor 509	3 year review, practice change	Forward to BOD for approval with revisions
5. Personal Safety Escort for Visitors and Staff 514	3 year review	Forward to BOD for approval

PROFESSIONAL AFFAIRS COMMITTEE
September 17th, 2015

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
6. Security Sensitive Areas 502	3 year review, practice change	Forward to BOD for approval with revisions
Section 8 – Emergency Preparedness		
1. Disaster Manual 802	3 year review	Forward to BOD for approval with revisions to delete policy
2. Disaster Plan for the Security Department 801	3 year review	Forward to BOD for approval
3. Emergency Situation Officer Recall 803	3 year review	Forward to BOD for approval
4. Medical Center Power Outage 804	3 year review	Forward to BOD for approval with revisions
Women and Newborn Services		
1. Balloon Cervical Ripening Catheter	3 year review, practice change	Forward to BOD for approval
2. Breastmilk Misadministration	3 year review, practice change	Forward to BOD for approval with revisions
3. Breast Milk, Pumping, Handling and Storage of	3 year review, practice change	Forward to BOD for approval

Tri-City Medical Center
Oceanside, California

ENGINEERING
SAFETY AND SECURITY

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policies & Procedures~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Interim Life Safety Program~~ ~~Policy Number: 5011 Page 1 of 6~~
~~Department: Engineering~~	~~EFFECTIVE: 11/1/87~~ ~~REVISED: 3/97; 5/00; 11/02; 5/03; 06/06; 6/12~~

SUBJECT: Interim Life Safety Program

ISSUE DATE: 11/87
REVIEW DATE(S):
REVISION DATE(S): 3/97, 5/00, 5/03, 6/06, 6/12

Department Approval Date(s):	**08/15**
Environmental Health and Safety Committee Approval Date(s):	**08/15**
Professional Affairs Committee Approval Date(s):	**09/15**
Board of Directors Approval Date(s):	

A. **POLICY:**

1. It is the policy of ~~Tri-City Medical Center~~**Tri-City Healthcare District (TCHD)** to assure the safety of all building occupants during periods of construction or when significant deficiencies compromise the level of life safety protection provided by the building.

B. **PURPOSE:**

1. Interim Life Safety Measures (ILSM) are administrative actions taken to temporarily compensate for the hazards posed by construction activities **and/or failures of life safety components of** the **building**.
2. Implementation of the ILSM is required in or adjacent to all ~~construction~~ **impacted** areas. ILSM apply to all personnel, including construction workers and must be implemented upon project development, and continuous enforced through project compliance.
3. ~~Interim Life Safety Measures (ILSM) are intended to provide a level of safety comparable to that described in NFPA 101 Life Safety Code 1997~~.

C. **PROCEDURE:**

1. Whenever ~~construction occurs~~**ILSM is in place** at ~~Tri-City Medical Center~~**TCHD**, the Director of Engineering or designate, the Safety Officer and Infection Control Practitioner will conduct routine inspections of the ~~construction sites~~**affected area** ~~at least weekly~~. A complete ILSM Assessment will be performed for each project with the Director of Engineering or designate, Safety Officer and Infection Control Practitioner**. The following items will be evaluated**. ~~If, during these inspections, it is determined that the construction affects the facility's ability to protect occupants from fire or the products of combustion Interim Life Safety Measures (ILSM),~~

~~will be implemented as follows~~:

a. Ensure all exits remain clear. This includes areas directly affected as well as all other exits.

b. Ensure free access to emergency services (i.e. vehicles, materials, etc.,are not blocking the access route or parking areas.)

c. Check for the disabling of the fire protection systems. A small disaster could escalate if the fire protection system is not functional. An alternate system must be provided any time the primary system is off-line for a period greater than 12 hours.

~~2.~~**d.** Fire alarm, detection, and suppression systems must not be impaired. A temporary (but equivalent) system shall be used if the system is impaired. ~~These systems must be tested monthly.~~

i. NOTE: If the fire alarm or fire sprinkler system are disabled for four or more hours in a 24 hour period, a fire watch will be implemented and documented.

~~3.~~**e.** Assure temporary construction partitions are smoke tight and constructed from non-combustible materials. Adequate signage shall discourage casual observers from opening or entering the partitions.

~~4.~~**f.** The Engineering Department will maintain all existing fire-fighting equipment in all areas of the present facilities. The *contractor* shall provide sufficient fire-fighting equipment to cover all areas of new construction and provide additional fire-fighting equipment in all areas being renovated.

~~5.~~**g.** Smoking is prohibited **on campus including parking lots and construction sites.** ~~in and adjacent to all construction areas. Strict enforcement of this policy will occur. Smoking is permitted only in designated areas.~~

~~6.~~**h.** The construction site(s) will be kept clean and orderly. Materials will not be stored in the corridors. All waste and debris will be removed at the end of each work day by the construction crews. Construction offices and break areas will be kept clean by the construction crews.

~~7.~~**i.** A minimum of two documented fire drills per shift per quarter (six per quarter) must occur in the construction zone, areas adjacent to the construction zones, and other areas affected by re-routing of exits. A report should be presented to the EOC Committee confirming and evaluating the drills, including recommendations and/or follow-up.

~~8.~~**j.** Hazard surveillance by Engineering personnel of the construction site shall be increased and documented. Attention is to be given to evacuation routes, construction areas, storage, office/lunch areas, and fuel storage.

~~9.~~**k.** Whenever the safety of adjacent areas is compromised because of construction, the appropriate staff shall be informed. Engineering will conduct training and alternate exit routes shall be identified, posted and the staff informed.

~~10.~~**l.** For areas where construction is occurring, department specific education programs covering all employees are to be conducted explaining interim life safety matters and current life safety deficiencies.

~~11.~~**m.** The construction site must be restricted from all but authorized staff. Adequate signage shall be provided, including indications of a "hard hat" area.

~~12.~~**n.** Alternate access must be provided for public and emergency traffic whenever a disruption occurs.

~~13.~~**o.** Contractor must ensure that roads and pathways are clear of construction debris, materials, etc.

~~14.~~**p.** Proper notification must be made to local authorities (fire, police, other) whenever life safety is diminished.

~~15.~~**q.** The governing body of the Medical Center will be kept informed of the status of life safety during project, via reports from the EOC Committee and/or the surveillance reports.

~~16.~~**r.** Construction workers must be made aware of egress routes.

~~17.~~**s.** Construction workers' egress routes must be inspected daily to ensure no obstacles.

~~18.~~**t.** Effective storage, housekeeping, and debris removal must be in place to reduce collection of combustibles in construction areas by the ~~c~~**C**onstruction ~~s~~**S**uperintendent.

~~19.~~**u.** Whenever fire zones are altered, appropriate staff (Security, Engineering, Telephone Operators, and the department affected) are trained in regard to new or different life safety measures regarding their changed compartmentalization of the fire zones and any new fire safety measures.

~~20. The contractor addresses safety at each construction meeting and it is shown through documentation that safety measures are adhered to by the contractor's staff.~~

~~21.~~**v.** All welding, brazing, and soldering shall take place only in designated areas where the risk of combustion due to sparks has been minimized. A "Hot Work Permit" must be obtained and approved by Plant Operations (where fire alarms are monitored) *prior* to the start of these activities' beginning.

D. **FORM(S):**

1. ILSM Assessment Form
2. **Pre-**Construction **Risk Assessment Form** ~~Site Inspection~~
3. Hot Work Permit

CONSTRUCTION SITE INSPECTION (Weekly)

Date:

Time:

Inspector:

DESCRIPTION	YES	NO	N/A	COMMENTS	FOLLOW UP
Contractor acknowledges Asbestos in writing					
Adequate barriers in place					
Smoke proof/ Noncombustible					
Dust Proof					
Signage in place					
Applicable codes complied with					
Contractor acknowledge AIA A201 & Supplement					
Occupational Health and Safety Admin.. Compliance					
Interim Life Safety in place					
Staff trained regarding Interim Life Safety					
Temporary Fire Protection in place					
Contractors aware of egress routes					
Increase in fire drills, other training					
All exits clear					
Free access to Emergency Service					
Alternate access for public and emergency use					
Additional fire fighting staff & equipment available					
Smoking is strictly prohibited					
Construction site clean and orderly					
Staff informed if adjacent area is affected					
Construction site access restricted					

CONSTRUCTION SITE INSPECTION

continued

DESCRIPTION		YES	NO	N/A	COMMENTS	FOLLOW-UP
Local authorities aware of Interim Life Safety						
Effective site storage of materials, Other						
Fire zones maintained, staff aware of changes						
Contractor confirms egress routes for staff clear						
Hard hats worn in construction areas						
Cutting and welding operations properly conducted						
All scaffolding complies with OSHA requirements (1926.451)						
There are at least two open entrances to the hospital at all times. One entrance is designated for patient/visitor/staff use, and one for emergency use.						
Construction site is secured at off-hours and weekends by contractor						
Sufficient lighting is provided by contractor						
All air vents (supply, return, and exhaust) are covered with plastic						
Penetrations of walls are being addressed on a daily basis						
Staff informed if adjacent area is affected						
Construction site access restricted						

ADDITIONAL COMMENTS

Interim Life Safety Measures Assessment Tool

Project / Deficiency:
Location: By:
Initial Date: Reassessment Date:

Evaluate deficiency and/or construction hazards to determine when and to what extent one or more of the following measures apply:

Impact Evaluation	Yes / No / NA	Measures Implemented
1. Will any area exits be obstructed? Will any construction materials, equipment, or debris block the free use of all exits adjacent to the construction site or impacted by the project? Will all existing exit signs remain in place and operational?		
2. Will any exterior access points to the building be blocked? Will access to emergency departments, entrances, fire lanes and exit discharges be impeded by obstructions, storage, or other impediments? **Label alternate routes as needed.**		
3. Will any fire alarm systems & suppression systems be compromised and / or altered?		
4. Will any construction partitions need to be erected?		
5. Will any additional fire extinguishers and equipment be necessary & provided on site? Equipment must be functional and tests and inspections are up to date.		
6. Will the Smoking prohibition need to be communicated, monitored and enforced?		
7. Will construction storage need to be minimized and housekeeping & debris removal policies communicated, monitored and enforced?		
8. Will additional fire drills be necessary for staff in affected areas and/or within construction area (contractor staff)?		
9. Will surveillance of the area be necessary?		
10. Will any additional training of staff and/or contractors be necessary to compensate for impaired structural or compartmental features of fire safety?		
11. Will facility-wide safety education programs need to be communicated to promote awareness of fire safety building deficiencies, construction hazards, and ILSM?		
12. List any other Life Safety Code deficiency / concerns identified:		
13. List any other Life Safety Code deficiency / concerns identified:		
14. List any other Life Safety Code deficiency / concerns identified:		

Additional Comments:

Tri City Medical Center
Assessment of the Impact of Construction Projects

Project:	Location(s):	Start Date:	End Date:
Project Coordinator:		Contractor:	

Category		Factors	Risk Evaluation
(A)	Noise	Impact, duration, scheduled time of work	
(B)	Air / Dust	Cutting, Grinding, Sanding, etc.	
(C)	Infection Control	Category of Risk: [__] 1 – 2 – 3 – 4 – 5	
(D)	Vibration	Tool use, demolition, distance	
(E)	Life Safety impact	Hot work, disabling alarms, penetrations, exit modifications, smoking	
(F)	Security	Site security, access control	
(G)	Disruption of utilities	Planned shutdowns, Construction near utility system supplies	
(H)	Emergency Services	Obstruct access to fire lanes or fire dept.?	

Brief description of work to be performed:

List areas of forecasted concerns for any/all of the Categories listed above	List appropriate measure(s) recommended for limiting disruption / code violation / potential adverse outcome.
(A)	
(B)	
(C)	
(D)	
(E)	
(F)	
(G)	
(H)	

Tri-City Medical Center
Facilities Management / Construction

PERMIT FOR WELDING-CUTTING-HOT WORK

**BEFORE STARTING HOT WORK, REVIEW ALL SAFETY PRECAUTIONS.
CAN THIS WORK BE AVOIDED OR IS THERE A SAFER WAY?**

THIS PERMIT IS REQUIRED FOR ANY TEMPORARY OPERATION INVOLVING OPEN FLAME OR PRODUCING HEAT AND/ SPARKS: WELDING,CUTTING, BRAZING, GRINDING, SOLDERING, OR USING TORCH TO THAW PIPING OR HEAT MATERIAL. THIS PERMIT APPLIES TO ONLY THIS JOB, IN THE AREA SPECIFIED, DURING THE TIME AND DATE NOTED.

INSTRUCTIONS

SUPERVISOR:
1. Complete PRECAUTION & SAFEGUARD CHECKLIST at right.
2. Complete form, copy, retain original.
3. Issue copy to competent person doing job.
4. Verify FIRE WATCH.

HOT WORK TO BE DONE BY:
- ☐ Employee.
- ☐ Contractor: _____

LOCATION:

_____

WORK TO BE DONE:

_____

PERSON DOING JOB:

_____

_____Signed

Signed:(Supervisor)

_____

I have verified that the above location has been inspected and the required PRECAUTIONS and SAFEGUARDS have been taken. Permission is authorized only for the above work.

PRECAUTIONS & SAFEGARDS CHECKLIST

- ☐ SPRINKLER PROTECTION in service and extinguisher available.
- ☐ Hot work equipment in good repair.

REQUIREMENTS WITHIN 50FT OF WORK

- ☐ Flammable liquids and combustible material removed from area.
- ☐ Floors swept and overhead structure cleaned from dust, lint and debris.
- ☐ Fire resistive covers and metal shields provided as needed.
- ☐ All floor and wall openings covered and/or protected
- ☐ WALLS/CEILINGS: Remove combustibles away from opposite side or adjacent structures.

WORK ON ENCLOSED EQUIPMENT

- ☐ Adequate ventilation provided.
- ☐ Thoroughly clean and remove all flammables and combustibles
- ☐ Atmosphere checked with gas detector.
- ☐ Purge any flammable vapors.
- ☐ Confirmed space/lockout permits, if required.

FIRE WATCH

- ☐ Trained and equipped Fire Watch provided during operations and at least 30 minutes after.

SPECIAL INSTRUCTIONS: _____

_____

_____

_____

PERMIT EXPIRES	DATE	TIME	FINAL CHECK-UP	DATE	TIME
WORK COMPLETE	DATE	TIME			

SIGNED: (WELDER)

SIGNED (INSPECTOR)

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: System Failure Report~~ ~~Policy Number: 2013~~ ~~Page 1 of 2~~
~~Department: Hospital-Wide~~	~~EFFECTIVE: 8/91~~ ~~REVISED: 9/94; 1/97; 5/00; 5/03, 6/06; 5/09, 8/11, 6/12~~

SUBJECT: System Failure Report

ISSUE DATE: 8/91
REVIEW DATE(S):
REVISION DATE(S): 9/94, 1/97, 5/00, 5/03, 6/06, 5/09, 8/11, 6/12

Department Approval Date(s):	**07/15**
Environmental Health and Safety Committee Approval Date(s):	**08/15**
Professional Affairs Committee Approval Date(s):	**09/15**
Board of Directors Approval Date(s):	

A. **PURPOSE:**
1. To establish and maintain a method of reporting, correcting and preventing failures of vital systems in the facility.

B. **POLICY:**
1. A system failure report shall be generated for any failure of a vital system serving Tri-City Healthcare District (TCHD). A "vital system" is defined as any system listed below or any other system that could adversely affect patient care or the safety and/or comfort of visitors or staff if it fails to operate.
   a. Normal power
   b. Emergency power
   c. Fire-alarm system
   d. Medical air
   e. Control air
   f. Oxygen system
   g. Nitrous oxide system
   h. Nitrogen system
   i. Chilled water
   j. Exhaust system
   k. Air-handling system
   l. Domestic water
   m. Fire sprinkler system
   n. Steam
      i. Hot water
   o. De-ionized water system

p. Vacuum System
q. Elevators

C. **PROCEDURE:**

1. Utilization of the report: A system failure report must be used for any system covered under the policy statement. However, it may also **be** used for any system, regardless of its importance, as long as the correct procedure is followed. The report should be initiated immediately following the failure.
2. Assignment of responsibility: in all cases, the responsibility for the investigation, resolution and prevention of the problem causing the system failure will be assigned to one person. That person will be designated the **S**~~s~~ystem **F**~~f~~ailure **R**~~r~~eport manager. The report manager will be appointed by the Director, the Engineering Manager or a **S**~~s~~upervisor within the **E**~~e~~ngineering **D**~~d~~epartment.
3. Report **M**~~m~~anager's duties: It is the duty of the of the **R**~~r~~eport **M**~~m~~anager to contact every person ~~required -~~ **impacted** to provide a swift analysis of the system failure and to formulate both the immediate and long term plan to prevent a recurrence. The **M**~~m~~anager will convey his or her findings and recommendations in writing via the **S**~~s~~ystem **F**~~f~~ailure **R**~~r~~eport to the Director of Engineering or his designee.
4. Report routing: Once assigned, the **S**~~s~~ystem **F**~~f~~ailure **R**~~r~~eport will remain with the **R**~~r~~eport **M**~~m~~anager until its completion. Upon such completion, it shall be routed directly to the Director of Engineering, who will review it. If the **D**~~d~~irector approves the reports, **the report will be emailed to impacted leaders, EOC Officer, and the Administration. A copy of the report will be stored on Engineering's Shared Drive.** ~~copies will be routed to the Vice President of Operations, the directors of safety and engineering operations departmental fil~~If the **D**~~d~~irector does not approve the report, he/she will send it back to the **R**~~r~~eport **M**~~m~~anager along with recommendations. The **R**~~r~~eport **M**~~m~~anager must carry out those recommendations and resubmit the report.
5. Report logging: ~~A~~ **S**~~s~~ystem **F**~~f~~ailure **R**~~r~~eport**s** ~~log~~ will be kept ~~in~~ **on** the **E**engineering ~~operations office~~ **Shared Drive in files for each calendar year**. Each report will be assigned an identification number**, numbering will restart from 1 at the beginning of each calendar year.** ~~that shall consist of the last two digits of the year followed by the number of the report issued in that year. (Example: 3rd report for 1997 would be assigned 97-3). Report managers shall enter their names, report numbers, dates assigned and systems affected in the logbook immediately after being assigned reports. Upon completion of the reports, the Director of Engineering shall enter the dates of completion into the departmental log.~~
6. Follow up and review: ~~Every three months~~ **Regularly** the Director of Engineering shall review all ~~incidents in the~~ **S**~~s~~ystem **F**~~f~~ailure **R**~~r~~eport**s** ~~logbook~~. An analysis will be undertaken to determine the effectiveness of the remedial actions taken, with particular attention to a trends or recurrences. ~~Each quarter, a summary report or that quarter's incidents will be generated along with the analysis and presented to the facilities Safety Committee.~~ If it is determined that further action is required on a system, then all of those actions shall be documented and reported **to the Environmental Health and Safety Committee.** ~~in the quarterly report.~~

D. **FORM(S):**

~~7.~~**1. Plant Operations Systems Failure Report**

TRI-CITY MEDICAL CENTER
ENGINEERING DEPARTMENT
SYSTEM FAILURE REPORT

SYSTEM_____ DATE OF FAILURE_____

DUTY ENGINEER_____ SHIFT_____

DESCRIBE THE PROBLEM (INCLUDE THE TIME, DURATION, LOCATION AND TYPE OF EVENT):

WHAT CAUSED THE PROBLEM (USER ERROR, IMPROPER/NO MAINTENANCE, VANDALISM, ETC.)?

WHAT AREAS WERE AFFECTED AND FOR HOW LONG?_____

WHAT EQUIPMENT/ACTIVITIES WERE AFFECTED AND FOR HOW LONG?_____

HOW WAS THE PROBLEM RESOLVED?_____

WHAT STEPS WERE TAKEN TO PREVENT A RECURRENCE?_____

NOTE: ATTACH ADDITIONAL DOCUMENTATION (CORRESPONDENCE, WORK ORDERS, ETC.)

THAT AMPLIFY THE PERTINENT DATA CONTAINED ON THIS FORM.

REVIEWED AND APPROVED BY:

DEPARTMENT SUPERVISOR DATE CHIEF ENGINEER DATE

CC: DIRECTOR OF ENGINEERING
SAFETY COMMITTEE CHAIRMAN

Tri-City Medical Center
Plant Operations
Systems-Failure Report

Date of failure	
Reporting Engineer	
Tracking Number	
System involved	
Failure Start Time	
Failure End Time	
Total Time	

Describe the problem?
What caused the problem?
What areas, equipment, or service were affected?
How was the problem resolved?
What steps were taken to avoid a recurrence?

Reviewed	
Department Supervisor:	**Date:**
Director of Engineering:	**Date:**

SUBJECT: Cleaning, ~~and~~ Disinfection **and Sterilization**

ISSUE DATE: 9/2001
REVISED: 3/05, 3/06, 10/06, 4/09, 4/12, 5/15
~~NEXT REVIEW DATE: 4/15~~ ~~STANDARD NUMBER: IC. 9~~

~~CROSS REFERENCE:~~
~~Standard and Transmission Based Precautions IC. 5~~
~~Participation of Staff in the Infection Control Program IC. 7~~
~~Bloodborne Pathogen Exposure Control Plan IC. 10~~
~~REVISED: 3/05, 3/06, 10/06, 4/09, 4/12~~

Department Approval Date(s):	**07/15**
Infection Control Committee Approval Date(s):	~~4/12~~**07/15**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**08/15**
Professional affairs committee Approval Date(s):	**09/15**
Board of Directors Approval Date(s):	

A. **PURPOSE:**

1. To provide guidelines for uniform and complete cleaning and disinfection or sterilization of patient care items as indicated on the basis of each item's intended use. Using the Spaulding classification scheme instruments and items for patient care are categorized as critical, semicritical, and noncritical. Situations which may impact the choice of disinfection or sterilization method may include, complicated medical equipment, heat sensitive devices, and inactivation of certain types of infectious agents. Manufacturer recommendations and FDA cleared instructions for chemical sterilants/high level disinfectants are considered in these cases.

~~1.~~**B. INTRODUCTION**

1. Meticulous physical cleaning must precede disinfection and sterilization procedures. Agents used on items are called sterilants or disinfectants. Agents use on skin or tissue are called antiseptics.

~~1.1.~~**2.** Sterilization is the complete elimination or destruction of all forms of microbial life. Before use on each patient, critical medical and surgical devices and instruments that enter normally sterile tissue or the vascular system or through which a sterile body fluid flows are sterilized.

~~1.1.1.~~**a.** Sterilization is accomplished by either physical or chemical processes. Steam under pressure, dry heat, or chemical sterilants such as plasma sterilization are used to process "critical" items.

~~1.2.~~**3.** High-level disinfection can be expected to destroy all microorganisms, with the exception of high numbers of bacterial spores.

~~1.2.1.~~**a.** Items determined to be "semi-critical" touch mucous membranes or non-intact skin.

~~1.2.2.~~**b.** High-level disinfection is accomplished by the preferred method of heat sterilization between patients when possible. Medical instruments that are not heat-stable (for example endoscopy and ultrasound probes) are processed using chemical disinfectants such **as** ~~Steris washers~~ **paracetic acid** or Cidex OPA.

4. Intermediate-level disinfection **can be expected to** ~~inactivates *Mycobacterium tuberculosis,* vegetative bacteria, most viruses and most fungi.~~**destroy vegetative bacteria, mycobacteria,**

most viruses, most fungi but not bacterial spores. An example would be a EPA-registered hospital disinfectant with label claim regarding tuberculocidal disinfectant. Appropriate for "noncritical" patient care items or surfaces with visible blood.

5. ~~2.4.~~ Low-level disinfection is appropriate for "noncritical" items that come in contact with intact skin. Some items that may come in contact with non-intact skin for a brief period of time are usually considered noncritical surfaces and are disinfected with intermediate-level disinfectants. ~~Since hydrotherapy tanks have been associated with spread of infection, facilities using hydrotherapy have may choose to disinfect them with recommended levels of chlorine.~~

~~2.~~C. POLICY

~~2.1.~~**1.** Sterilization Process

- ~~2.2.~~**a.** All patient care objects needing sterilization will be cleaned of gross contamination in the area used and sent to Sterile Processing Department for complete processing. Don protective ~~gloves~~ **gloves and other required PPE** prior to touching patient care items potentially contaminated with blood or body fluids.
- ~~2.3.~~**b.** Visually check for used sharps and safely dispose of in a sharps container.
- ~~2.4.~~**c.** Lightly rinse objects in warm water.
- ~~2.5.~~**d.** Use an enzyme cleaner to assist with the removal of proteinaceous material (tissue, blood and body fluids).
- ~~2.6.~~**e.** After cleaning, place them in a rigid container for transport or pick-up.
- ~~2.7.~~**f.** Refer to Sterile Processing Department policies and procedures.

~~3.~~**2.** High Level Disinfection

- ~~3.1.~~**a.** High-level disinfection is provided for processing semicritical patient-care equipment that touches either mucous membranes or nonintact skin.
- ~~3.2.~~**b.** Refer to Patient Care Services Procedures Manual "High Level Disinfection Procedure" for detailed instruction.

~~4.~~**3.** Low level disinfection

- ~~4.1.~~**a.** Environmental services (EVS) cleans/disinfects surfaces (e.g., floors, tabletops) on a regular basis, when large spills occur, and when these surfaces are visibly soiled.
- ~~4.2.~~**b.** EVS staff follows manufacturers' instructions for proper use of disinfecting products, such as recommended use-dilution, contact time, material compatibility, storage, shelf-life, and safe use and disposal.
- **c.** Walls, blinds, and window curtains in patient-care areas are cleaned when visibly contaminated or soiled.
- ~~4.3.~~**d.** **Privacy curtains in patient- care areas are cleaned on a routine schedule (most areas are quarterly), in addition they are cleaned when visibly contaminated or soiled.**
- ~~4.4.~~**e.** An EPA-registered hospital disinfectant designed for housekeeping purposes in patient care areas is used.
- ~~4.5.~~**f.** Wet-dust horizontal surfaces regularly is accomplished using clean cloths moistened with an EPA-registered hospital disinfectant.
- ~~4.6.~~**g.** An EPA-registered sodium hypochlorite product is used to clean rooms housing patients with *C. difficile* ~~enterocolitis.~~**Infection**
- ~~4.7.~~**h.** Rolling stock and other equipment that is to remain on the unit or at the bedside will be low-level disinfected using an EPA registered hospital disinfectant between patients whenever possible and when visibly soiled. Some examples of equipment include blood pressure cuffs on portable machines, IV poles, ventilators or bedside commodes (cover with plastic bag); bed scales, wheelchairs, medication and supply carts.

~~5.~~**4.** Spills of blood and other potentially infectious materials are contained and cleaned as soon as possible.

- ~~5.1.~~**a.** Promptly clean and decontaminate spills of blood and other potentially infectious materials. Disinfect areas contaminated with blood spills using an EPA-registered

tuberculocidal agent, or products with specific label claims for HIV or HBV or freshly diluted hypochlorite solution. If the spill contains large amounts of blood or body fluids, clean the visible matter with disposable absorbent material, and discard the contaminated materials in appropriate, labeled containment.

~~5.2.~~**b.** Hospital-approved products (for example Sanicloth and Dispatch) are to be used by staff for cleaning of small spills.

~~5.3.~~**c.** Large spills (over 200cc) are cleaned by Environmental Services. A solidifying agent may be used for large spills.

~~5.4.~~**d.** Wear personal protective equipment to prevent exposure from touch or splashes. This should always include gloves and the addition of a plastic apron or gown and face protection as needed.

~~5.5.~~**e.** Contaminated glass or sharps are picked up with forceps or like instrument. Place in an emesis basin or other puncture proof container to carry to a sharps container for disposal.

~~a.~~**f.** If the paper towels are used to mop up the spill and they are **saturated and/or** dripping with blood, dispose of in red biohazard bag trash. Paper towels not **saturated and/or** dripping with blood are placed in a regular trash container. Cloth towels and linen used to clean spills are placed in the soiled linen containers.

~~6.~~**5.** Occupational Safety and Health Administration (OSHA) requires Environmental Protection Agency (EPA) approved products for cleaning of blood and other potentially infectious materials.

~~6.1.~~**a.** These products are labeled as "tuberculocidal" or effective against hepatitis B and HIV.

~~1.~~**b.** Follow the manufacturer's instructions for how long the surface must stay wet to be effective (contact time).

D. REFERENCES:

1. Centers for Disease Control and Prevention. (2007). Guideline for Isolation Precautions in Hospitals.

~~2. Rutala, W. (1996). APIC Guideline for selection and use of disinfectants. American Journal of Infection Control, 24 (4), 313-335~~

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3. Centers for Disease Control and Prevention. Guidelines for environmental infection control in health-care facilities: recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC). MMWR 2003;52 (No. RR-10)

4. ~~**Rutala, W., Weber, D., & the Healthcare Infection Control Practices Advisory Committee (HICPAC) (2008).** Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008. William A. Rutala, Ph.D., M.P.H., David J. Weber, M.D., M.P.H., and the Healthcare Infection Control Practices Advisory Committee (HICPAC)~~**Retrieved from** http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html

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SUBJECT: Philosophy **~~POLICY NUMBER: IC. 1~~**

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~~CROSS REFERENCE:~~
~~Surveillance Program IC .2~~
~~Epidemiologic Investigation of a Suspected Outbreak IC .3~~
~~Healthcare Associated Infections, Defined IC .4~~
~~Reducing Facility Acquired Infections IC. 13~~
~~Participation of Staff in the Infection Control Program IC. 7~~

~~REVISED: 7/1/02, 4/09, 4/15 APPROVAL: Infection Control Committee: April 2014~~

A. **MISSION:**

1. The Infection Prevention and Control Department has been established to address compliance with local, state, and federal regulations as well as standards set by accrediting agencies. The department is committed to reducing adverse outcomes such as health care associated infections (HAIs), improving patient care by supporting the staff in all areas of the facility, minimizing occupational hazards associated with the delivery of health care, and fostering scientific-based decision making
2. Prevention of HAIs is recognized as one of the most important priorities at ~~Tri-City Medical Center~~**Tri-City Healthcare District (TCHD)** and The Centers of Disease Control and Prevention (CDC) estimates **that in 2011, there were approximately 722, 0000 HAIs in Acute Care hospitals and about 75,000 hospital patients with HAIs died during their hospital stay**. ~~each year, approximately 2 million patients admitted to acute care hospitals in the United States develop an HAI and approximately 90,000 of these patients die.~~ Hospital-acquired infections (HAIs) are estimated to cost $4.5 to $5.7 billion per year to treat and approximately 1/3 of HAIs could be prevented. Prevention of infection requires an integrated, responsive process involving collaborative efforts throughout the hospital. This includes the identification of risk as well as efforts directed toward risk-reduction for patients, staff, visitors, students and others in the facility.
3. Scope of Service – The Infection Control (IC) Program provides a district wide framework, using a coordinated process of sound epidemiological principles, to reduce disease transmission. Activities are consistent with principles of Continuous Quality Improvement and include a multidisciplinary, participative approach to quality care.
   a. The Medical Director of Infection Prevention and Control is the designated infection control officer who, in cooperation with the hospital infection control committee, shall ensure implementation of the Infection Control Program. This includes oversight and coordination of the development, testing, and implementation of NPSG 7.
   b. Qualified staff with education and/or credentials that document knowledge and expertise in Infection Control manage the department.
   c. The Infection Prevention and Control Services utilizes experts and resources such as:

~~d.~~**i.** The Occupational Safety and Health Administration (OSHA) and other pertinent federal, state, and local regulations.

~~e.~~**ii.** Standards set by the Joint Commission (TJC) for the accreditation of Health Care Organizations

~~f.~~**iii.** Guidelines, position statements, recommendations and studies published by recognized experts, such as, the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Prevention and Control (CDC), and the California Healthcare Association (CHA).

~~g.~~**d.** In consultation with the Medical Staff and the Infection Control Committee, the Infection Preventionists (IP) shall implement a systematic process for monitoring and evaluating the quality and effectiveness of the infection prevention and control program. Results shall be forwarded to appropriate parties to exchange findings and/or for action.

4. Department Goals

a. The department strives to improve the quality of health care and the work environment by enhancing infection prevention and control activities within the district. The IP participates in Council and Committee meetings as the infection prevention and control expert. Examples of actions include:

~~b.~~**i.** Recognize and maintain awareness of requirements, guidelines and recommendations that affect infection prevention and control and disseminate the information.

~~c.~~**ii.** Provide documentation related to compliance with federal, state, and local regulatory and accrediting agencies.

~~d.~~**iii.** Evaluate risks and other adverse events that are present with HAIs and make recommendations for reduction that are fair, scientifically sound, and recognize resource limitations.

~~e.~~**iv.** Provide sound information to those seeking advice on how to decrease the risk of disease and microorganism transmission.

~~f.~~**v.** Review and revise clinical practice policies and procedures related to infection prevention and control.

~~g.~~**vi.** Provide assistance and participate in staff education to facilitate the creation of an environment of consistent, optimal patient care practices.

~~i.~~**1)** Annually evaluate and update the new employee orientation and the reorientation programs including notes, presentation materials, and handouts as needed.

~~ii.~~**2)** Conduct department specific education for areas involved in direct patient care, as requested. Presentations are most often at staff meetings and focused physician, nursing and CNA education classes are also utilized to increase participation.

~~iii.~~**3)** When specific problems are identified, there is an educational component to problem solving that may include small group education, one-on-one efforts, or committee presentations. A variety of adult learning techniques are used to educate staff.

5. Surveillance Program

a. Institution surveillance for infection control activities is a systematic, active, and ongoing observation. The authority for the program rests with the Infection Control Committee as defined in the Medical Staff Bylaws.

i. A literature review reveals that specific efforts directed toward urinary tract infection, surgical wound infection, and device related infections such as ventilator associated pneumonia and intravascular line infections are strongly associated with reduced infection rates and have been considered in the development of our plan.

~~ii.~~**1)** The plan is updated and approved annually by the Infection Control Committee. Please see **Infection Prevention and Control Risk Assessment** and Surveillance Plan ~~IC. 2~~

~~iii.~~**2)** The Infection Prevention and Control Department uses the results and interpretations of **the** surveillance activities as a basis for modification of the surveillance plan during the course of the year if it becomes apparent that this would improve services to patients, staff, students, visitors, or others.

~~b.~~**ii.** The CDC guidelines (National Healthcare Safety Network- NHSN) for identifying HAIs are used at ~~Tri-City Medical Center~~**TCHD** to define infections in acute care (Healthcare Associated Infections Plan). ~~Tri City Medical Center~~**TCHD** Home Health uses definitions published by APIC.

~~c.~~**iii.** Outbreak Investigations are included in our plan.

~~i.~~**1)** While a number of factors might be involved in transmission including healthcare workers, equipment, and environment, the most important objective is to control further transmission.

~~ii.~~**2)** Should an outbreak be suspected, control measures would be guided by the Infection Preventionist in consultation with the Infection Control Officer and instituted by the department. Collaborative actions are taken with the affected department and/or medical service.

~~iii.~~**3)** Outside resources and governing agencies will be contacted if appropriate and/or required.

~~d.~~**b.** Reporting Internally/Externally: see **Infection Control** Internal and External Reporting Table ~~to follow, Appendix A~~.

i. Results and interpretations of surveillance activities are reviewed on a regular basis and reported internally to Infection Control Committee and others as appropriate.

1) Findings**, recommendations, actions, and evaluations are documented in meeting minutes.**~~, and interpretations of surveillance activities are reviewed on a regular basis and reported internally to Infection Control Committee and others as appropriate~~.

2) Results shall be forwarded to appropriate parties to exchange findings and/or for action.

ii. External reporting of communicable diseases as required by law.

1) Diseases in the California Title 17 Code of Regulations to the local health authority.

2) Suspected or known active tuberculosis cases to San Diego County TB Control department.

3) Assist with determining infectious disease exposure of emergency response personnel (local police, ambulance and fire departments).

4) NHSN enrollment is maintained. HAIs are entered in this national database in compliance with California Department of Public Health **and Centers for Medicare and Medicaid Services (CMS) requirements**.

6. Employee Health ~~Department~~ ~~Liason~~ **Services**

a. Infection Prevention and Control works closely with Employee Health on issues related to infectious diseases and district staff. Employee Health, ~~assisted by workpartners~~, plays an important role in the program and responsibilities include the following.

i. Writes, revises and updates Employee Health policies including restrictions for work related in infectious diseases, OSHA required reporting, and programs to decrease infectious risk

ii. Conducts initial hire screening and annual assessments and offers vaccinations.

1) Screens new employee for infectious diseases and immunity.

2) Encourages and/or offers appropriate vaccinations to employees and volunteers

3) Performs annual screening for symptoms of active tuberculosis and PPD conversions.

iii. **Infection Control Department assists in notifying Employee Health of potential employee exposures based upon lab findings for pathogens requiring droplet/airborne isolation.**
~~3)~~**1)**

~~iii.~~**iv.** Follows and treats employee exposures, using the latest department of health and CDC guidelines for:
1) Blood and body fluids.
2) Other infectious diseases (for example chickenpox and meningitis)

~~iv.~~**v.** Reports on worker injury and illness
1) As required by federal, state and local regulations.
2) To the Environment of Care and Infection Control Committees at least quarterly and ~~others such as Managers Council and Division~~ Managers and Directors as appropriate.

B. **REFERENCE LIST**

1. Centers for Disease Control and Prevention, Public Health Focus: Surveillance, Prevention, and Control of Nosocomial Infections MMWR October 23, 1992 / 41(42); 783-787.
2. **Centers for Control and Prevention. (2015, January). Healthcare-associated Infections (HAIs). Retrieved from http://www.cdc.gov/HAI/surveillance/index.html**
3. Pugliese G, Lamberto, B & Kroc, K. Development and Implementation of Infection Control Policies and Procedures In: Mayhall G. ed. Hospital Epidemiology and Infection Control. 2nd ed. Philadelphia: Lippincott, Williams & Wilkins; 1999:1357 - 1366.
4. ~~Carico~~ Friedman, C. (2014). Infection Prevention and Control Programs. In P. Grota (Ed.), APIC Text of Infection Control and Epidemiology (4th ed). Washington DC; 2014.

C. **RELATED DOCUMENTS**

~~C.~~**1. IC Internal and External Reporting Table**
~~1.~~**2. IC Manual** Surveillance Program ~~IC .2~~
~~2.~~**3. IC Manual** Epidemiologic Investigation of a Suspected Outbreak ~~IC .3~~
~~3.~~**4. IC Manual** Healthcare Associated Infections, Defined ~~IC .4~~
~~4.~~**5. IC Manual** Reducing Facility Acquired Infections ~~IC. 13~~
~~5.~~**6. IC Manual** Participation of Staff in the Infection Control Program ~~IC. 7~~

Appendix A - **Internal and External Reporting**

Infection / Problem	Rationale	Data Sources	Reported To
Bacteremia related to Central Lines (BSI) on all inpatient units	Associated with high mortality & morbidity.	• Positive cultures • Chart review	• Infection Control Committee • Critical Care Services • Affected Units
Ventilator Associated Events in Intensive Care settings	Associated with high mortality & morbidity.	• Ventilator Settings (PI weekly report) • Chart Review	• Infection Control Committee • Critical Care Services • Affected Units
Specific Surgical Site Infections (SSI) • HPRO & KPRO • Cardiac • Colon • All 29 Surgeries required by CDPH	Potential for high risk and repeat problems. To compare with NHSN data and identify opportunities for improvement.	• Positive cultures • Coding Reports • Chart review • RL Solutions	• Infection Control Committee • Surgical Services • Other Medical Staff and hospital committees as appropriate.
Multidrug Resistant Organisms • Methicillin Resistant *Staph. aureus* • Vancomycin resistant enterococcus • C. difficile • ESBL • MDR- other	Potential for high risk and repeat problems. Monitor effectiveness of Standard & Contact Precautions. Prevent secondary cases. Antibiotic use implications.	• Positive cultures • Chart review	• Infection Control Committee • Managers Council, Clinical Practice Committee, other Medical Staff and hospital committees as appropriate
Reportable Diseases (CMR) • Inpatients • Outpatients	Required by California Administrative Code (Title 17).	• Laboratory results • Staff reports • Requests from Public Health Services	• San Diego County Department of Public Health Serives (Health and Human Services Agency)
Severe *Staphylococcus aureus* infection in previously healthy person	Required by California Administrative Code (Title 17).	• Laboratory results • Staff reports	• San Diego County Department of Public Health Services (Health and Human Services Agency)
Tuberculosis • Inpatients • ED & Clinic patients • Outpatients • Employees • Volunteers	Monitor effectiveness of Aerosol Transmissible Disease plan (TB Exposure Control Plan). Potential for high risk and repeat problems. Required by OHSA, the Gotch Bill and California Codes.	• Laboratory results • Employee PPD screening • Reports from other facilities or public health.	• San Diego County TB Control • Infection Control Committee • Environment of Care Committee • Special Subcommittees
Outbreak Investigations	Early identification and control of clusters of infections. Potential for high risk and repeat problems.	• Positive cultures • Laboratory logs • Staff/QR reports	• Infection Control Committee • Other Medical Staff and hospital committees as appropriate. • Outside agencies as appropriate

Exposure Investigations • **EH Sharps Injuries** • **Internal requests** • **External requests**	**Identification of HCW exposures.** **Early identification and treatment of contacts to communicable diseases.** **Potential for high risk and repeat problems.** **Required by OHSA and California Codes**	• **Employee Health** • **Positive cultures** • **Unit rounds** • **Assist with EMS Requests (Ryan White Act Health and Safety Code)**	• **Infection Control Committee** • **Environment of Care Committee** • **First Responders** • **San Diego County Bureau of AIDS and Communicable Diseases**
Annual Reviews • **OSHA TB, ATD, & BBP Exposure Control Plans** • **Surveillance Program and Risk Assessment** • **QI Projects** • **MDRO Risk Assessments**	**Compliance with state and federal OSHA standards.** **Assist with hospital initiatives and goals.** **Active participation of Infection Control at all levels of the organization.**	• **National and state regulations** • **Recognized experts in the field of IC (APIC, CDC, and JCAHO)** • **Identified areas for improvements**	• **Interdisciplinary Education Council, Infection Control and EOC Committees** • **Quality Assurance Committee, Managers Council, Patient Care Coordinating Council, Clinical Practice Council, Professional Practice and Research Council, Interdisciplinary Education Council, Infection Control Committee and special work groups or taskforces, as requested**

SUBJECT: ~~Isolation System:~~ Standard and Transmission-Based Precautions

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~~CROSS REFERENCE:~~
~~Participation of Staff in the Infection Control Program IC. 7~~
~~Bloodborne Exposure Control Plan IC. 10~~
~~Tuberculosis Exposure Control Plan IC. 11~~
~~Significant Organisms IC. 6~~

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

1. ~~For many years, "isolation" has been the cornerstone of a hospital's prevention and control program. Since the 17th century bubonic plague ravages in Britain and Europe, quarantines in some form or another have not changed in intent. The number of diseases for which quarantine or isolation has been selected as the principal control measure has increased since that time.~~ The Centers for Disease Control and Prevention (CDC) and the Hospital Infection Control Advisory Council (HICPAC) published the Guidelines for Isolation Precautions in Hospitals in 2007. Changes were made to include respiratory hygiene/cough etiquette practices. Masking for spinal procedures and application of PPE prior to entering the room of a patient in Droplet or Contact Precautions
2. The **current**~~revised~~ guidelines continue to support two levels of precautions, Standard Precautions and Transmission-based Precautions. Standard Precautions are the primary strategies to be used in the care of all patients to protect both healthcare workers and patients. Transmission-based Precautions are designed only for the care of specified patients, or patients known or suspected to be infected or colonized with epidemiologically important pathogens transmitted via airborne, droplet, or contact with dry skin or contaminated objects.

B. **POLICY:**

1. **For immunocompromised patients see Patient Care Services (PCS) Neutropenic Precautions**
   - ~~2.~~**a. Use Standard Precautions, with emphasis on hand hygiene.**
   - ~~3.~~**b. Private room preferred. If semi-private room is used, select a roommate with no identified infection, including respiratory tract, urinary tract, or skin/wound infection.**
   - ~~4.~~**c. ~~There is no current recommendation that a~~ A patient ~~should~~is not required to wear a standard surgical mask when out of the room.**
2. ~~5.~~ Physicians' role ~~in implementing Standard Precautions and Transmission-based Precautions~~
   a. If a patient is known or suspected to be infected with a highly transmissible disease, or if a patient is infected or colonized with an epidemiologically important microorganism, appropriate isolation precautions should be written in the physician's order forms.
   b. In addition to hand washing before and after patient contact, wearing gloves before and discarding gloves and washing hands after touching any body substance, physicians

need to evaluate their interaction with patients, and use barriers such as masks, eyewear and apron based upon anticipated contact with infectious materials.

c. Physicians should be aware of their status in regard to current vaccination (rubella, measles, varicella, hepatitis B) and participate in the Medical Center's annual tuberculosis screening program. All physicians who have frequent contact with blood and body fluids should be immunized against hepatitis B.

~~6.~~**3.** The role of nurses and other direct care providers **is to:**~~in implementing Standard Precautions and Transmission-Based Precautions~~

a. Assure that isolation orders are entered.

b. **Perform hand hygiene**~~In addition to hand hygiene~~ before and after patient contact, wearing gloves before and discarding gloves and washing hands after touching any body substance.~~,~~ **N**~~n~~urses need to evaluate their interaction with the patient and use barriers such as masks, eyewear, and **gowns and/or** aprons based upon possible and anticipated contact with infectious aerosols, splashes, vomitus, etc. that may result during the contact.

c. If a patient has a disease that requires Transmission-based precautions, the nurse is responsible **to**~~for triage of~~ **triage** persons wishing to enter the patient's room.

d. Any **direct care** provider who uses reusable equipment for a patient in contact precautions is responsible to disinfect that item before it is used for another patient.

e. The nurse is responsible to communicate to receiving departments the isolation status of a patient. This is accomplished by completing the "hand off communication form" isolation section.

~~7.~~**4.** All direct care providers need to know their own hepatitis B, chicken pox, rubella and measles status and participate in the Medical Center's annual TB skin testing program. This participation is required by the hospital.

~~8.~~**5.** All direct care providers who have frequent contact with blood or body fluids should be immunized against hepatitis B. Free hepatitis vaccination is a benefit of employment at Tri-City Medical Center.

~~9.~~**6.** **Specimen Labeling**~~Reasons for NOT labeling specimens~~

a. **Standard Precautions tell us to consider all bodily fluids as potentially infectious regardless of the patients diagnosis. Standard precautions need to be utilized while handling all specimens. (**In 1990, the Clinical Laboratory established formal policies requiring that all specimens be handled as if potentially infectious. To place "blood and body fluid precautions" on specimen conveys the notion to others to treat this particular specimen with caution, but other specimen without the labeling need not be handled as carefully. ~~Standard Precautions tell us to consider all bodily fluids as potentially infectious regardless of the patient' diagnosis.~~ If needed, it is permissible to note the patient's diagnosis on laboratory requests, pathology requests, radiology request, etc. Please note that it is illegal in the state of California to note a person's HIV status on requests**)**.

~~10.~~**7.** Handling of soiled linen from patients' rooms

a. All linen must be handled in a consistent and identical manner because there are no "infectious linen" designations under Standard Precautions. All linen leaves the Medical Center in unmarked plastic bags. The contract laundry, also regulated by OSHA and the state, requires workers to wear protective barriers when handling soiled linen at all times. Linen should be handled minimally.

~~11.~~**8.** Dishware and eating utensils

a. The combination of hot water and detergents used in dishwashers is sufficient to decontaminate dishware and eating utensils. Therefore, no special precautions are needed for dishware (e.g., dishes, glasses, cups) or eating utensils; reusable dishware and utensils may be used for patients requiring Transmission-Based Precautions.

~~12.~~**9.** Disposal of waste from patients' rooms

a. All trash generated from individual patient rooms ~~can be disposed of in the regular trash unless~~ **follow general hospital waste guidelines. If waste is** saturated **and/**or

dripping with blood **place in the red "Biohazard" trash. See Infection Control Policy: Blood borne Pathogen Exposure Control Plan.**

~~13.~~**10.** All closed system fluid filled containers (e.g., Pleur-evac, autotransfusion, etc) are to be disposed of as follows:
   a. Obtain a red "biohazardous" plastic bag from the soiled utility room.
   b. Place the container into the bag and tie it securely by gathering the circumference and using a single knot to close the bag. Be sure to reinforce the bag if there is a leak or if leaking is anticipated.
   c. If a patient's room does not have a "biohazard" waste receptacle, carry the red bag to the soiled utility room and place it into the labeled biohazard barrel.

~~14.~~**11.** All suction canister liners and tubing should be changed every 24 hours or when ¾ full, whichever comes first. Suction canisters liners may be emptied in the hopper or treated with a Liquid Treatment System (LTS). Once the contents solidify, the LTS, the canister liner and its contents are discarded in the regular trash. Wound Dressings
   a. All wound dressings are to be disposed of in a manner as to confine and contain any body fluids that may be present. Wound dressings dripping with blood or bloody body fluids should be discarded in a red biohazard bag and placed into the biohazard barrel. Dressings with small amount of blood can be disposed of in the regular trash. Examples of these are IV dressings, trach site dressings, bandaids or cotton balls used in fingerstick glucose testing,
   b. Small dressings can be enclosed in a disposable glove used to remove the dressing. Pull the glove off inside out containing the dressing inside of it. The dressing and gloves can be discarded into the regular trash container in the patient's room.

C. **STANDARD PRECAUTIONS:**

1. Standard Precautions ~~combine the principles of Universal Precautions and Body Substance Isolation. Universal Precautions (Blood and Body Fluid)~~ **are**~~is~~ designed to reduce risk of transmission of blood-borne pathogens ~~while Body Substance Isolation is designed to reduce~~ transmission of pathogens to and from mucus membranes and non-intact skin.
   a. All blood, body fluids, secretions, excretions (except sweat) are handled as if potentially carrying bloodborne pathogens. Clean gloves are required when touching non-intact skin and mucus membranes.
2. Elements of Standard Precautions
   a. All personnel should implement Standard Precautions at all times regardless of the patient's diagnosis
   b. Hand Hygiene: See **Infection Control Policy: Hand Hygiene** ~~IC.8 and HR policy 415~~
      i. Respiratory Hygiene/Cough Etiquette education of healthcare facility staff, patients, and visitors is accomplished through New Employee and Physician Orientation, the patient hand book and signage posted at cough etiquette stations provided throughout the hospital. Tissues are provided along with hand hygiene solution and adult and child sized masks in patient waiting areas throughout the hospital.
   c. Gloves
      i. Wear gloves when touching blood, body fluids, secretions, excretions, contaminated objects, mucous membranes and non-intact skin.
      ii. Change gloves between tasks and procedures on the same patient when moving from one body site to another.
      iii. Remove gloves after use, before touching uncontaminated items and environmental surfaces, and before going to another patient.
      iv. Decontaminate hands immediately after removing gloves.
   d. Masks, Eye/Face Shields:
      ~~f.~~**i.** Wear a mask, eye protection or a face shield to protect mucous membranes of the eyes, nose, and mouth during procedures and activities that are likely to create splashes or sprays of blood, body fluids, secretions and excretions. (See

Infection Control Policy: ~~IC.10~~ Blood borne Pathogen Exposure Control Plan, Appendix: **Standard Precautions: Personal Precautions Equipment Table** ~~F~~)

~~g.~~**ii.** Wear a mask for insertion of catheters or injection of material into spinal or epidural spaces via lumbar puncture procedures (e.g., myelogram, spinal or epidural anesthesia).

e. Gown

i. Wear gown or plastic apron to protect the skin and prevent soiling of clothing during procedures and patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions or excretions or cause soiling of clothing.

3. **Flowers and P~~p~~otted P~~p~~lants**

i. Designate care and maintenance of flowers and potted plants to staff not directly involved with patient care

ii. If plant or flower care by patient-care staff is unavoidable, instruct the staff to wear gloves when handling the plants and flowers and perform hand hygiene after glove removal

~~D.~~**4.** Patient Care Equipment

~~1.~~**a.** Handle used patient care equipment contaminated with blood, body fluids, secretions and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of microorganisms to other patients and the environment.

~~2.~~**b.** Ensure that reusable equipment is properly cleaned before it is used for the care of another patient.

~~3.~~**c.** Single use items should be discarded.

~~4.~~**5.** Environmental Control

a. Routine cleaning and disinfection of environmental surfaces, beds, bedrails, bedside equipment, and other frequently touched surfaces per protocol.

~~5.~~**6.** Safe injection practices — **see PCS Medication Administration policy. T**he following practices apply to the use of needles, cannulas that replace needles, and, where applicable intravenous delivery systems:

a. Use aseptic technique to avoid contamination of sterile injection equipment.

~~b. Do not administer medications from a syringe to multiple patients, even if the needle or cannula on the syringe is changed.~~

~~c. Needles, cannulae and syringes are sterile, single-use items; they should not be reused for another patient nor to access a medication or solution that might be used for a subsequent patient.~~

~~d. Use single-dose vials for parenteral medications whenever possible.~~

~~e.~~**b.** Do not administer medications from single-dose vials or ampules to multiple patients or combine leftover contents for later use.

~~f.~~**c.** **Multi-dose vials should be dedicated to a single patient whenever possible.** If multidose vials must be used both the needle or cannula and syringe used to access the multidose vial must be sterile.

~~6.~~**7.** Do not keep multidose vials in the immediate patient treatment area and store in accordance with the manufacturer's recommendations; discard if sterility is compromised or questionable.

~~E.~~**D.** **TRANSMISSION-BASED PRECAUTIONS:**

1. Transmission-base**d** Precautions are used in addition to Standard Precautions for diseases that require extra barriers to prevent transmission.

a. Types of Transmission-based Precautions:

i. Airborne Precautions

ii. Droplet Precautions

iii. Contact Precautions

~~F. Transmission-based Precautions~~

~~1.~~**b.** Notify receiving department/services if patient requires transmission-based precautions

(i.e. Airborne, Contact or Droplet Precautions).

2. Airborne Precautions
   a. In addition to Standard Precautions, use airborne precautions for patients known or suspected to be infected with microorganisms transmitted by airborne droplet nuclei.
   b. Place patient in a Airborne Infection Isolation room AIIR with at least 6-12 air exchanges per hour, HEPA filtration and negative pressure. If the AIIR rooms are not available Engineering can assist with a temporary set-up. **Every effort must be made to place a p~~P~~atient ~~must be placed~~ in a AIIR with in 5 hours of identification.**
   c. Wear respiratory protection (N95 respirator or Powered Air Purifying Respirator) when entering the room. See the **Infection Control Policy: ATD:** Tuberculosis Control Plan ~~IC. 11~~ for more information.
   d. Minimize patient dispersal of microorganisms by placing a surgical mask (not an N95 respirator) on the patient during transport.
3. Droplet Precautions
   a. In addition to Standard Precautions, use Droplet Precautions for a patient known or suspected to be infected with organisms that are transmitted by droplets
   b. Place the patient in a private room or cohort patients who have the same infection with the same microorganism.
   c. Wear masks when entering the patient room.
   d. Mask patients during transport.
4. Contact Precautions
   a. In addition to Standard Precautions, use Contact Precautions for specified patients known or infected or colonized with epidemiologically important microorganism that can be transmitted via direct contact with the patient or equipment in the patients environment such as MRSA and VRE. (See **Infection Control Policy:** management of patient with **MDRO's**~~MRSA IC6.3 and VRE IC6.6~~)
   b. Place patient in a private room or cohort patients who are carrying the same microorganisms. When a private room is not available and cohorting is not achievable, consider the epidemiology of the microorganism and the patient population when determining patient placement. First try to select someone with no invasive lines (IV, central line, foley, trach, etc) or open wound. If this is not possible, then select someone with an invasive line that carries a low risk of infection, such as a peripheral IV or NG tube. Consultation with infection control **staff**~~professionals~~ is advised when there are questions about patient placement.
   c. Gloves
      ~~d.~~**i.** Wear gloves whenever touching the patient's intact skin or surfaces and articles in close proximity to the patient (e.g.,medical equipment, bed rails) Don gloves upon entry into the room or cubicle.
   ~~e.~~**d.** Gowns
      ~~f.~~**i.** Wear a gown whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the patient. Don gown upon entry into the room or cubicle.
      ~~i.~~**ii.** Remove gown and gloves and observe hand hygiene before leaving the patient-care environment
   ~~g.~~**e.** Dedicate the use of non-critical equipment to a single patient, when possible
   ~~h.~~**f.** Clean and disinfect commonly used items before use of another patient **with hospital approved disinfectant**~~.~~
   ~~i.~~**g.** Patient transport
      ~~j.~~**i.** Remove and dispose of contaminated PPE and perform hand hygiene prior to transporting patients on Contact Precautions. Don clean PPE to handle the patient at the transport destination.

~~G.~~ ~~**MANAGEMENT OF IMMUNOCOMPROMISED PATIENTS**~~

~~1. Immunocompromised patients who are identified as patients at high risk have the greatest risk~~

~~for infection and include persons with severe neutropenia (i.e., an absolute neutrophil count [ANC] of <500 cells/mL) for prolonged periods of time, recipients of allogeneic HSCT, and those who receive the most intensive chemotherapy (e.g., patients with childhood acute myelogenous leukemia).~~

~~2. Do not allow staff or visitors who have symptoms of respiratory infection to enter the room.~~

~~3. Use Standard Precautions, with emphasis on hand hygiene.~~

~~4. Private room preferred. If semi-private room is used, select a roommate with no identified infection, including respiratory tract, urinary tract, or skin/wound infection.~~

~~5. Do not place patient in a negative pressure room, unless they have a condition which requires Airborne Precautions.~~

~~6. There is no current recommendation that a patient should wear a standard surgical mask when out of the room. The patient should however avoid contact with anyone exhibiting symptoms of a respiratory illness.~~

~~7. Do not allow fresh or dried flowers, or potted plants in patient care areas for immunosuppressed patients.~~

~~8. Patient will be placed on a Neutropenic Diet.~~

E. RELATED DOCUMENTS:

1. **PCS Neutropenic Precautions**
2. **PCS Medication Administration policy**
3. **Infection Control Policy: ATD: Tuberculosis Control Plan**
4. ~~9.~~ **Infection Control Policy: Blood borne Pathogen Exposure Control Plan**

~~H.~~F. REFERENCES

1. ~~I.~~ Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing *Transmission of Infectious Agents in Healthcare Settings, June 2007 http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf*

~~J. Amori, G. Isolation Systems in: APIC Text of Infection Control and Epidemiology. Washington DC, 2000:15.1-8.~~

2. Sehulster LM, Chinn RYW, Arduino MJ, Carpenter J, Donlan R, Ashford D, Besser R, Fields B, McNeil MM, Whitney C, Wong S, Juranek D, Cleveland J. Guidelines for environmental infection control in health-care facilities. Recommendations from CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC). Chicago IL; American Society for Healthcare Engineering/American Hospital Association; 2004.

3. **Grota, P. (Ed.). (2014) APIC Text of Infection Control and Epidemiology (4th ed). Washington DC: Association for Professionals in Infection control and Epidemiology, Inc.**

~~K.~~

Tri-City Medical Center
Oceanside, California

Women and Newborn Services
Neonatal Intensive Care Unit (NICU)

SUBJECT: **CRITERIA FOR CASE REFERRALS TO MORBIDITY AND MORTALITY (M&M) MEETINGS**

ISSUE DATE: **8/06**
REVISION DATE(S): **4/09, 8/12**

Department Approval Date(s):	**02/15**
Division of Neonatology Approval Date(s):	**04/15**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**08/15**
Professional Affairs Committee Approval Date(s):	**09/15**
Board of Directors Approval Date(s):	

A. **PURPOSE:**
1. To facilitate discussion for educational purposes and to improve the outcomes of newborns.

B. **POLICY:**
1. It is the policy of Tri-City Medical Center to have ~~at least~~ a minimum of quarterly **Morbidity and Mortality** (M&M) review meetings.

C. **PROCEDURE:**
1. The neonatologist/**Allied Health Professional**~~**licensed independent practitioner (LIP)**~~ in collaboration with the obstetrician identifies neonates that meet the criteria for the M&M meeting.
2. These criteria include, but are not limited to any:
   a. Death;
   b. Transfer out;
   c. Birth that requires extensive resuscitation;
   d. Major birth trauma (i.e., neonatal **respiratory** depression);
   e. IVH 3 & 4;
   f. ROP requiring laser surgery;
   g. Complications from procedure resulting in the prolongation of hospital stay or disability;
   h. Major congenital abnormalities; or
   i. Apgar s**cores of** less than 5 at 1 minute and 5 minutes of age
3. The team ~~will~~ consist**s** of all disciplines involved in the decision making and care for mom and baby, i.e., genetics; lab; clinical nurse specialist; social worker; performance improvement representative; neonatologist; obstetrician; NICU and OB nurses; ultrasound technician; and/or pathologist.
4. The M&M is held quarterly.
5. Team members are invited to participate through email and/or telephone calls.

D. **SUPPORTIVE DATA:**
1. Collaborative aims of M&M are to improve the health of pregnant women, infants and children by collecting high quality information on perinatal outcomes and research utilization, which then allow for performance improvement and bench marking processes in perinatal care and neonatal intensive care units.

E. **REFERENCE LIST:**

~~California Perinatal Quality Care Collaborative (CPQCC), 2005~~

1. **CCS Manual of Procedures, Chapter 3.25, CCS Standards for Neonatal Intensive Care Units; Chapter 3.25-29. 1999**

~~F. APPROVAL PROCESS~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Medical Executive Committee~~
~~4. Professional Affairs Committee~~
~~5. Board of Directors~~

DELETE - Policy will be replaced by Mosby's policy

Tri-City Medical Center	Women's & Children's Services Manual - NICU
PROCEDURE: LUMBAR PUNCTURE, ASSISTING WITH	
Purpose:	To outline the nursing management of the newborn undergoing lumbar puncture.
Supportive Data:	A lumbar puncture may be done for diagnostic purposes to determine the pressure within the cerebrospinal cavities, to determine the presence of an obstruction to the flow of cerebrospinal fluid, or to remove a specimen of cerebrospinal fluid for laboratory examination. Cessation of post-hemorrhagic ventricular dilation in association with serial lumbar punctures has been well documented.
Equipment:	1. Pediatric lumbar puncture tray 2. Antiseptic solution or antiseptic swab sticks 3. Sterile gloves 4. Goggles or mask with shield 5.1. Additional spinal needles
Issue Date: 9/07	Revision Date: 6/09, 6/11, 8/12

A. **PROCEDURE:**

1. Verify informed consent has been obtained.
2. Perform hand hygiene.
3. Place newborn on radiant warmer maintaining the monitoring devices currently in use.
4. Open the pediatric lumbar puncture tray aseptically.
5. Pour antiseptic solution in the labeled area of the tray or when directed by physician, have additional personnel provide antiseptic solution swab stick from commercially prepared and labeled package.
6. Perform "time-out" to verify patient and procedure with physician.
7. Place the newborn in the lateral recumbent or sitting position per physician preference.
8. Ensure that comfort is provided for the infant during/after the procedure. Refer to NICU "Pain Management" (6070-108) policy.
9. Monitor newborn's tolerance/intolerance during the procedure.
10. Notify physician of signs of intolerance (e.g., apnea, cyanosis, bradycardia).
11. Cleanse off antiseptic solution after the physician has applied the bandage strip.
12. Discard items in appropriate receptacles.
13. Return newborn to incubator or open crib as applicable.
14. Perform hand hygiene.
15. Send correctly labeled specimens to the lab immediately.
16. Remove bandage strip as directed by physician.
17. Document procedure, including patient's response, in the infant's medical record.

B. **EXTERNAL LINKS:**

C. **REFERENCES**

1. Verklan, M.T. & Walden, M. (Eds.). (2009). *Core curriculum for neonatal intensive care nursing*, 4th ed. St. Louis: Saunders.
2. Bowden, V. & Greenberg, C. (2008). *Pediatric nursing procedures*, 2nd ed. Philadelphia: Wolters Kluwer; Lippincott Williams & Wilkins.

D. **APPROVAL PROCESS**

1. Clinical Policies & Procedures Committee
2. Nurse Executive Council
3. Medical Executive Committee
4. Professional Affairs Committee

E.A. Board of Directors

Department Review	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
6/09, 6/11, 8/12, 3/15	3/15	n/a	8/15	09/15	

Tri-City Medical Center	Women's and **Newborn**~~Children's~~ Services Manual - NICU
PROCEDURE:	**~~NASOJEJUNAL (NJ)~~ TRANSPYLORIC TUBE, INSERTION, MAINTENANCE, AND REMOVAL OF**
Purpose:	To facilitate nutrition to infants who are unable to take adequate calories orally or through a nasal/oral gastric tube due to problems related to gastro esophageal reflux, apnea and bradycardia, or assisted ventilation.
Supportive Data:	Nasojejunal feedings are most often used when there is a danger of pulmonary aspiration. The pyloric sphincter and peristalsis of the small bowel provides a barrier that lessens the risk of regurgitation and aspiration.
Equipment:	1. Enteral tube (type and size appropriate for intended purpose) **2.** Non-sterile gloves ~~2.~~**3.** **Hydrocolloid dressing or appropriate skin protective barrier** ~~3.~~**4.** Transparent dressing ~~4.~~**5.** 5-10 ml syringe **6.** Stethoscope **7. Water-soluble lubricant or sterile water** ~~5.~~**8.** **Syringe feeding pump and ~~extention~~extension tubing.**
Issue Date:11/08	

A. **PROCEDURE:**

1. **Insertion**

a. Obtain physician **or Allied Health Professional**~~**Licensed Independent Practitioner (LIP)**~~ order for placement of ~~NJ~~**transpyloric** tube and KUB x-ray for confirmation of placement after insertion.

b. Perform hand hygiene and apply non-sterile gloves.

c. Assemble appropriate equipment.

d. Confirm patient identity using two-identifier system. ~~Refer to Patient Care Services "Identification, Patient" policy~~

e. Position patient on right side and head of bed elevated **to 30-45 degrees**.

f. Immobilize patient as needed.

g. Determine the length of tube to be inserted by measuring the tube from the **tip**~~bridge~~ of the nose to the earlobe, and from the earlobe to the termination of the xiphoid process, then **from the xyphoid process to the right lateral costal margin.**~~add 10 – 12 cm.~~

h. Mark the measured distance on the tube with a small piece of tape **or make a note of the pre-printed centimeter measurement on the tubing.**.

i. Lubricate the distal end of the tube with **sterile water or** water-soluble lubricant.

j. Insert the tube gently through the nares, aiming down and back.

k. If there appears to be resistance, ***do not force***. Try rolling the enteral tube gently. If still unable to pass the enteral tube, remove it and try the other nostril. Do not pass the enteral tube beyond the original mark until further assessment is made. Remove enteral tube at once if there are signs of distress, coughing, gasping, **apnea, bradycardia** or cyanosis.

l. Allow the patient to **stabilize** ~~rest~~ and resume insertion procedure.

m. Continue to pass enteral tube until marked position is at the tip of the nostril or at the lip.

n. **After approximately 10 minutes with infant still positioned on the right side,** Verify placement of tube **by gently aspirating with a syringe.**~~in stomach by listening with a stethoscope over the epigastric area while injecting small amount (1-3 ml) of air and/or aspirate gastric contents and then return.~~ **The tube should be correctly placed if the aspirate has no air (snap back) or is bilious (gold or yellow in color).**

Department Review	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
6/09, 6/11, 8/12, 5/15	5/15	n/a	8/15	09/15	

~~o. Once gastric placement is verified, continue to advance tube 1-2 cm at a time, alternating with injecting 5 ml of sterile H_2O over a 15-minute period. Number of attempts of insertions should be limited to two. If successful NJ placement is not achieved, consult with the physician.~~

~~i. Injection of water promotes passage of the tube through the pyloris.~~

~~ii. Once the tube has advanced past the pyloris, air should not be able to be aspirated. Aspiration should yield bile or nothing.~~

~~p. Check placement by aspirating back on syringe. Plunger on syringe should "snap-back" due to negative pressure.~~

~~q. NJ tube should not be used until placement is confirmed via x-ray by attending physician.~~

o. If tube is not in far enough, retape to give external slack and allow peristalsis to advance the tube to the correct position. Avoid pushing the tube for advancement after initial placement. If the tube does not cross the pyloris within the first 30 minutes of placement it most likely wont and the procedure should be restarted.

~~r.~~**p.** Secure tube in place with transparent dressing **and obtain ~~xray~~x-ray confirmation before use**.

~~s.~~**q.** Place a small label with insertion **centimeter ~~cm~~ marking and** date on enteral tubing just below the hub.

~~t.~~**r.** Discard used supplies and gloves in appropriate receptacle.

~~u.~~**s.** Perform hand hygiene.

~~v.~~**t.** Document the following in the patient's medical record:

i. Date, time, tube size, tube location, and length of the tube at the mark located at the mouth or nostril.

~~i.~~**ii.** Tolerance of the procedure.

2. **Maintenance:**

a. Ongoing proper placement is verified by:

i. Measuring the distance from nares to the distal end of the ~~NJ~~ **transpyloric** tube every shift.

ii. A "snap-back" upon aspiration of the plunger on a syringe.

iii. **Residuals**~~Aspirates~~ do not need to be checked when feeding through a~~n~~ ~~NJ~~**transpyloric** tube.

b. Refer to physician orders for feedings. Feedings should be delivered at a continuous rate **with a pump that can detect obstruction**. Infusion duration is never to be less than two hours. NO BOLUS FEEDINGS.

3. **Removal:**

a. Removal of the ~~NJ~~**transpyloric** tube:

i. Perform hand hygiene and apply non-sterile gloves.

ii. Remove transparent dressing using warm water or saline prep pad.

iii. Pull tube out of nose in a steady motion. If resistance is encountered, rotate the tube and again attempt removal. The tube should not be forced out. If resistance continues to be met, location of the tube may need to be verified using x-ray.

iv. Discard used supplies and gloves in appropriate receptacle.

~~B.~~**v.** Document the procedure in the patient's medical record.

~~C.~~B. REFERENCES:

~~1. Altimier, L., Brown, B., Tedeschien, L. (2006). NANN Guidelines for Neonatal Nursing Policies, Procedures, Competencies, and Clinical Pathways. 4th Edition.~~

~~2. Anderson, D. (2002). Feeding the Ill or Pre-term Infant. *Neonatal Network*; 21(7), 7-14.~~

~~3. Ista, E., & Joosten, K. (2005). Nutritional assessment and enteral support of critically ill children. *Critical Care Nursing Clinics of North America*, *17*(4), 385-93.~~

1. Gomella, Tricia Lacy, M. Douglas Cunningham, and Fabien G. Eyal, eds. *Neonatology: management, procedures, on-call problems, diseases, and drugs.* 7th. New York: McGraw Hill Education Lange, 2013.

2. MacDonald, M., J. Ramasethu, and K. Rais-Bahrami. *Atlas of procedures in neonatology* (5th ed.). Philadelphia: Lippincott, Williams, & Wilkins. 2012.

~~4.~~**3.** Merenstein G.G. & Gardner S.L. (2011). Handbook of neonatal intensive care, 7th Ed. St. Louis, MO. Mosby.

~~D. **APPROVAL PROCESS**~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Medical Executive Committee~~
~~4. Professional Affairs Committee~~
~~5. Board of Directors~~

DELETE - This policy will be replaced with the Mosby's policy

Tri-City Medical Center | Women's & Children's Services Manual - NICU

PROCEDURE:	**URINARY CATHETER, INSERTION AND REMOVAL OF**
Purpose:	To outline the nursing responsibilities in the placement of a urinary catheter.
Supportive Data:	Catheterization of the bladder involves introducing a tube through the urethra and into the bladder. The insertion may be for a straight or indwelling catheter. The procedure is used for any number of reasons, including, but not limited to, obtaining urine for analysis and/or culture for those who are not able to void spontaneously. Urinary catheterization requires a physician's order. This procedure will require two personnel.
Equipment:	1. Examination light 2. Sterile gloves 3. Semi-permeable dressing 4. Cotton tip applicators **For Straight Catherization:** 1. Latex Free 5FR Pedi Cath Kit which includes: -drape -sterile gloves -surgical lubricant -PVP swabstick packet -protective cather sheath -catheter -graduated specimen tube/cap **For Indwelling Catheterization:** 1. Urinary collection kit with catheter – 3.5 Fr. or 5.0 Fr.
Issue date: 10/06	Revision date(s): 9/07, 6/09, 6/11, 8/12

I. **PROCEDURE:**

1. Male Infant:

a. Perform hand hygiene.

b. Gather necessary equipment, supplies and additional personnel.

c. Confirm patient identity using two-identifier system. Refer to Patient Care Services "Identification, Patient" (IV.A) policy

d. Swaddle the infant's arms and have the second person restrain the infant supine in the frog-leg position.

e. Establish a sterile working area using a sterile towel spread open or with the sterile collection kit tray.

f. After donning sterile gloves, utilize sterile technique to prepare all necessary equipment on the sterile field.

g. Drape sterile towels across the lower abdomen and across the infant's legs. If utilizing for straight catheterization, a specimen collection container, the open end of the catheter may be placed inside the container on the sterile towel prior to catheter insertion for immediate specimen collection upon catheter placement.

h. Stabilize the shaft of the penis with the non-dominant hand. This hand is now considered contaminated.

i. If the infant is uncircumcised, gently retract the foreskin just enough to expose the meatus. Do not attempt to lyse adhesions. The young male infant has physiologic phimosis, and the foreskin cannot be fully retracted. If the foreskin is tightly adherent, attempt to line up the preputial ring and the meatus.

j. Apply gentle pressure at the base of the penis to avoid reflex micturition.

k. Using the free hand for the rest of the procedure, clean the glans three times with antiseptic solution. Begin at the meatus and work outward and down the shaft of the penis. Blot dry with sterile gauze if necessary.

l. Gently insert the catheter through the meatus just until urine is seen in tube.

Department Review	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
9/07, 6/09, 6/11, 8/12, 3/15	4/15	n/a	8/15	09/15	

i. During insertion, apply gentle upward traction on the penile shaft to prevent kinking of the urethra.
ii. If the meatus cannot be visualized, insert the catheter through the preputial ring in a slightly inferior direction. If there is any question about catheter position, abandon the procedure.
iii. If resistance is met at the external sphincter, hold the catheter in place, applying minimal pressure. Generally, spasm will relax after several minutes, allowing easy passage of catheter. If not, suspect obstruction and abandon the procedure.
iv. Do not move the catheter in and out. This will increase the risk of urethral trauma.
v. Do not insert extra tubing length in an attempt to stabilize a catheter to be left indwelling. This will increase the risk of knotting.
vi. Collect specimen for culture. Securely attach the cap of the specimen container.
vii. If the catheter is to remain indwelling, secure catheter to inner thigh with a semi-permeable dressing.
viii. If the catheter is to be removed, gently withdraw it when urine flow ceases.
ix. Discard used supplies in the appropriate receptacle.
x. Perform hand hygiene.
xi. Attach a printed patient label to the specimen container, place in plastic bag with appropriate paper work attached and send to lab.
xii. Document the volume of urine obtained and the infant's response to the procedure in the patient medical record.

2. Female Infant:
a. Follow the above appropriate steps for patient and equipment preparations (steps 1.a-g.).
b. Retract the labia minora.
i. Use sterile gauze sponges with non-dominant hand, or
ii. Have an assistant retract the labia with two cotton-tipped applicators.
c. Using the free hand for the rest of the procedure, cleanse the area between the labia minora three times with antiseptic solution.
i. Swab in an anterior to posterior direction to avoid drawing fecal material to the field.
ii. Blot dry with sterile gauze.
d. Visualize the meatus.
i. The most prominent structure is the vaginal introitus. The urethral meatus lies immediately anterior (between the clitoris and the introitus.)
ii. The meatus may be observed by the introital fold. Gently push the fold down with a cotton-tipped applicator.
iii. If the meatus is not visible, the infant may have female hypospadias (the meatus is on the roof of the vagina, just inside the introitus.) The urethra must then be catherized blindly, which may require a curved tip catheter or urologic assistance.
e. Gently insert the catheter only until urine appears in the tube. Do not insert extra tubing.
f. Follow above steps (L. vi-xii).

3. Removal of an Indwelling Catheter:
a. Perform hand hygiene.
b. Collect necessary equipment and supplies.
c. Don non-sterile gloves.
d. Position the infant supine in the frog-leg position with the arms swaddled.
e. Place a waterproof pad under the infant's buttocks.
f. Gently remove any tape holding urinary catheter in place.
g. Gently remove the urinary catheter by withdrawing slowly and evenly.
h. Wash the infant's genital area with warm water and mild cleansing agent. Rinse and dry the area.
i. Remove the waterproof under-pad and re-diaper the infant.
j. Properly dispose of all used supplies including the urinary catheter and drainage and collection bag, noting the final amount of urine collected.
i. Perform hand hygiene.
i. Document the procedure, including infant's response to the procedure, in the patient medical record.

B. **EXTERNAL LINKS:**

C. **REFERENCES:**

1. Bowden, V. & Greenberg, C. (2008). *Pediatric nursing procedures*, 2nd ed. Philadelphia: Wolters Kluwer; Lippincott Williams & Wilkins.
2. MacDonald, M. G. & Ramasethu, J. (Eds.). (2007). *Atlas of procedures in Neonatology*, 4th ed. Lippincott Williams & Wilkins.

D. **APPROVAL PROCESS:**

1. Clinical Policies & Procedures Committee
2. Nurse Executive Council
3. Medical Executive Committee
4. Professional Affairs Committee
5. Board of Directors

Tri-City Medical Center
Oceanside, California

PHARMACY ~~SERVICES POLICY~~ MANUAL

ISSUE DATE: 08/12	**SUBJECT: Automatic Dose Rounding**
REVISION DATE(S):	**~~POLICY NUMBER: 8390-6005~~**
Department Approval Date(s):	**07/12, 07/15**
Pharmacy and Therapeutics Approval Date(s):	**07/12, 07/15**
Medical Executive Committee Approval Date(s):	**08/12, 08/15**
Professional Affairs Committee Approval Date(s):	**09/15**
Board of Directors Approval Date(s):	**08/12**

A. **PURPOSE:**

1. **To provide a procedure for rounding medication dosages to deliver high-quality, cost-effective pharmaceutical care while minimizing charge errors and medication waste.** **~~waste of medications.~~**

~~To minimize charge errors in accounting, and promote optimal cost effective patient care.~~
~~Avoid the waste of medications~~

~~B. POLICY STATEMENT~~

~~To maintain a protocol of rounding medication dosages to fit with available product sizes, which is consistent with safe medication administration and minimal risk, while maintaining optimal therapeutic response.~~

B. **PROCEDURE:**

1. **It is preferred that the prescriber round the dose of a medication to the nearest available package size or closest measurable dose.**
2. **If the prescriber does not round to the nearest available package size or closest measurable dose, the pharmacist will round a dose to the nearest available package size or closest measurable dose providing the following criteria are met:**
   - a. Doses may be adjusted by the pharmacist for ~~the targeted~~ **approved** medications listed below **or pursuant to an approved protocol (for example enoxaparin and heparin per the Pharmacy Procedure: Anticoagulation Dosing and Monitoring).**~~within 10% (plus or minus) of the calculated prescribed dose~~
     - i. **Approved Medications:**
       1) **Chemotherapy**
       2) **Immune globulin**
       3) **G-CSF: granulocyte colony-stimulating factors (i.e., filgrastim)**
       4) **Erythropoetin stimulating factors (i.e. Epogen)**
       5) **Coagulation factors (VII, VIII, IX, Prothrombin Complex Concentrate)**
       6) **Alpha-proteinase inhibitors (i.e. Zemaira, Aralast)**
       7) **Antimicrobials, antifungals, and antivirals**
       8) **Tranexamic acid**
   - b. **Doses of non-chemotherapeutic agents will be adjusted within 10% (plus or minus) of the calculated prescribed dose.**
   - c. Chemotherapeutic agents may be adjusted ~~within 1% (plus or minus) of the calculated prescribed dose~~**pursuant to Pharmacy Policy:Chemotherapy, Prescribing, Processing, and Preparation**
   - d. **The dose for the ordered medication is within the normal dosing range based upon the indication, age, weight, and clinical status.**

3. **The pharmacist shall contact the prescriber prior to rounding the dose of an unapproved medication.**
4. **Dose-rounding for patients on an investigational protocol will occur based on protocol specifications only.**

~~1.~~**5.** The prescrib~~ering physicians~~ shall be notified of potential rounding of doses greater than 10% **for non-chemotherapeutic agents** ~~(or 1% for chemotherapy)~~ and shall approve the new dose prior to any changes made by the pharmacist. **For Chemotherapeutic agents, the prescriber will be notified pursuant to Pharmacy Policy: Chemotherapy, Prescribing, Processing, and Preparation.**

~~2.~~**6.** The pharmacist **shall** round~~s~~ the dose and complete~~s~~ the order "per protocol" in the patient medical record.

C. **RELATED DOCUMENTS**:

1. **Pharmacy Policy**: **Chemotherapy, Prescribing, Processing, and Preparation**
2. **Pharmacy Procedure: Anticoagulation Dosing and Monitoring**

~~Doses rounded outside the range need to be completed with a verbal telephone order~~
~~Medications to be included:~~

~~Chemotherapy~~
~~IVIG~~
~~G-CSF: granulocyte colony-stimulating factors (i.e., filgrastim)~~
~~Hemophilia factors~~
~~Antibiotics~~

~~**References:**~~

~~Dooley M, Singh S, Michael M. Implications of dose rounding of chemotherapy to the nearest vial size. Support Care Cancer 2004.12;653-656.~~
~~Fasola G, et al. Drug waste minimization and cost-containment in Medical Oncology: Two-year results of a feasibility study. BMC Health Services Research 2008.8;70~~
~~Sigel J, Safe Practices for IVIG Management. Pharmacy Purchasing & Products. 2010:7;16~~

Tri-City Medical Center
Oceanside, California

~~POLICY~~ PHARMACY MANUAL

ISSUE DATE: 03/00 **SUBJECT:** Decreasing Medication Errors

REVISION DATE: 07/06, 07/09~~8~~, 01/12 ~~POLICY NUMBER: 8390-2113~~

Department Approval Date(s):	**03/15**
Pharmacy & Therapeutics Committee Approval Date(s):	**06/05, 07/06, 07/09, 1/12, 07/15**
Medical Executive Committee Approval Date(s):	**06/05, 07/06, 07/09, 1/12, 08/15**
Professional Affairs Committee Approval Date(s):	**09/15**
Board of Directors Approval Date(s):	**06/05, 07/06, 07/09, 1/12**

A. **POLICY**:

1. It is the policy of ~~Tri-City Medical Center~~**Tri-City Healthcare District (TCHD)** ~~to institute a "Medication Safety Awareness Program" and~~ to take a proactive approach by focusing performance improvement activities ~~on~~ **toward reducing** medication ~~use~~**errors**. **Staff is reminded**~~Be aware~~ that errors can occur at any step of the process: prescribing, ordering, dispensing, administering or monitoring the effects of the medication.
2. The Institute for Safe ~~Medical~~ **Medication** Practices **(ISMP)** has identified some common sources of errors:
   a. Unavailable patient information prior to dispensing or administering a drug (lab values, allergies, etc.)
   b. Unavailable drug information (written resources)
   c. Miscommunication of drug orders (similar names, use of zeros, inappropriate abbreviations, poor handwriting)
   d. Problems with labeling, packaging
   e. Drug Standardization, storage (stocking multiple concentrations of the same drug, look-alike containers)
   f. Drug device use and monitoring (lack of standardization in drug delivery devices, unsafe equipment)
   g. Environmental stress (distractions, noise during transcription or dispensing, ~~too long shifts~~ **long work hours**)
   h. Limited staff education ~~(on problem prone drugs)~~
   i. Limited patient education
3. The Institute of Safe Medication Practices also determined that a majority of medication errors resulting in death or serious injury were caused by "high alert medications":
   a. Insulin
   b. Opiates and narcotics
   c. Injectable potassium chloride (or phosphate) concentrate
   d. Intravenous heparin
   e. Sodium chloride solutions above 0.9%
4. ~~Tri-City Medical Center~~**TCHD** has adopted the following strategies to decrease the incidence of medication errors:
   a. A unit dose system of medication distribution has been implemented.
   ~~b. A quarterly Pharmacy Newsletter will be distributed to every patient care unit and to physicians, updating information on drugs and Formulary changes.~~
   ~~c.~~**b.** Information on ordered medications will be produced on the nursing units and provided, in writing, for the patient/family on discharge. The Pharmacist will be available to counsel patients on complex drug therapies.
   ~~d.~~**c.** The Pharmacy and Therapeutics Committee has developed standardized practices for prescribing medications:
      i. All drug orders must be written in the metric system. Units must be spelled out.

ii. Medication orders must include the name of the drug, dosage amount and form.
iii. A leading zero (0) must always precede a decimal point for a dose less than one (1); a trailing zero (0) is never to be used after a decimal.
iv. The use of unapproved abbreviations (see ~~listing)~~ **"Patient Care Services Policy: Use of ~~Unapproved~~ Abbreviations ~~Policy~~)** will be avoided.

~~e.~~**d.** Storage of medications will assist in distinguishing similar products from one another.

~~f.~~**e.** There will be special awareness with appropriate safeguard policies followed in the ordering, storage and administration of the identified "high-risk drugs".

~~g. Pharmacists will make daily rounds on all patient care units.~~

~~h.~~**f.** ~~Medication errors will be reported~~**Staff are encouraged to report medication errors which are then reviewed,** ~~and~~ trended**, and reported to the** ~~via the~~ Pharmacy and Therapeutic**s** Committee

g. Medication event reporting ~~Policy IV.V located in the Patient Care Services manual will be utilized for reporting of all medication errors.~~ **shall be done according to Administrative Policy Incident Report - Quality Review Report (QRR) RL Solutions 396.**

h. The physician shall be notified of all medication errors upon discovery. If there was no harmful outcome from the error, the notification may take place during the next business day.

~~i. Medication errors attributable in whole or in part, to the Pharmacy or its personnel will adhere to the reporting process described in PCS Policy IV.V and will also do the following:~~

~~i. Notify the physician of the error~~
~~ii. Investigation of Pharmacy medication errors is initiated within two business days from the date the medication error is discovered~~
~~iii. The record for quality assurance review for a medication error contains the following:~~
~~1) Date, location and participants in the quality assurance review~~
~~2) Pertinent date and other information related to the medication error(s) reviewed~~
~~3) Findings and determinations~~
~~4) Recommended changes to Pharmacy policy, procedure systems or processes, if any~~
~~5) The record of the quality assurance review is immediately retrievable in the Pharmacy and is maintained in the Pharmacy for at least one year from the date it was created.~~

~~j.~~**B. RELATED DOCUMENTS:**

1. **Patient Care Services Policy: Use of ~~Unapproved~~ Abbreviations**
2. **Administrative Policy: Incident Report-Quality Review Report (QRR) RL Solutions 396**

Tri-City Medical Center
Oceanside, California

~~POLICY~~ PHARMACY MANUAL

ISSUE DATE: 01/85

SUBJECT: Drug Compounding for Medication Not Commercially Available

REVISION DATE: 03/06

~~POLICY NUMBER: 8390-3112~~

Department Approval Date(s):	**06/15**
Pharmacy and Therapeutics Approval Date(s):	**06/05, 03/06, 07/09, 1/12, 07/15**
Medical Executive Committee Approval Date(s):	**06/05, 03/06, 07/09, 1/12, 08/15**
Professional Affairs Committee Approval Date(s):	**09/15**
Board of Directors Approval Date(s):	**06/05, 03/06, 07/09, 1/12**

A. **POLICY**:

1. It is the policy of this institution to allow orders for compounded drugs or drug mixtures not commercially available as appropriate to meet the needs of the patient population, following applicable state and federal law, rules and regulations. Compounded drugs may be prescribed and when the licensed independent practitioner determines, in his/her professional judgment, that the compounded drug's benefits over any approved alternative, justify the risk for a particular patient. The goal is **procurement or** preparation of safe and effective products using the best available resources and techniques.

B. **PROCEDURE**:

1. The Pharmacy Department ~~will~~ **may** ~~prepare~~ **procure** compounded drugs **from a contracted Compounding Pharmacy** in situations where drug **products are**~~s~~ not commercially available **and/or a suitable alternative does not exist.**

a. The following includes, but may not be limited to reasons for ordering and/or preparing compounded drugs:

i. The drug required is not manufactured in the needed strength.

ii. The prescriber requests a different form of the drug to improve patient compliance with prescribed drug therapy (for swallowing or taste purposes, etc.).

iii. The prescribed drug needs to be combined in forms not available from the manufacturer to improve patient response to prescribed drug therapy.

iv. The patient is allergic to inactive ingredients (dye, lactose, etc.) in the manufactured form of the drug.

v. The prescribed therapy requires tailoring to the individual patient (intravenous feeding solutions, chemotherapy, etc.).

vi. The prescribed therapy requires tailoring to the individual patient (intravenous feeding solutions, chemotherapy, etc.).

2. The Pharmacy Department shall not prepare compounded drug products for administration into the eye or inhalation; or any drug product from non-sterile ingredients. Refer to Pharmacy Policy Sterile Product Preparation.

~~1.~~**3. Extemporaneously prepared products by the Pharmacy Department must be supported by evidence-based literature and a recipe must exist** ~~are widely used based on literature reports and where there exists a recipe~~ for ~~-~~the preparation of ~~these~~ products. ~~The following includes, but may not be limited to reasons for ordering and preparing compounded drugs:~~

~~a. The drug required is not manufactured in the needed strength.~~

~~b. The prescriber requests a different form of the drug to improve patient compliance with prescribed drug therapy (for swallowing or taste purposes, etc.).~~

~~c. The prescribed drug needs to be combined in forms not available from the manufacturer to improve patient response to prescribed drug therapy.~~

~~The patient is allergic to inactive ingredients (dye, lactose, etc.) in the manufactured form of the drug.~~

~~The prescribed therapy requires tailoring to the individual patient (intravenous feeding solutions, chemotherapy, etc.).~~

4. The drug to be compounded must be individually prescribed for an identified patient.
5. A bulk drug substance (the chemical that becomes the drug's active ingredient) qualifies for use in compounding when:
   a. It is found in a FDA-approved drug.
   b. It is listed in a book of widely used drug substances published by the *United States Pharmacopeial Convention* (authoritative body).
   c. It is listed in a FDA rule as acceptable for pharmacy compounding.
6. Previously marketed drugs found to be unsafe or ineffective and removed from the market ~~may~~ **shall** not be compounded.
7. **If inclusion criteria are met and no exclusion criteria exist,** ~~P~~**p**rior to preparing the compounded drug, the Pharmacist will review the medical record of the patient. The risks of the patient receiving compounded drug, along with the benefits, will be weighed in the context of a specific patient's medical condition. If the Pharmacist, in his/her clinical expertise feels the risks outweigh the benefits, the prescriber will be contacted for revision of the order.
8. If the prescriber has ordered a compounded drug that is either found to be unsafe or ineffective and removed from the market, or is listed in the FDA's regulations as difficult to compound the prescriber will be contacted for ~~revision~~ **discontinuation** of the order.
   a. If the prescriber ~~does not revise~~**refuses to discontinue** the order and insists on preparation of the compounded drug, the Pharmacist will contact the Chairperson of the Pharmacy and Therapeutics Committee to resolve the situation with the prescriber.

~~If a recipe is not available or if the product is to be made from nonsterile drugs or impure chemicals, the Pharmacy and Therapeutics Committee will review the possibility of Pharmacy mixing these products on an individual basis.~~

C. REFERENCES:

1. California Code of Regulations (CCR), Chapter 17, Title 16, section 1735

Tri-City Medical Center
Oceanside, California

~~POLICY~~ PHARMACY MANUAL

ISSUE DATE: 06/05

SUBJECT: Medication Dispensing/Distribution ~~Drug Distribution~~

REVISION DATE: 03/06, 01/12

~~POLICY NUMBER: 8390-4303~~

Department Approval Date(s):	06/15
Pharmacy & Therapeutics Committee Approval Date(s):	06/05, 03/06, 07/09, 1/12, 07/15
Medical Executive Committee Approval Date(s):	06/05, 03/06, 07/09, 1/12, 08/15
Professional Affairs Committee Approval Date(s):	09/15
Board of Directors Approval Date(s):	06/05, 03/06, 07/09, 1/12

A. ~~POLICY~~PURPOSE:

1. **To define the policies used to ensure the safe dispensing and distribution of medications that are in accordance with law and regulation, licensure, and professional standards of practice.**

~~1. Tri-City Medical Hospital maintains a patient medication dose system that utilizes unit-of-use packaging to minimize the need for further manipulations that introduce opportunities for error and minimize diversion.~~

B. ~~PROCEDURE~~POLICY:

1. **The Pharmacy Department is responsible for the control and distribution of all medications.**
2. **Medications in patient care areas are available in the most ready to administer forms commercially available or, when possible, in unit-doses that have been repackaged by the pharmacy or a licensed repackager.**
3. **The Pharmacy makes every attempt to utilize a consistent dose packaging system; however, if a different system is required for use, the Pharmacy staff will provide education about the use of the dose packaging system to the appropriate medication administration staff and patients. This includes dose packaging systems for controlled substances.**

~~1.~~**4.** In response to a new ~~drug~~ **medication** order, the Pharmacist ~~will~~ **shall** ~~encode the prescription into the patient medication profile~~**review the order for appropriateness prior to dispensing or releasing the medication for administration to the patient** ~~. The Pharmacist will check for drug allergies, therapeutic overlap, drug interactions and incompatibilities.~~**pursuant to Pharmacy Policy Pharmacist Order Verification and Patient Care Services Policy Medication Administration.**

5. **If the medication is not in the Automated Dispensing Machine (ADM),** ~~T~~the Pharmacy Technician **or Pharmacist Intern shall** prepare~~s~~ the ~~initial doses~~**medication for delivery in accordance with Pharmacy Policies: Medication Preparation, Technician Checking Technician Program, and Automated Dispensing Machine.** ~~if medication is not in the Pyxis. These doses are then checked and initialed by the Pharmacist before being sent to the patient care unit.~~
6. **Only a licensed pharmacist or authorized Pharmacy Department personnel under the direct supervision of a licensed pharmacist shall package medications or make labeling changes in accordance to Pharmacy Policy Labeling Standards.**
7. **Medications will be dispensed and distributed to patient care areas in a timely manner and in accordance with Pharmacy Policies: Automated Dispensing Machine, Controlled Substances, Floor Stock, and Delivery of Medications Ordered as STAT and at Specified Time Intervals.**

8. **When delivering medication to nursing units, pharmacy staff shall check return bins to retrieve any discontinued or unused medications that should be returned to the pharmacy.**
~~Before administration of a medication, a nurse **or other appropriate licensed individual** will review **the** physician order **after the pharmacist has verified it in accordance to Patient Care Services Policy Medication Administration.**against pharmacist-entered order. The licensed individual administering the medication will record the administration of medication on the EMAR.[AMH1]~~
9. **Unused** ~~U~~unit-of-use packaging ~~is designed so that unused~~ doses may be returned to inventory for reuse **and credited to the patient** ~~for another patient. i~~If the package is intact **(security and integrity maintained)** and within the expiration period.~~,~~
~~2.~~10. **Unusable medications will be removed from storage areas of the hospital pursuant to Pharmacy Policy Unusable Medications.** ~~returned **un-used** doses may be returned to inventory and credited to the patient.~~
~~The Pharmacy makes every attempt to utilize a consistent dose packaging system; however, if a different system is required for use, the Pharmacy staff will provide education about the use of the dose packaging system to the appropriate medication administration staff and patients. This includes dose packaging systems for controlled substances.~~

C. **REFERENCE LIST~~AND RELATED DOCUMENTATION~~:**
~~3.~~1. **The Joint Commission Standards MM. 03.01.01 EP 10, MM.05.01.01, MM.05.01.11, MM.05.01.19 (2015)**

Tri-City Medical Center
Oceanside, California

PHARMACY ~~POLICY~~ MANUAL

ISSUE DATE: 09/90

SUBJECT: Drug Product Procurement and /Inventory ~~Control~~Management

REVISION DATE: 09/91, 01/97, 01/05, 07/06, 3/15
REVIEW DATE: 02/03, 01/05, 07/06, 07/09, 1/12

~~**POLICY NUMBER: 8390-2102**~~
~~**CROSS REFERENCE:**~~

Department Approval Date(s):	05/15
Pharmacy and Therapeutics Approval Date(s):	07/15
Medical Executive Committee Approval Date(s):	08/15
Professional Affairs Committee Approval Date(s):	09/15
Board of Directors Approval Date(s):	

A. **POLICY:**

1. **The Pharmacy Department shall be responsible for the procurement, distribution, and control of all drug products used in the hospital for inpatient and ambulatory patients.** ~~Responsibility for control of medications within this hospital rests with the Pharmacy Department. Policies and procedures are designed to ensure the safe and accurate dispensing of medications throughout the hospital. These policies will be approved by the Pharmacy and Therapeutics Committee.~~

B. PROCEDURE:

~~2.~~1. **Medication** Acquisition: ~~The Pharmacy Department is responsible for the acquisition of pharmaceuticals for Tri-City Medical Center. The Pharmacist is responsible for specification as to quality, quantity and source of supply all drugs used in the hospital. Special consideration is given to the current ASHP Guidelines for Selecting Pharmaceutical Manufacturers and Suppliers. Only those medications approved by the Pharmacy and Therapeutics Committee for use will be routinely be stocked and stored.~~

- a. **Pharmacy or Designee (i.e. Materials Management) shall ensure the highest quality of and the best price for drug products through careful consideration and selection of drugproduct manufacturers and suppliers.**
- b. **Only those medications approved for formulary use will be procured and stored as delineated in Pharmacy Policy Formulary System.**
- c. **Whenever possible, only those medications which are commercially available and/or in single-unit packages and in ready-to-administer form shall be procured.**
- ~~a.~~d. **Procurement of medications during emergencies shall be determined and performed as delineated in Pharmacy Policies Medication Shortages and Loaning and Borrowing of Medications for Emergency Purposes.**
- e. **Antidote medications will be procured and stocked in accordance to Pharmacy Policy Antidote Stocking.**
- f. **Orders will be made by the Pharmacy Buyer or designee and prepared daily using the wholesaler computerized ordering system or ordered directly from the manufacturer.**
- g. **After the product is delivered directly to Pharmacy or via Materials Management, the order will be checked against the packing slip and invoice.**
  - i. **If the items received were not accompanied by an invoice, drug products will be put aside until an invoice is obtained and the items are entered into inventory.**
  - ii. **Upon arrival of the order from the wholesaler the pharmacist will confirm the shipment container quantities match the expected quantities.**

iii. **If the order is complete, the pharmacist checking the order must initial and date the ~~invoice or~~ packing slip as an indication the products were received.**

iv. **If the order is incomplete, the Pharmacy Buyer will be notified and shall contact the appropriate wholesaler for rectification.**

1) **Receipt of ~~a Schedule II drug~~controlled substance medications shall be checked against the ~~original DEA~~**controlled substance packing slip for quantity and accuracy, signed and dated **by ~~the~~a pharmacist.**

2) **Any discrepancies shall be noted and referred to the appropriate person.**

3) **The CII Safe Receive Report is compared to the invoice to ensure all ordered products are accounted for and placed in the CII Safe.**

h. **A copy of each invoice will be forwarded to Accounts Payable.**

~~b.~~i. **A copy of Schedule II invoices shall be kept with the DEA order form filed for three years. Copies of Schedule III, IV, V invoices shall be kept in a separate file for three years.**

~~c. Practical decisions about the source of multi-vendor (generic equivalent) drugs is deferred to the purchasing group and the competitive bid structure.~~

~~d. Medications for distribution to patient care units are provided in the most ready-to-administer form available, in prepackaged patient unit doses whenever possible.[AMH1]~~

~~• All medications and chemicals used to prepare medications are accurately labeled with contents, expiration dates and appropriate warnings.[AMH2]~~

2. Storage:

a. Medications **shall be ~~are~~ received**, stored**, and prepared** under proper conditions **in accordance with State and Federal Regulations, governing agencies, and manufacturer recommendations to ensure medication integrity, safety and security.**

b. **Storage of medications outside of the pharmacy shall be done in a secure manner, utilizing automated dispensing devices whenever possible.** ~~as stated by the medication manufacturer to assure stability of that medication.~~

c. **Unusable drugs will be removed from stock as delineated in Pharmacy Policy Unusable and Outdated Drugs.**

~~• Medications are delivered and stored in a secure manner.~~

~~B. The Pharmacy Department is locked at all times. Access is limited to pharmacists and Pharmacy Department personnel under the direct supervision of a Pharmacist.[AMH3]~~

Tri-City Medical Center
Oceanside, California

PHARMACY~~POLICY~~ MANUAL

ISSUE DATE: 05/94 **SUBJECT: Labeling Standards**

REVISION DATE: 10/96, 02/97, 08/00, 06/05, 03/06, 4/09, 01/12 **~~POLICY NUMBER: 8390-4202~~**

Department Approval Date(s):	**06/15**
Pharmacy & Therapeutics Committee Approval Date(s):	**02/03, 06/05, 03/06, 07/09, 1/12, 07/15**
Medical Executive Committee Approval Date(s):	**02/03, 06/05, 03/06, 07/09, 1/12, 08/15**
Professional Affairs Committee Approval Date(s):	**09/15**
Board of Directors Approval Date(s):	**02/03, 06/05, 03/06, 07/09, 1/12**

A. **POLICY**:

1. All ~~drug containers~~**medications** shall be **clearly** labeled ~~and drug labels must be clear,~~ **in a** consistent **and**~~,~~ legible **manner,** ~~and~~ in compliance with state and federal requirements, **professional standards, and regulations**.

~~1.~~**2.** There shall be a standard method for appropriately and safely labeling medications dispensed to both inpatients and outpatients. ~~Labeling requirements shall be in general compliance with the current ASHP Technical Assistance Bulletin on Single Unit and Unit Dose Packages of Drugs.~~

~~2. Purchased unit-of-use medication labels shall include at a minimum:~~
- ~~a. Generic drug name~~
- ~~b. Dose (the amount included in the unit-of-use package)~~
- ~~c. Manufacturer's lot number~~
- ~~d. Expiration date~~
- ~~e. Name of manufacturer or repackager~~

3. **Any medication or medication container (i.e. syringe, bag, bottle, tube, jar) that is prepared but not immediately administered must be labeled in accordance with this policy.**
   - a. **Note: The Joint Commission defines immediately administered as; "An immediately administered medication is one that is prepared or obtained, taken directly to a patient, and administered to that patient by an authorized staff member, without any break in process."**

~~3. Intravenous admixture labels shall include at a minimum:~~
- ~~a. Name and location of the patient~~
- ~~b. Generic drug name~~
- ~~c. Name and amount of the basic solution~~
- ~~d. Dose (the amount of active drug(s) in the final product)~~
- ~~e. Time/date due~~
- ~~f. Expiration time/date~~
- ~~g. Special storage requirements~~
- ~~h. Infusion rate (if appropriate)~~
- ~~i. The initials of the technician who made the admixture and the Pharmacist who checked the final product~~
- ~~j. Dispense ID Aztec bar code~~

4. **When preparing individualized medications for multiple patients or when the person preparing a medication is not the person administering the medication, the label must also include the patient's name and the patient's location**

~~4. Repackaged unit-of-use medication labels shall include at a minimum:~~
- ~~a. Generic or Brand drug name~~
- ~~b. Dosage form (if special or other than oral)~~
- ~~c. Strength~~

~~d. Strength of dose~~
~~e. Special notes (i.e., refrigerate)~~
~~f. Internally assigned control number and expiration date~~
~~g. Bar Code representing the NDC or CDM~~

~~5. Prescriptions intended for use outside of the hospital shall be labeled to ensure complete understanding and compliance by the patient/family.~~
~~a. Patient's name~~
~~b. Physician's name~~
~~c. Date the prescription is filled~~
~~d. Serial file number for the prescription~~
~~e. Generic drug name and manufacturer's name (manufacturer's name not required if Brand name is used)~~
~~f. Amount of drug in the dosage form unit~~
~~g. Directions for use (dose, frequency and conditions if applicable)~~
~~h. Quantity in the container~~
~~i. Expiration date~~
~~j. Name, address and telephone number of the pharmacy~~

~~6. Multiple patients utilizing batch prepared parenteral medication or the preparer does not administer the medication shall include labels that include at a minimum:~~
~~a. Name and location of the patient(s)~~
~~b. Generic drug name or trade name~~
~~c. Amount of drug in the dosage form unit~~
~~d. Directions for use (dose and frequency)~~
~~e. Cautionary remarks, i.e., refrigeration required, IM use only~~
~~f. Expiration date (if over 24 hours) and time (if under 24 hours)~~

5. For labeling of medications dispensed to a sterile field see Patient Care Services Policy Labeling Medications/Solutions On and Off a Sterile Field

~~7. See attached: "Labeling Medication On and Off a Sterile Field".~~

B. PROCEDURE:

1. Labels prepared by the pharmacy are typed or printed from a computer.
~~**Medications are labeled so recalls and proper controls can be initiated as necessary.**~~

2. To the extent feasible, labels are affixed directly to the immediate container and not to an overwrap such as a box, foil wrap, or plastic bag. In cases where the physical characteristics of the immediate container of the medication do not permit full labeling, a partial label containing, at a minimum, the patient name and location may be placed on the container and the complete labeling applied to an appropriate outer container

3. All medications dispensed from the pharmacy, including compounded IV admixtures and parenteral nutrition, contain, at a minimum, the following information on the label:
a. The patient's name and location
b. The proprietary and/or nonproprietary name of the medication
c. Medication strength or concentration
d. Dose
e. Dosage form, including any pertinent statements bearing on special characteristics of the dosage form (i.e. sustained release, enteric coated, sublingual, chewable, solution, elixir, suspension, etc)
f. Bar-code
~~**Lot number or pharmacy control number**~~
g. Manufacturer or distributor (if not evident from a proprietary name or~~f~~ from pharmacy prepackaging records
h. Expiration date or beyond use date
i. Expiration time, when it occurs in less than 24 hours
j. Date prepared and ingredients including diluents on all compounded IV admixtures and parenteral nutrition

k. Quantity dispensed
l. Infusion rate, if IV and if applicable
m. Directions for use and any applicable storage, handling, or cautionary statements (e.g., refrigerate, shake well, not to be chewed, "Caution: Chemotherapy", "Not to be given IV, For Irrigation Only")

4. Medication bar-codes are scanned and verified to assure they read and are linked in the computer system(s) to the right medication, right strength and right dosage form
5. Medications that are mislabeled (i.e., labels are illegible, incomplete, incorrect, etc.) are segregated from the active inventory and are not used
6. Source or bulk containers prepared for use during compounding will be labeled pursuant to Pharmacy Policy Sterile Product Preparation
7. Chemotherapy will be labeled pursuant to Pharmacy Policy Chemotherapy Prescribing, Processing, and Preparation
8. Prescriptions intended for use outside of the hospital shall be labeled to ensure complete understanding and compliance by the patient/family and shall include at a minimum:
   a. Patient's name
   b. Prescriber's name
   c. Date the prescription is issued
   d. Prescription number or other means of identifying the prescription
   e. Generic drug name and manufacturer's name (manufacturer's name not required if Brand name is used)
   f. Strength of the drug
   g. Directions for use
   h. The condition or purpose for which the drug was prescribed if the condition or purpose is indicated on the prescription
   i. Quantity of the drug dispensed
   j. Expiration date of the drug dispensed
   k. Name and address of the pharmacy

~~B.~~C. RELATED DOCUMENTS:

1. Patient Care Services Policy Labeling Medications/Solutions On and Off a Sterile Field
2. Pharmacy Policy Sterile Product Preparation
3. Pharmacy Policy Chemotherapy Prescribing, Processing, and Preparation

D. REFERENCES:

1. The Joint Commission Standards MM.05.01.09; MM.03.01.01 EP:7 (2015)
2. Centers for Medicare and Medicaid Services (CMS) 482.25(b)
3. California Code of Regulations, Title 16, Section 4076 and 4128
4. American Society of Hospital Pharmacists. ASHP technical assistance bulletin on single unit and unit dose packages of drugs. Am J Hosp Pharm.1985; 42:378–9.

Tri-City Medical Center
Oceanside, California

~~POLICY~~ PHARMACY MANUAL

ISSUE DATE: 06/05

SUBJECT: Medication Management Program

REVISION DATE: 07/06, 01/12

~~POLICY NUMBER: 8390-8002~~

Department Approval Date(s):	**06/15**
Pharmacy & Therapeutics Committee Approval:	**06/05, 07/06, 07/09, 1/12, 07/15**
Medical Executive Committee Approval:	**06/05, 07/06, 07/09, 1/12, 08/15**
Professional Affairs Committee Approval Date(s):	**09/15**
Board of Directors Approval:	**06/05, 07/06, 07/09, 1/12**

A. **POLICY**:

1. The Pharmacy and Therapeutics Committee, acting on behalf of the medical staff, shall implement a Medication Management Assessment and Evaluation Program to provide a system to ensure medication use within the organization is conducted in a safe and optimal manner. The Medication Management Assessment and Evaluation program requires the routine evaluation of literature for new technologies and best practices that have been demonstrated to enhance safety in other organizations to determine if these practices are conducted successfully within the organization or if they should be implemented to improve the medication management system. The Medication Management Assessment and Evaluation Program identifies risk points (including medication errors and adverse drug reactions) and identifies areas to improve patient safety as well as the overall use of medications throughout the organization.
2. For the purposes of this program the definition of medication includes:
   a. Prescription medications
   b. Sample medications
   c. Herbal remedies
   d. Vitamins
   e. Nutraceuticals (substances not controlled by the FDA, not proven beneficial by authoritative sources, however the public commonly utilizes – example: Ingestible Shark Cartilage)
   f. Over-the-counter drugs
   g. Vaccines
   h. Diagnostic and contrast agents
   i. Radioactive medications
   j. Respiratory therapy treatments
   k. Parenteral nutrition
   l. Blood derivatives
   m. Intravenous solutions (plain, with electrolytes and/or other drugs)
   n. Any product designated by the FDA as a drug
3. The Pharmacy and Therapeutics Committee will maintain oversight for the Medication Management Assessment and Evaluation Program. The program is based on the principles of performance improvement, with a focus on identification and measurement of processes and activities that are high-volume, high-risk, problem-prone and patient safety related. The program includes data collection and measurement of medication management processes, identification of opportunities or areas of improvements, the testing of incremental improvements and the recommendation of improvements to the organization's leaders. The main goal of improving the performance of medication management processes is to continuously improve patient health outcomes and reduce the occurrence of medication related errors and medication related adverse patient outcomes, including adverse drug reactions. The following essential processes will be

conducted to adequately assess and evaluate how medication is managed throughout the institution.

a. Process Design
b. Performance Measurement
c. Performance Assessment
d. Performance Improvement

4. The Pharmacy Director is responsible for reporting medication management processes to the Pharmacy and Therapeutics Committee, whose members in turn are responsible for assessing, monitoring and evaluating the processes and outcomes of the medication management throughout the institution.

B. **PROCEDURE**:

1. The Pharmacy and Therapeutics Committee will collaborate and work together as a team with the Pharmacy Director, and other designated members of the institution, to develop, implement and evaluate the organizationwide Medication Management Assessment and Evaluation Program. As appropriate to the setting, individuals involved in the system of medication management include licensed independent practitioners, healthcare professionals and staff involved in medication management processes.
   a. Assessment and Evaluation Process: The following core medication management processes carried out by the organization are measured, assessed and evaluated:
      i. Selection and procurement
      ii. Storage
      iii. Ordering and transcribing
      iv. Preparing and dispensing
      v. Administration
      vi. Monitoring the effects and side effects on patients
   b. Over time, data is collected on all of the above processes.
2. The Pharmacy Department provides fundamental functions as well as key oversight responsibilities and activities in the system of medication management. The Pharmacy Department performs the following functions and activities:
   a. Selection and procurement of medications
   b. Storage of medications
   c. Maintenance of adequate medication inventory
   d. Oversight of ordering and transcribing processes
   e. Preparation of medications
   f. Medication dispensing
   g. Direct and indirect scheduled medication security and control
   h. Drug floor stock distribution
   i. Drug utilization monitoring and evaluation
   j. Provision of drug information to the organization's staff
   k. Patient/family/staff counseling and education
   l. Provision of formal and informal inservice to the nursing and other staff licensed to administer medications
   m. Provision of IV additive service
   n. Clinical dosing of specific medications (i.e., aminoglycosides)
3. The Pharmacy Department will be responsible to monitor the outcomes of its important functions and activities through internal performance improvement activities through investigation, data collection and monitoring of the internal processes conducted within, or by, the Pharmacy and its personnel. External performance improvement activities related to medication management will be monitored by the Pharmacy Department through data collection from a wide variety of sources including, but not limited to, medication error reports (which include real and potential errors), and adverse drug reaction reports.

4. The Pharmacy Department will collect data systematically for improvement priorities and continuing measurement. The process of data collection activities will be (when appropriate and as often as possible) collaborative and interdisciplinary in nature.
5. To adequately monitor and evaluate the medication management system in place within the institution the Pharmacy Department collects data on the following:
   a. Processes and outcomes
   b. Medication errors (real and potential)
   c. Adverse drug reactions
   d. High-risk, high-volume and problem-prone processes
   e. Patients needs, expectations and department specific patient satisfaction questionnaires and/or surveys
   f. Infection control activities
   g. Patient safety reports
   h. Current literature for new technologies and best practices
   i. Risk management issues and findings
6. Performance Measures:
   a. Administration of medication is of high-risk and therapeutic benefit to the patient. Medication management processes are measured on an ongoing basis. The following are performance measures or categories of measures for which data is collected, aggregated, reviewed and analyzed in an effort to identify risk points and areas to improve patient safety. The list is not exhaustive and may be revised in accordance with data collected, which may indicate the benefit of inclusion or exclusion of a performance measure from the monitoring and evaluation cycle. Measures include, but may not be limited to:
      i. Medication errors - wrong drug, dosage, time, route or rate of administration, wrong patient, omission, duplication or administration without an order, adverse reaction to medication (includes potential errors or "near misses")
      ii. Medication order filled incorrectly
      iii. Medication order prepared incorrectly
      iv. STAT medication not sent within established time frames
      v. Controlled substance missing and/or incorrect count
      vi. Occurrences that have an adverse result on a patient
      vii. Equipment breakage/failure that has an adverse result on a patient
      viii. Equipment not available
      ix. Security incident
      x. Expired, recalled or otherwise unusable drug dispensed
      xi. Formulary management
      xii. Labeling of drugs
      xiii. Education of patients and family
      xiv. Drug recall measures
      xv. Surveillance, prevention and control of infection
      xvi. Research investigational drugs
      xvii. Management of Human Resources (i.e., licensure requirements and entry level qualifications)
      xviii. Patient outcomes; long and short range continuing education
      xix. Technical quality control activities
      xx. Adverse drug reactions
7. Drug Usage Evaluation is an important component of the Medication Management Assessment and Evaluation Program. The Pharmacy and Therapeutics Committee, acting on behalf of the medical staff shall implement as a component of the overall Medication Management Assessment and Monitoring Program a Drug Usage Evaluation Program to ensure the safe, appropriate and efficacious use of medications throughout the institution. Drug usage will be monitored in a systematic and continuous manner. The Pharmacy and Therapeutics Committee will determine the specific medications to be evaluated as well as the criteria to be applied. Based on the

findings of the Drug Usage Evaluation Program, the Pharmacy and Therapeutics Committee will forward recommendations to the medical staff to correct or improve medication use.

8. Priorities for the selection of medications for evaluation shall be based on one (1) or more of the following factors:
   a. The number of patients affected by the medication use (i.e., frequency of medication use)
   b. The significance, including degree of risk, to individual patients
   c. The degree to which use of the medication is known or suspected to be problem-prone
   d. Ability to improve the outcome of a specific disease for which medication is an integral part of the treatment
9. Criteria for evaluation will be developed by the Pharmacy Department, in conjunction with the medical staff, based on objective measures that reflect the appropriate use of the medication as determined by community medical standards, current literature and best practices. The evaluation shall focus on processes that measure:
   a. Prescribing or ordering of medications
   b. Transcribing of medications
   c. Preparing and dispensing
   d. Administration
   e. Monitoring the medications' effects on patients
10. The Pharmacy Department, in conjunction with the medical staff, will conduct the evaluations, obtaining quantitative data and present a written report of findings to the Pharmacy and Therapeutics Committee on a quarterly basis. Reports shall include criteria, findings, causes/conclusions and recommendations.
11. The Pharmacy and Therapeutics Committee will determine actions to be recommended to the medical staff based on an analysis of:
   a. Thresholds or control limits exceeded
   b. Undesired patterns or trends
   c. Opportunities to improve performance or minimize adverse reactions
12. To adequately address the amount of medications that may prove beneficial for drug usage evaluation priorities for ongoing assessment have been developed. These priorities are based upon the following:
   a. The number of patients taking a medication
   b. The balancing of risk with therapeutic potential
   c. Medications known or suspected to be problem-prone
   d. Therapeutic effectiveness, (i.e., use of antibiotics to treat pneumonia)
13. The Pharmacy and Therapeutics Committee shall determine if, and when, a medication evaluation requires discontinuation or needs to be continued as a:
   a. Full evaluation
   b. Limited evaluation
14. Based on the findings of the Drug Usage Evaluation Program, the Pharmacy and Therapeutics Committee will forward recommendations to the medical staff to correct or improve medication use.
   a. The performance assessment process conducted for evaluation of the medication management program, as a whole is systematic, interdisciplinary and interdepartmental. The Pharmacy Department uses a systematic process to assess collected data. Other disciplines will collect data related to medication management processes conducted within their department. The assessment process will include statistical quality control techniques as needed. Data assessment begins with a clear understanding of the medication management processes under review. The framework for systematic assessment includes the multidisciplinary analysis of data to answer questions about the processes and outcomes that are being monitored throughout the organization. The following issues shall be assessed and evaluated:
      i. Current level of performance
      ii. Stability of current processes
      iii. Identification of areas that could be improved

iv. Identification of improvement priorities
v. Effectiveness of strategies implemented to improve performance
vi. Specifications for new or redesigned processes determined and met

15. An interdisciplinary approach will be made to make comparisons of processes and outcomes over time. The data will be compared and reference databases utilized as needed. Priorities for improvement will be assessed. Improvement activities will be implemented based upon assessment conclusions. The Pharmacy Department as well as the Pharmacy and Therapeutics Committee (as appropriate) will collaborate as necessary with other disciplines throughout the organization.
16. The organization will systematically improve the performance of its medication management system. The Pharmacy and Therapeutic Committee will assess and evaluate data provided and will determine and implement strategies to improve performance. The Pharmacy and Therapeutics Committee will implement actions that result in desired, measurable changes in processes. To achieve improvements and improve patient safety, the Pharmacy and Therapeutics Committee will participate in the following performance improvement activities:
    a. Planning
    b. Testing
    c. Assessing results and redesigning if necessary
    d. Implementing
    e. Assessing the effectiveness of implemented actions
    f. Reevaluation as deemed necessary to assure gains made are sustained

C. **ANNUAL REVIEW:**

1. The Medication Management Assessment and Evaluation Program will be assessed and measured annually for its effectiveness and consistency within the improving organization performance framework in place within the facility. If the identified improvements are not realized within a defined time period, the organization will reexamine the process within the function that is being monitored. The findings, conclusions, recommendations and actions will be communicated by the Pharmacy and Therapeutics Committee to the following:
    a. Medical Executive Committee
    b. Governing Body

ISSUE DATE: 03/06

SUBJECT: Receiving and Tracking Narcotic Pump Refills Prepared by Outside Vendors

REVISION DATE: 03/06, 01/12

~~POLICY NUMBER: 8390-10021~~

Department Approval Date(s):	**06/15**
Pharmacy & Therapeutics Committee Approval Date(s):	**03/06, 07/09, 1/12, 07/15**
Medical Executive Committee Approval Date(s):	**03/06, 07/09, 1/12, 08/15**
Professional Affairs Committee Approval Date(s):	**09/15**
Board of Directors Approval Date(s):	**03/06, 07/09, 1/12**

A. **PROCEDURE**:

1. Narcotic pump refills for T**ri-City Healthcare District**~~MC~~ patients will be processed in the following manner:
   a. The outside vendor will be instructed to always deliver the medication to **TCHD**~~TCMC~~ inpatient pharmacy
   b. All medication**s** will be signed ~~onto the Greenfield/Option Care Narcotic sign-in sheet~~**in on the sheet located on the CII safe.**
   c. All medication will then be signed in the Pyxis CII safe in the following manner:
      i. Go to "increase meds"
      ii. Go to "receive meds"
      iii. Type "narcotic pump refill outside RX"
      iv. Type quantity under "acq. qty" field
      v. Under "Vendor" box, hit drop down arrow and select appropriate vendor
      vi. Enter the RX # in the invoice field
      vii. In the DEA-222 field, type patient's name
      viii. Hit the "+" (plus sign)
      ix. Select Save
      x. Place the vendor invoice (or the Pyxis load receipt if invoice not available) on the pharmacy buyer's desk
         1) Write patient's full name on CII safe printout
         2) Write drug and dose on CII safe printout
2. Medication sent to stations will be signed out in the following manner:
   a. Go to "Decrease Meds"
   b. Go to "Send Meds"
   c. Select location or floor med will be delivered to
   d. Select "narcotic pump refill outside RX"
   e. Type the quantity of med being sent
   f. Select the "+" (plus) sign
   g. Check the "print on save" box
   h. Hit the save key
      i. Write patient's full name on CII safe printout
      ii. Write drug and dose on CII safe printout
      iii. Return sheet to Pharmacy Buyer's desk

Tri-City Medical Center
Oceanside, California

~~POLICY~~ PHARMACY MANUAL

DELETE- duplicate content, Relevant content covered in Pharmacy Policies Drug Distribution and Automatic Dispensing Machine

~~ISSUE DATE: 05/85~~ ~~SUBJECT: Unit Dose Distribution System~~

~~REVISION DATE: 05/94, 02/97, 08/00, 06/05, 07/06~~ ~~POLICY NUMBER: 8390-4302~~

Department Approval Date(s):	06/15
Pharmacy & Therapeutics Committee Approval Date(s):	02/03, 06/05, 07/06, 07/09, 1/12, 07/15
Medical Executive Committee Approval Date(s):	02/03, 06/05, 07/06, 07/09, 1/12, 08/15
Professional Affairs Committee Approval Date(s):	09/15
Board of Directors Approval Date(s):	02/03, 06/05, 07/06, 07/09, 1/12

~~A. POLICY:~~

~~1. The unit dose system of drug distribution is the primary drug delivery system for this facility. It is designed to:~~
- ~~a. Promote the safe and effective administration of drug therapy at a reasonable cost~~
- ~~b. Detect and prevent errors~~
- ~~c. Promote effective utilization of personnel~~
- ~~d. Minimize drug deterioration, obsolescence, pilferage and reduce hospital inventory~~
- ~~e. Reduce and simplify medication record keeping requirements~~
- ~~f. Provide greater drug control and accuracy in medication administration and record keeping~~

~~2. Oral liquids that are unavailable in unit doses may be repackaged in appropriate sized containers if not commercially available in smaller quantities.~~

~~B. PROCEDURE:~~

~~1. The Pharmacist, Pharmacy Technicians, Pharmacy Couriers and Pharmacy volunteers make rounds to all patient care units to retrieve discontinued medications and other pharmacy related items.~~

~~2. All STAT orders are processed immediately (within 30 minutes) and delivered to the appropriate patient care units as soon as possible. The nursing personnel are encouraged to phone the STAT order to the Pharmacist for immediate service.~~

~~3. A profile is created in the hospital Pharmacist computer for each patient admitted to the hospital via the Admitting Department. Other information entered upon admission and by the patient care unit includes: patient name, hospital number, room number, date of birth, age, gender, attending physician, diagnosis, height, weight and allergies. The Pharmacy Department routinely checks for missing allergy histories and contacts the patient care unit for the information.~~

~~4. All medications ordered for each patient are entered into the patient's computerized profile by the Pharmacist~~

~~5. With each order entry, the Pharmacist reviews the patient's entire medication profile for incompatibilities, potential hypersensitivity reactions, duplications in therapy or other potential risks.~~

~~6. The Pharmacist is responsible for clarifying any orders in which there are questions as the appropriateness of drug therapy, dose, route, etc. Should any discrepancies be discovered, the Pharmacist shall contact the physician or the nurse to resolve them prior to dispensing. If necessary, a Clinical Intervention Log Sheet shall be completed.~~

~~7. Only a licensed Pharmacist or authorized Pharmacy Department personnel under the direct supervision of a licensed Pharmacist shall dispense medications, make labeling changes or transfer medications to different containers.~~

~~8. Medications for patients having an operative procedure are discontinued on the day the patient is scheduled for the procedure. Medication orders must be written following the procedure.~~

~~9. Medications for patients transferred into or out of the critical care/special care unit shall be reviewed by a physician and noted if orders are to be continued or discontinued.~~

~~10. All reusable medication returned to the Pharmacy Department is to be returned to stock.~~

~~11. Medications in the unit dose area are replenished daily by ordering required medications through the Pharmacy purchasing system and Pyxis system.~~

~~12. Electronic medication administration records (EMAR) for hospital inpatients are generated by the hospital mainframe computer system on a daily basis.~~

DELETE – moved to Patient Care Services Manual: Incentive Spirometer (IS) Instruct and Monitoring Procedure

Tri-City Medical Center | Pulmonary M

POLICY:	INCENTIVE SPIROMETRY INSTRUCT AND FOLLOW-UP
Purpose:	To create a standardized process for the instruction and subsequent use of the Incentive Spirometry device.
Issue Date:	1/2014
Revision Date(s):	
Board of Director Approval Date(s):	

A. POLICY: To provide a standardized process for the implementation and administration of Incentive Spirometry.

1. Indications: Patient's with the presence of pulmonary atelectasis or conditions predisposing pulmonary atelectasis when used with:
   a. Upper abdominal or thoracic surgery
   b. Lower abdominal surgery
   c. Prolonged bed rest
   d. Surgery in patients with COPD
   e. Lack of pain control
   f. Presence of thoracic or abdominal binders
   g. Restrictive lung defect associated with a dysfunctional diaphragm or involving respiratory musculature.
   h. Patient's with an inspiratory capacity of < 2.5 liters
   i. Patient's with neuromuscular disease

2. Contraindications:
   a. Patients who cannot be instructed or supervised on the device.
   b. Patients who are unable to cooperate or understand proper use of the device.
   c. Patients who are too young to be able to properly use the device.
   d. Patients who have developmental delays and are not able to use the device.
   e. Patients unable to take a deep breath due to pain & /or diaphragmatic dysfunction.
   f. Patients unable to generate adequate inspiration with a vital capacity less than 10 ml/kg, or an inspiratory capacity less than 33% of predicted normal.

B. PROCEDURE:

1. A physicians order is required for Incentive Spirometry.
2. Ideally the RCP will do the initial Incentive Spirometry instruct. However, there may be times necessary when nursing will perform the initial instruct.
3. Incentive Spirometry is accomplished by using a device that indicates inspiratory volume achieved. The patient is instructed to inhale deeply and slowly. At a maximum inspiration to hold and sustain that volume for at least five seconds.
   a. Ideally the patient is to sit up as upright as their condition allows.
   b. The patient is to hold the spirometer in a vertical position.
   c. Patient is to place the lips tightly around the mouthpiece and take in a slow inhalation to raise the ball. They should breathe in so slowly that they "keep the indicator between the lines" (located on the right side of the device.)
   d. At maximum inhalation, the mouthpiece is removed followed by a breath hold and normal exhalation.

Department Review	Division of Pulmonary	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
06/15	n/a	n/a	07/15	09/15	

e. The Respiratory Care Practitioner will pre-determine the patient's predicted volume based on male/female, age of patient and height of patient. They then will mark this predicted volume with a permanent marker so the patient knows the goal they are trying to reach.
f. The RCP will use best clinical judgment to approximate the patient's predicted value if the patient's age or height does not fall on the predicted values chart.
g. The effectiveness of incentive Spirometry may depend on patient selection, careful instruction and follow-up supervision. This follow-up supervision may be performed by either the RN or the RCP.
h. The RCP and RN will stress to the patient to practice the device at least 10 breaths every hour while awake.
i. Patient should then be instructed to cough (may need to splint incision with a pillow) and bring up phlegm if possible.
j. Results of therapy will be documented in the medical record. If patient is unable to perform, this must be charted in the medical record (and preferably include a flag with comment) so the reason is documented why patient is unable to perform.

C. Expected Outcomes:

a. Improvement in previously absent or diminished breath sounds.
b. Improvement of arterial oxygen tension (PaO2) and /or pulse oximeter saturations (SpO2) or reduced fraction of inspired oxygen requirement (FiO2.)
c. Resolution or improvement of atelectasis
d. Decreased respiratory rate
e. Absence of fever
f. Normal pulse rate

D. Collaborative process between Nursing and Respiratory will include:

a. Patient ideally will be initially instructed on the Incentive Spirometer by the RCP (Respiratory Care Practitioner) and then receive 2 subsequent treatments by the RCP.
b. Following this initial and two subsequent treatments, the RCP will speak directly with the patient's nurse in order to ensure a collaborative hand off for the continued use of the Incentive Spirometer device.
c. The RN will continue to document patient's use of the incentive spirometer device in the electronic medical record.

E. Documentation will occur in the Hospital Approved Electronic Record.

H. REFERENCE LIST:

1. AARC Clinical Practice guidelines, Incentive Spirometry, 2011.

I. APPROVAL PROCESS:

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES POLICY MANUAL

SUBJECT: ~~Discipline Specific~~ **Staff Meetings**

ISSUE DATE: 7/91
REVISION DATE(S): 1/94, 4/97, 10/99, 2/03, 1/06, 1/09, 3/12

Department Approval Date(s):	**07/15**
Department of Medicine Approval Date(s):	**N/A**
Pharmacy and Therapeutics Approval Date(s):	**N/A**
Medical Executive Committee Approval Date(s):	**N/A**
Professional Affairs Committee Approval Date(s):	**09/15**
Board of Directors Approval Date(s):	

~~**ISSUE DATE: 7/91**~~

~~**SUBJECT: DISCIPLINE-SPECIFIC STAFF MEETINGS**~~

~~**REVISION DATE: 1/94, 4/97, 10/99, 2/03, 1/06, 1/09, 3/12**~~

~~**STANDARD NUMBER: 201**~~

~~**REVIEW DATE:**~~

~~**CROSS REFERENCE:**~~

~~**APPROVAL:**~~

~~This Policy / Procedure applies to the following Rehabilitation Services' locations:~~

~~☐ 4002 Vista Way, Oceanside, CA~~

~~☑ 2124 El Camino Real, Suite 100, Oceanside, CA~~

~~☑ 6250 El Camino Real, Carlsbad CA~~

A. POLICY:

1. **To ensure a regular forum for communication between management and staff which is discipline and area specific.** ~~To ensure timely communication from management to staff and to provide a forum for staff to communicate,~~**Discipline** ~~and/or discuss, day-to-day issues~~ **area** ~~specific to their area~~.
2. ~~1.~~**2.** ~~Each supervisor is responsible for scheduling a meeting with their staff every other~~**Team meetings will occur at routine intervals, no less than once per** month ~~(minimum).~~**and subject to change per department needs.** The meeting will be directed by ~~the supervisor~~**Rehabilitation Services Leadership Team** or a designee.

B. PROCEDURE:

1. ~~Each supervisor~~**The Rehabilitation Services Leadership Team** chooses an appropriate time and place for their meetings. These meetings are standing when possible. It is each ~~supervisor's~~**Leadership Team Mmember's** responsibility to communicate meeting specifics to their area staff.
2. ~~Each supervisor~~**The Rehabilitation Services Leadership Team** presents any information that should reach staff prior to the department meeting.
3. Meetings are informal to encourage two-way communication.
4. ~~3.~~**Meeting minutes will be documented and shared with discipline and/or area specific staff.**

DELETE- **due to redundancy. Duplication of Admin Policy # 430.**

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES POLICY MANUAL

SUBJECT: **Maintaining Current Licenses, Registrations, and Certifications**

ISSUE DATE: **7/91**
REVISION DATE(S): 1/94, 3/97, 9/97, 10/99, 2/03, 1/06, 1/09, 3/12

Department Approval Date(s):	**07/15**
Department of Medicine Approval Date(s):	**N/A**
Pharmacy and Therapeutics Approval Date(s):	**N/A**
Medical Executive Committee Approval Date(s):	**N/A**
Professional Affairs Committee Approval Date(s):	**09/15**
Board of Directors Approval Date(s):	

~~**ISSUE DATE:** 7/91~~ ~~**SUBJECT:** MAINTAINING CURRENT LICENSES, REGISTRATIONS AND CERTIFICATIONS~~

~~**REVISION DATE:** 1/94, 3/97, 9/97, 10/99, 2/03, 1/06, 1/09, 3/12~~ ~~**STANDARD NUMBER: 301**~~

~~**REVIEW DATE:**~~ ~~**CROSS REFERENCE:**~~

~~**APPROVAL:**~~

~~This Policy / Procedure applies to the following Rehabilitation Services' locations:~~

~~☐ 4002 Vista Way, Oceanside, CA~~

~~☑ 2124 El Camino Real, Suite 100, Oceanside, CA~~

~~☑ 6250 El Camino Real, Carlsbad CA~~

~~A. PURPOSE~~

~~1. To ensure that the appropriate documentation is current and valid for all licensed, registered and certified personnel.~~

~~B. POLICY~~

~~**POLICY:**~~

~~1. All appropriate **applicable** personnel in the Rehabilitation Services Department will maintain current and valid licensure, registration or certification, as appropriate.~~

~~C. ACCOUNTABILITY~~

~~1. The Supervisor will be responsible for monitoring the current licensure registration or certification status for all appropriate personnel. The Director of Rehabilitation Services will have ultimate responsibility to ensure current licensure.~~

~~D. **PROCEDURE:**~~

~~1. All personnel will provide evidence of licensure, registration and/or certification, as appropriate.~~

~~2. The license/registered/certified applicant will furnish to their supervisor the date of licensure/registration exam and subsequent evidence of successful completion with the license/registration number including expiration date. If the therapist does not successfully complete the first exam, they are not eligible to continue working as a licensed/registered applicant. They are then required to successfully complete a second exam in order to be eligible to practice as a therapist.~~

~~3. Supervisors **Human Resources** will verify licensure, registration and/or certification of staff through primary source verification via secure electronic communication (website) or telephone.~~

~~4. Copies of aforementioned items will be maintained on file in the department **with Human Resources** and will be monitored (checked and updated) on an ongoing basis.~~

~~5. Supervisors **The Rehabilitation Services Leadership Team** will forward updated licensure information to Human Resources upon request.~~

~~6. Personnel who have not provided evidence of current licensure, registration and/or certification, or application for renewal of licensure, will not be permitted to work.~~

~~7. Licensed applicants and clinical fellows may document in the medical record with a co-signature of a licensed/certified therapist.~~

~~License/Registered/Certified Applicants will furnish to the Rehabilitation Services Leadership Team the date of licensure/registration exam and subsequent evidence of successful completion with the license/registration number including expiration date. If the therapist does not successfully complete the first exam, they are not eligible to continue working as a licensed/registered applicant. They are then required to successfully complete a second exam in order to be eligible to practice as a therapist.~~

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES POLICY MANUAL

SUBJECT: **Mission Statement, Goals and Objectives**

ISSUE DATE:
REVISION DATE(S):

Department Approval Date(s):	**07/15**
Department of Medicine Approval Date(s):	**N/A**
Pharmacy and Therapeutics Approval Date(s):	**N/A**
Medical Executive Committee Approval Date(s):	**N/A**
Professional Affairs Committee Approval Date(s):	**09/15**
Board of Directors Approval Date(s):	

~~☐ 4002 Vista Way, Oceanside, CA~~

~~☑ 2124 El Camino Real, Suite 100, Oceanside, CA~~

~~☑ 6250 El Camino Real, Carlsbad CA~~

A. **POLICY:**

1. ~~MISSION STATEMENT~~

~~1.~~ ~~**This Policy / Procedure applies to**~~Tri-City **Healthcare District**~~**Medical Center**~~ Rehabilitation ~~**Center/**~~Services **is dedicated to providinge comprehensive, individualized and high quality healthcare to maximize** the ~~**following Rehabilitation Services' locations:**~~

~~**Tri-City Rehabilitation Center/Services' mission is to return**~~**function and quality of life for all patients** ~~**with a disability to a functional, productive life in their**~~ **and members of our community.**

2. ~~Our program offers a comprehensive team approach assisting~~ **Goals and Objectives:**

   a. **To render high quality rehabilitation services to assist** each patient ~~**(and**~~ **in reaching their maximum potential so they may assume** their ~~**family as needed) to set and reach personal goals**~~**rightful place** in ~~**a caring environment that enhances**~~**society, while learning to live within** the **limits of their capabilities.**

   b. **To alleviate pain, restore function, and improve quality of life by using accepted and current techniques & approaches in physical, occupational, speech, audiology and** therapeutic ~~**process**~~**recreation. These include tests, measurements, procedures, modalities, treatment programs, and wellness education. Caregivers and family members are integrated into the treatment programs whenever possible. Therapeutic equipment is provided as appropriate**.

~~**Our purpose is to provide this service in a professional and personalized manne**~~

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES POLICY MANUAL

SUBJECT: **Physical Plant**

ISSUE DATE: **7/91**
REVISION DATE(S): 1/94, 4/97, 10/00, 1/09, 3/12

Department Approval Date(s):	**07/15**
Department of Medicine Approval Date(s):	**N/A**
Pharmacy and Therapeutics Approval Date(s):	**N/A**
Medical Executive Committee Approval Date(s):	**N/A**
Professional Affairs Committee Approval Date(s):	**09/15**
Board of Directors Approval Date(s):	

~~**ISSUE DATE:** 7/91~~
~~**REVISION DATE:** 1/94, 4/97, 10/00, 1/09, 3/12~~
~~**REVIEW DATE:** 2/03, 1/06~~

~~**SUBJECT:** PHYSICAL PLANT~~
~~**STANDARD NUMBER: 105**~~
~~**CROSS REFERENCE:**~~
~~**APPROVAL:**~~

☐ ~~4002 Vista Way, Oceanside, CA~~
☑ ~~2124 El Camino Real, Suite 100, Oceanside, CA~~
☑ ~~6250 El Camino Real, Carlsbad CA~~

A. **POLICY:**~~SEE ATTACHED FLOOR PLANS~~

1. This Policy / Procedure applies to the following Rehabilitation Services' locations:
   - ~~1.~~**a.** Rehabilitation Services is located in 1 North wing of Tri-City Medical Center.
   - ~~2.~~**b.** Outpatient Rehabilitation Services is located at ~~161 Thunder Drive, Suites 112 and 113, Vista~~**2124 El Camino Real Suite 100, Oceanside**, CA ~~9208~~**92054**.
   - **c.** Tri-City Wellness Center is located at 6250 El Camino Real, Carlsbad, CA 92009.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES POLICY MANUAL

SUBJECT: **Productivity Reporting System**

ISSUE DATE: **12/88**
REVISION DATE(S): 1/91, 1/94, 9/97, 10/00, 1/06, 3/12

Department Approval Date(s):	**07/15**
Department of Medicine Approval Date(s):	**N/A**
Pharmacy and Therapeutics Approval Date(s):	**N/A**
Medical Executive Committee Approval Date(s):	**N/A**
Professional Affairs Committee Approval Date(s):	**09/15**
Board of Directors Approval Date(s):	

~~**ISSUE DATE:** 12/88~~

~~**REVISION DATE:** 1/91, 1/94, 9/97, 10/00, 1/06, 3/12~~
~~**REVIEW DATE:** 2/03, 6/04, 1/09~~

~~**SUBJECT:** **PRODUCTIVITY REPORTING SYSTEM**~~
~~**STANDARD NUMBER: 203**~~
~~**CROSS REFERENCE:**~~
~~**APPROVAL:**~~

~~This Policy / Procedure applies to the following Rehabilitation Services' locations:~~

- ☐ ~~4002 Vista Way, Oceanside, CA~~
- ☑ ~~2124 El Camino Real, Suite 100, Oceanside, CA~~
- ☑ ~~6250 El Camino Real, Carlsbad CA~~

~~A. PURPOSE~~

~~1. To provide a timely information system concerning productivity and to assist in the assurance of proper resource management.~~

~~B.~~**A. POLICY:**

1. Internal productivity will be monitored on a daily basis with reports generated ~~biweekly and monthly for all therapeutic areas~~**at routine intervals**.

~~C.~~**B. PROCEDURE:**

1. Each therapeutic area **and/or discipline** will have a productivity system.
2. Each system will vary based upon the specific needs of each area **and/or discipline**.
3. After each treatment and/or at the completion of the day, patient encounters are recorded through the Compass billing submission. Charges are reviewed to ensure accuracy of data.
4. A productivity report for each area is generated on a biweekly basis.
~~1.~~**5.** ~~Supervisors~~**The Rehabilitation Services Leadership Team will** review the reports periodically and adjust staffing resources as is deemed appropriate.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES POLICY MANUAL

SUBJECT: **Staff Rotations**

ISSUE DATE: **11/88**
REVISION DATE(S): 1/91, 11/94, 5/97, 1/00, 1/06, 1/09, 4/12

Department Approval Date(s):	**07/15**
Department of Medicine Approval Date(s):	**N/A**
Pharmacy and Therapeutics Approval Date(s):	**N/A**
Medical Executive Committee Approval Date(s):	**N/A**
Professional Affairs Committee Approval Date(s):	**09/15**
Board of Directors Approval Date(s):	

~~**ISSUE DATE:** 11/88~~
~~**REVISION DATE:** 1/91, 11/94, 5/97, 1/00, 1/06, 1/09, 4/12~~
~~**REVIEW DATE:** 1/03~~

~~**SUBJECT: STAFF ROTATIONS**~~
~~**STANDARD NUMBER: 615**~~
~~**CROSS REFERENCE:**~~
~~**APPROVAL:**~~

~~This Policy / Procedure applies to the following Rehabilitation Services' locations:~~

- ☐ ~~4002 Vista Way, Oceanside, CA~~
- ☑ ~~2124 El Camino Real, Suite 100, Oceanside, CA~~
- ☑ ~~6250 El Camino Real, Carlsbad CA~~

A. PURPOSEPOLICY:

1. ~~To offer an opportunity for~~ **Occupational Therapy, Physical Therapy and Speech Language Pathology is accountable through Leadership Structure of Rehabilitation Services to promote a** varied clinical experience ~~and workload~~**, through the change in their primary work area,** while maintaining a system of continuity of care in each work area.

~~B. POLICY~~

~~1. Therapy staff members may be given the opportunity to change their primary work area upon request, or as appropriate.~~

~~C.~~**B. PROCEDURE:**

1. A minimum of one therapy staff member will be the primary therapy ~~caregivers~~**provider** in each ~~of these areas~~**designated area which includes but is not limited to**:
   - **a.** ~~Inpatient~~ **Outpatient services**
     - ~~a.~~**i.** Orthopedics
     - **ii. Neurologic**
     - **iii. Lymphedema**
     - **iv. Hands**
     - **v. Aquatics**
     - **vi. Swallow Studies**
     - **vii. Pediatrics**
     - **viii. Other Specialties based on current practice**

b. Inpatient **services**
~~b.~~**i.** Medical/Surgical
ii. Acute Rehabilitation
iii. Orthopedics

2. Upon request, the staff may be given the option of rotating to another primary work area, or as **deemed** appropriate **by the Leadership Structure of Rehabilitation Services.**
3. Rotations will proceed with the following considerations:
   a. Each area must maintain a minimum of one staff member~~.~~ **or** ~~as indicated~~ **based on patient care needs**
   ~~b. Each area will be open to all staff members for rotation.~~
   ~~c.~~**b.** Staff will orient ~~and conference newly rotating staff members~~ to the work area~~and patients.~~
   ~~d.~~**c.** ~~Patients and nursing staff~~**Staff** will be notified of upcoming rotations as appropriate/applicable~~.~~

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES POLICY MANUAL

SUBJECT: **Statement of Accountability**

ISSUE DATE: **6/88**
REVISION DATE(S): 1/94, 4/97, 10/99, 10/00, 2/03, 1/09, 11/09, 3/12

Department Approval Date(s):	**07/15**
Department of Medicine Approval Date(s):	**N/A**
Pharmacy and Therapeutics Approval Date(s):	**N/A**
Medical Executive Committee Approval Date(s):	**N/A**
Professional Affairs Committee Approval Date(s):	**09/15**
Board of Directors Approval Date(s):	

~~**ISSUE DATE:** 6/88~~

~~**SUBJECT:** STATEMENT OF ACCOUNTABILITY~~

~~**REVISION DATE:** 1/94, 4/97, 10/99, 10/00, 2/03, 1/09, 11/09, 3/12~~

~~**STANDARD NUMBER: 102**~~

~~**REVIEW DATE:** 1/91, 7/91, 2/03, 1/06~~

~~**CROSS REFERENCE:**~~

~~**APPROVAL:**~~

~~This Policy / Procedure applies to the following Rehabilitation Services' locations:~~

~~☑ 4002 Vista Way, Oceanside, CA~~

~~☑ 2124 El Camino Real, Suite 100, Oceanside, CA~~

~~☑ 6250 El Camino Real, Carlsbad CA~~

A. **POLICY:**

~~**DIRECTOR OF REHABILITATION SERVICES**~~
~~**STATEMENT OF ACCOUNTABILITY**~~

1. The Director of Rehabilitation Services is responsible to the **Senior Director** ~~Vice President~~ and the Rehabilitation Services Staff for the overall direction and supervision of the department and the administrative direction of Rehabilitation Services.
2. In the event of the absence of the Director, an appropriate designee will be assigned, which may include **the Senior Director,** a therapy supervisor, a vice president, a supervisor of another department, or other designee.

Tri-City Medical Center
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SECURITY
SECURITY OPERATIONS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: April 13, 1992~~ ~~Reviewed: 2/94, 10/97, 9/01, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 2/94, 9/01, 7/03, 5/11~~ ~~Approvals: Director of Security~~	~~Subject: Aero Medical Transport Responsibilities~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 223~~

SUBJECT: Aero Medical Transport Responsibilities

ISSUE DATE: April 13, 1992 **POLICY NUMBER:** 223
REVIEWED DATE(S): 2/94, 10/97, 9/01, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 2/94, 9/01, 7/03, 5/11

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To provide guidelines for Security Department personnel while assisting with a Aero Medical Transportation upon the Medical Center campus

B. **POLICY:**
1. It is the policy of the Security Department to ensure that prompt and professional service is provided during an Aero Medical Transport.

C. **PROCEDURE:**
1. When the Security Department receives notification from the **ED** Radio **Room** or Charge Nurse in the Emergency Department of an incoming Aero Medical Transport the 3-Post Officer will respond to the Helicopter Landing Pad on the roof of the Emergency Department and complete the following.
   a. The responding Officer will report to the Landing Pad and activate the landing lights.
   b. The Lead/Charge Officer will then contact the Central Plant Engineer and inform them of the Estimated Time of Arrival.
   c. The Officer will then await the arrival of the Aero Medical Transport agency.
   d. Once the Aero Medical Transport agency Helicopter is in sight, the Officer will immediately shut down the air handlers for the Emergency Department.
   e. If the Helicopter is going to be on the ground for longer than fifteen minutes the Officer will contact the Central Plant Engineer and ask them to turn the air handlers back on and will inform the Engineer that they will make contact before take off and re-shut down the air handlers.

f. Once the Aero Medical transport is complete the Lead/Charge Officer will make contact with the Central Plant Engineer and inform them of the departure of the Helicopter

g. If the Aero Medical Transport arrives without acceptable notice, a detailed entry will be notated in the Officer's DSR with times and the names of the ~~ER~~ **ED** Radio Nurse and ~~ER~~ **ED** Charge Nurse. A notation will also be made in the Heliport Log stating no or little notice given.

Tri-City Medical Center
Oceanside, California

SECURITY
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~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: April 02, 2003~~ ~~Reviewed: 04/03, 11/06, 3/09, 6/11~~ ~~Revision: 00/00~~ ~~Approvals: Director of Security~~	~~Subject: BHU STAT Response (STAT Response to Behavioral Health Services Department)~~ ~~Page 1 of 2~~
~~Submitted By: Tri-City Medical Center Security Department~~	~~Procedure Manual: Security Department SDPPM - # 215~~

SUBJECT: BHU STAT Response (STAT Response to Behavioral Health Services Department)

ISSUE DATE: April 02, 2003 **POLICY NUMBER:** 215
REVIEWED DATE(S): 04/03, 11/06, 3/09, 6/11
REVISION DATE(S):

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To establish a set of guidelines for Security Department Personnel to follow in response to a STAT call to the Behavioral Health Services Department.

B. **POLICY:**
1. All Security Department Personnel will follow the procedures of this policy when responding to a STAT call to the Behavioral Health Services Department.

C. **PROCEDURE:**
1. When the Security Department receives a STAT call to the Behavioral Health Services Department the on-duty Security Department Personnel will respond to the Behavioral Health Services Department in a safe manner.
2. Once the Security Department Personnel arrive at the Behavioral Health Services Department the responding Officers will immediately report to the Charge Nurse to receive a briefing and overview of the incident and possible resolutions.
   a. The responding Security Department Personnel will find out why the STAT call was placed.
   b. The responding Security Department Personnel will find out who is involved in the incident.
   c. The responding Security Department Personnel will find out what the Charge Nurse would like as the outcome.

3. The Security Department Personnel will attempt to neutralize the incident by communicating the desires of both the Staff and Patient and to mediate the incident. Security Department Personnel will make every attempt to neutralize the incident without the use of force.
4. Once the Security Department Personnel arrive at the Behavioral Health Services Department in response to a STAT call and observe an immediate need to intervene due to a violent or dangerous incident the Security Department Personnel will immediately take interventional action to neutralize the incident.
   a. Security Department Personnel will use an appropriate response level (Use of Force) to immediately intervene and neutralize the incident.
   b. Once the incident is neutralized the Security Department will gather all information regarding the incident including what led up to the incident and who was involved in the incident and why the incident occurred.
   c. All Security Department Personnel will meet with the Clinical Staff and participate in the Behavioral Health Services Department critical incident debriefing

D. **NON-COMPLIANCE:**

1. Non-Compliance with any portion of this policy will result in disciplinary action leading up to and or including termination.

Tri-City Medical Center
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SECURITY
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~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: March 17, 1994~~ ~~Reviewed: 12/96, 6/03, 11/06, 6/11~~ ~~Revision: 6/03~~ ~~Approvals: Director of Security~~	~~Subject: Emergency Department Patient Parking~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM - # 225~~

SUBJECT: Emergency Department Patient Parking

ISSUE DATE: March 17, 1994 **POLICY NUMBER:** 225
REVIEWED DATE(S): 12/96, 6/03, 11/06, 6/11
REVISION DATE(S): 6/03

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**

1. To ensure that **arriving** patients seeking medical treatment in the Medical Center's Emergency Department have an unrestricted location for the timely loading and unloading and that there is a lot location which is reserved for long term vehicle parking.

B. **POLICY:**

1. It is the policy of the Security Department that all on-duty Officers will actively enforce an unrestricted area for the timely loading and unloading of patients and long term parking of vehicles for patients in the Emergency Department.

C. **PROCEDURE:**

1. It is vitally important that all arriving patients, seeking medical treatment in the Emergency Department, or Women's ~~Resource~~ Center, be afforded an unrestricted location, adjacent to the main entrances for the timely unloading and or loading.
2. It is the primary responsibility of the Security Officer assigned to the Emergency Department to actively patrol and enforce, as needed this area. In addition, if circumstances warrant, other on-duty Security Officers will be requested to assist with this area.
3. Upon contacted a legally parked vehicle, the Security Officer will note that time and after a reasonable designated time have PBX page the owner and request the moving of the vehicle. This vehicle will be monitored until such time that it is moved.
4. The Security Officer paging any parked vehicle will complete an appropriate Daily Security Report entry for each paging occurrence.

5. Any vehicle, is either parked in such a matter as to create a serious traffic hazard or whose occupants aren't seeking medical treatment, will be IMMEDIATELY paged through PBX as described in Section 3.3 of this policy.
6. At no time will any Security Officer offer statements that could be perceived as a threat to tow any owner's parked vehicle unless it is creating an extreme traffic hazard or the occupants aren't seeking medical treatment.
7. Before any vehicle is physically removed from the Medical Center campus the initiating Security Officer will first notify the Security Supervisor or Designee.

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~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: April 15, 1994~~ ~~Reviewed: 6/00, 3/01, 6/03, 11/06, 3/09, 6/11~~ ~~Revision: 2/97, 3/01, 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Exterior Door Security~~ ~~Page 1 of 2~~
~~Submitted By: Tri-City Medical Center Security Department~~	~~Procedure Manual: Security Department SDPPM - #222~~

SUBJECT: Exterior Door Security

ISSUE DATE: April 15, 1994 **POLICY NUMBER:** 222
REVIEWED DATE(S): 6/00, 3/01, 6/03, 11/06, 3/09, 6/11
REVISION DATE(S): 2/97, 3/01, 7/03

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. As part of the security program at the Medical Center, the locking and unlocking of all doors will be accomplished by the appropriate, designated on-duty Security Officer in accordance with the following policy.

B. **POLICY:**
1. It is the policy of the Security Department to ensure that the proper procedure of locking and unlocking of exterior doors is completed in a timely and efficient manner.

C. **PROCEDURE:**
1. The Security Officer assigned to the following post will be responsible for ensuring that the following door locations are **locked** at the appropriate time frame and day of the week:
   a. **E-1 SECURITY POST 1700 - 2200**
      i. Business and Management Services, west side door, (Monday – Sunday) 20:30 hours.
      ii. Ancillary, northwest door, (Monday – Sunday) 20:30 hours.
      iii. Women's Center, (Monday – Sunday) 20:30 hours.
      iv. Ancillary, northeast door to lower level, (Monday – Sunday) 20:30 hours.
      v. South Tower, south side lower level door, (Monday – Sunday) 20:30 hours.
      vi. Business and Management Services, east side door, (Monday – Friday) 20:30 hours.
      vii. French Rooms, (Monday – Sunday) 20:30 hours.
      viii. Shipping and Receiving, both sets double doors, (Monday – Sunday) 17:00 hours. **Also turn on the exterior loading dock lights**
   b. **E-2 SECURITY POST 1700 – 2200**

i. Administration, all interior and exterior doors, (Monday – Friday) 17:00 hours
ii. 2095 Vista Way/Location #T, (Monday – Friday) 21:00 hours.
iii. Main Lobby (Monday – Friday) 20:30 hours.
iv. Outpatient Discharge door, (Monday – Sunday) 20:30 hours.
v. Imaging Department reception area, both east side and west side doors, (Monday – Sunday) 20:30 hours.

c. **G-2 SECURITY POST 2200**
i. Pavilion basement east side stairwell doors, (Monday – Sunday) 22:00 hours.
ii. All Pavilion classroom and assembly room doors, (Monday – Sunday) 22:00 hours.
iii. Outpatient discharge door, (Monday – Sunday) 22:00

2. The Security Officer assigned to the designated post will be responsibly for ensuring that following door locations are **unlocked** at the appropriate time frame and day of the week:
a. **G-1 SECURITY POST – 0430**
i. Business and Management Services, west side door, (Monday – Friday) 05:40 hours.
ii. Ancillary, northwest door, (Monday – Sunday) 04:30 hours.
iii. Women's Center, (Monday – Sunday) 04:30 hours.
iv. Ancillary, northeast door to lower level, (Monday – Sunday) 04:30 hours.
v. South Tower, south side lower level door, (Monday – Friday) 04:30 hours.
vi. Business and Management Services, east side door, (Monday – Friday) 04:30 hours.
vii. French Rooms, (Monday – Sunday) 04:30 hours.

b. **G-2 SECURITY POST – 0430**
i. Administration, all interior and exterior doors, (Monday – Sunday) 04:30 hours.
ii. Main Lobby (Monday – Friday) 04:30 hours.
iii. Outpatient Discharge door, (Monday – Sunday) 04:30 hours.
iv. Imaging Department reception area, both east side and west side doors, (Monday – Sunday) 04:30 hours.

c. **D-1 SECURITY POST – 0700**
i. Behavioral Health Unit (Monday – Sunday) 07:00 hours.

d. **D-2 SECURITY POST – 0700**
i. 2095 Vista Way/Location #T, (Monday – Friday) 07:00 hours.

3. Doors to Administration will remain locked on Saturday, Sunday and all holidays.
4. Doors to the Business and Management Services building will remain locked on Saturday, Sunday and holidays, unless payroll processing is being completed. Each shift officers will be responsible for adjusting his/her unlocking schedule to accommodate this process.
5. It will be the responsibility of the Security Supervisor/designee to inform all Security Officers, in writing, of any exceptions to this procedure.
6. Doors will not be propped open or otherwise manipulated to prevent locking. Doors left unlocked for any reason will constitute a breach of security. All doors found in this condition will be immediately secured and the officer will proper document his/her actions (including door location and number) on their Daily Security Report (DSR).
7. Any staff/physician request for after hour access to any locked location will be conducted in accordance with current Security Department policy.

Tri-City Medical Center
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SECURITY
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~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: May 05, 2003~~ ~~Reviewed: 11/06, 3/09~~ ~~Revision: 4/08, 6/11~~ ~~Approvals: Director of Security~~	~~Subject: Lost and Found Procedures for Security Department~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 230~~

SUBJECT: Lost and Found Procedures for Security Department

ISSUE DATE: May 05, 2003 **POLICY NUMBER:** 230
REVIEWED DATE(S): 11/06, 3/09
REVISION DATE(S): 4/08, 6/11

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

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

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

C. **PROCEDURE:**
1. Receiving Lost and Found Items
   a. When Security is requested to receive a Lost and Found item, the responding Security Officer will inquire as to the owner's name, phone number, and call them as to ensure that every attempt has been made to identify and return the item to the owner. If this information is collected late at night, the shift will still collect the contact information, and ask the following shift to place the call. If after every reasonable attempt has been made, it is the responding Officer's responsibility to properly log in the item(s) to the Lost and Found Logbook #2.
   b. A Lost and Found Property Slip will be completed with a detailed description of the item(s) contents. The responding Officer's information must be included in the "Received by" area as well as the item number documented on the Property Slip, owner's name, and owner's phone number.
   c. All applicable information will be logged into the **Lost and Found Logbook #2**. The Property Slip needs to be placed inside the belongings bag, and the item number labeled with label facing toward the front on the outside of the bag with the bag tied in a knot so the belongings do not fall out when moved.

d. All Lost and Found items will be logged into the Lost and Found Logbook before being sent to their area for storage (i.e. Pharmacy, Safe, Customer Relations). Valuables such as jewelry, money, checks, credit cards etc. will be collected when a second officer is available as a witness. Valuables will be locked in the small (Drop) safe located inside the Lost and Found office and Logged in the **Lost and Found Valuables Property Logbook #5**. The item(s) will be placed in a white Valuables envelope with article description, date inserted, and officer's signature printed on a valuables inventory sheet and placed on the outside of the envelope. Driver's License, ID cards, health cards, and paperwork will be placed in the locked metal cabinet as well as bulk items of value (i.e. laptops, cell phones, and other electronic devices). Prescription eyeglasses and Patient Care items (i.e. hearing aides, medic alert devices, dentures etc.) are to go to the Customer Relations office located next to the Main Admitting Department waiting room.

2. Lost and Found Inquiries
   a. The Responding Security Officer will complete a detailed search for the lost item(s). If the item is not located, the individual's name, phone number, date of inquiry and description of the lost item(s) need to be taken and logged into the **Lost and Found Inquiry Logbook #3**.
3. Returning Lost and Found items.
   a. When requested to return an item, every attempt will be made to ensure that the item is being returned to the proper owner.
   b. The Officer will have the owner or person receiving the property complete the Lost and Found Property slip by signing for the item.
   c. The Officer will then complete the Lost and Found disposition section of the Lost and Found Log and file the Property slip in the Property Slip Bin.
   d. When returning lost and found valuables, the Officer must verify that the person claiming the item is the owner, and positive ID made through photo identification. If the person claiming the item is someone other than the owner, they must show proof of Durable Power of Attorney for the owner or a letter from the owner approved by the Customer Service Representative.
4. Destruction of Lost and Found Property
   a. If any Lost and Found items are not returned within 90 days, the items will be disposed of in a manner specified by the Director of the Risk, Legal, and Regulatory Department.
   b. Any soiled articles, flammable items (i.e. lighters, matches, flammable liquids or items containing flammable liquids), or perishable items such as food will be logged into the Lost and Found Log Book then disposed of and notated in the disposition area with the reason for disposal.

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

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SECURITY
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~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: January 25, 1994~~ ~~Reviewed: 1/96, 1/97, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Media Relations~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM - # 229~~

SUBJECT: Media Relations

ISSUE DATE: January 25, 1994 **POLICY NUMBER:** 229
REVIEWED DATE(S): 1/96, 1/97, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 7/03

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To establish a systematic process for Medical Center Security Officers to utilize when interacting with members of the Media upon the Medical Center campus.

B. **POLICY:**
1. It is the policy of the Security Department to cooperate with all members of the Media whenever possible. In an effort to facilitate this process the following procedure will be followed. Reference Administrative Policy #372 Consent to Photograph/Videotape and Policy #524 Disclosure of Information to Public and Media

C. **PROCEDURE:**
1. Only the **Chief Marketing Officer (CMO),** Director of Marketing ~~and Communications~~, Chief Executive Officer, or the CEO's Designee shall release any information or statements on behalf of the President and Chief Executive Officer or the Medical Center to members of the Media pertaining to any and all incidents that might occur in or on the Tri-City Medical Center campus **and offsite locations**.
2. When any Security Officer becomes aware that a member of the Media is on the Medical Center campus or receives a request of any type or is approached by any member of the Media, the Officer will immediately forward such requests to the ~~Director of Marketing and Communications~~ **CMO** by calling direct, paging, or going through the operator. Once contact has been established with the Public Relations representative the Security Officer will escort and wait with the Media representative until such time that they are met by the Public Relations representative at a designated location.

3. At no time will any member of the Media be allowed to obtain any type of information verbal or written, or gain entry into the Medical Center without prior approval from the **CMO,** Director of Marketing ~~and Communications~~ or Designee.
4. If a Security Officer is unable to positively establish that a member of the Media has received proper authorization to be at the Medical Center, the Officer will politely ask the member of the Media to immediately leave the Medical Center campus.
5. At no time will any Security Officer seize or impound any photographic or reproductive equipment, film or written correspondence from any member of the Media.

D. **~~ATTACHMENT~~RELATED DOCUMENTS:**

1. Administrative Policy #372 ~~and~~: **Consent of Photography/Videotape**

~~1.~~**2. Administrative Policy** #524**: Disclosure of Information to Public and Media**

Tri-City Medical Center
Oceanside, California

SECURITY
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~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: May 16, 2011~~ ~~Reviewed: 6/11~~ ~~Revision:~~ ~~Approvals: Director of Security~~	~~Subject: Patient Valuables Collection and Return~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM - # 237~~

SUBJECT: Patient Valuables Collection and Return

ISSUE DATE: May 16, 2011 **POLICY NUMBER:** 237
REVIEWED DATE(S): 6/11
REVISION DATE(S):

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To establish guidelines for Security Department personnel to utilize when receiving Patient Valuables.

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

C. **PROCEDURE:**
1. Receiving Patient Valuables
   a. When Security ~~Is~~ **is** requested to collect ~~Patient~~ **patient** ~~Valuables~~**valuables**, the responding Security Officer will first encourage the patient to send the item(s) home with a family member for ~~safe~~ **safe**-keeping.
   b. If the patient is unable or unwilling to send the item(s) home for safe keeping, the Officer will bring a grey UniVault bag to the location of the patient. The Officer will collect the item**(s)** with the ~~Patient's~~ **patient's** ~~Nurse~~ **nurse** as a witness to the collection process. Once the item is collected, the Officer will inventory the item(s) and write a complete and accurate description of the item(s) on the outside of the UniVault bag using a sharpie or other permanent type marker, then place the item(s) in the bag securing it. Only valuables will be collected and placed in the bag (i.e. if the patient is securing a wallet, the valuables are removed from it in the patient's presence, and placed in the UniVault bag, then the wallet is returned to the patient.) All information on the bag must be filled out completely, and signed by the patient. If the patient is unable to sign, the ~~Patient's~~ **patient's** nurse will sign as a witness. **T**he top flap

portion of the bag is to be removed and filled out, then given to the patient as receipt of collection. Two (2) copies of the completed inventoried bag must be made by placing the bag directly on a copy machine, one copy is to be given to the Patient's Nurse to be included in the Patient's chart, and the second copy is to be placed in the "For Copies Only" tray located on the counter above the Small (Drop) Safe in the Lost and Found office. The Officer must verify the patient's phone number with the patient (not collected from the chart) to ensure current and accurate contact information.

c. All applicable information will be logged into the **Patient Valuables Property Logbook #4** including the ~~Patient's~~ **patient's** name, ~~Phone~~ **phone** number, and bag serial number. The bag will be placed in the slot and dropped with the Officer verifying the bag fully dropped in.

2. Returning Patient Valuables.
   a. When requested to return a ~~Patient's~~ **patient's** ~~Valuables~~**valuables**, every attempt will be made to ensure that the item**(s)** is**/are** being returned to the proper owner.
   b. The Officer will collect the UniVault ~~Receipt~~ **receipt** from the owner, or if it has been lost or misplaced, will receive the copy of the bag from the ~~Patient's~~ **patient's** ~~Chart~~**chart**.
   c. The Officer will take the UniVault ~~Receipt~~ **receipt** or chart copy and contact the Cashiering Department or Administrative Coordinator (After Hours) to meet and open the Small (Drop) Safe to collect the ~~Patient's~~ **patient's** ~~Valuables~~**valuables**. The Officer will return to the floor and in the presence of the ~~Patient~~ **patient** and ~~Nurse~~**nurse**, will cut the bag open on the dotted line of the bag. The Officer will inventory the contents of the UniVault Bag and compare them to the ~~Inventory~~ **inventory** listed on the outside of the bag while checking off the inventory items. When the ~~Patient~~ **patient** is satisfied that all their ~~Valuables~~ **valuables** are accounted for, the Officer will have the ~~Patient~~ **patient** sign the UniVault Bag and the copy. The Officer will make two copies of the signed inventory sheet and give to the ~~Patient's~~ **patient's** nurse to be included in the ~~Patient's~~ **patient's** chart as a permanent record of receipt.
   d. The Officer will return the signed UniVault Bag and the signed inventory sheet and place both in the "For Copies Only" tray located on the counter above small (Drop) safe.
   e. The Lost and Found Administrator will collect the signed receipts and attach them to the copy filed in Lost and Found, and file them together in the Disposition section of Patient Valuables filing cabinet.

3. Destruction of Patient Valuables Property
   a. If any ~~Patient~~ **patient** ~~Valuables~~ **valuables** items are not claimed within 180 days, the items will be disposed of in a manner specified by the Director of the Risk, Legal, and Regulatory Department.

D. **~~ATTACHMENT~~ RELATED DOCUMENTS:**

1. **Patient Care Services**~~Administrative~~ Policy **(formerly** #317**): Patient Valuables Liability and Control**

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: April 19, 1994~~ ~~Reviewed: 12/96, 12/01, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 12/01, 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Patrol of areas Under Construction~~ ~~Page 1 of 1~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM - # 226~~

SUBJECT: Patrol of Areas Under Construction

ISSUE DATE: April 19, 1994 **POLICY NUMBER:** 226
REVIEWED DATE(S): 12/96, 12/01, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 12/01, 7/03

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To ensure that areas under construction are safe and secure for all staff, visitors, and patients who might frequent the location.

B. **POLICY:**
1. It is the policy of the Security Department that all on-duty Security Officers will randomly patrol all areas under construction for any situation or condition, which would jeopardize the safety, security, and welfare of any staff, visitor, and patient at the Medical Center.

C. **PROCEDURE:**
1. All on-duty Security Officers will routinely and randomly patrol all areas under construction, which are located in their assigned area of responsibility.
2. When a situation or condition, which creates a hazard, is detected, the Security Officer will immediately take the necessary corrective action. This includes but is not limited to, notification of the on-duty engineer, the placing of barricades, tape, etc. to secure the location.
3. If this situation or condition is detected during normal business hours, the Special Projects coordinator, of the Facilities Management Department will be contacted and advised of all pertinent information.

Tri-City Medical Center
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SECURITY
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~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: November 10, 1992~~ ~~Reviewed: 4/94, 10/97, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Property Custody~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM - # 232~~

SUBJECT: Property Custody
ISSUE DATE: November 10, 1992 **POLICY NUMBER:** 232
REVIEWED DATE(S): 4/94, 10/97, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 7/03

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date (s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To establish a set of guidelines for Security Department personnel to utilize in association with the impounding of any property or property seized for safekeeping.

B. **POLICY:**
1. It is the policy of the Security Department to ensure that all items impounded or seized for safekeeping are properly logged and secured.

C. **PROCEDURE:**
1. Impounding of Dangerous Weapons
   a. Anytime an Officer observes or learns of a Dangerous Weapon on the Medical Center, the Officer will seize the item and place it into the Locked Cabinet in the Emergency Department Security Office. A Property Custody form will be completed and a copy given to the owner.
2. Items seized for Safekeeping
   a. Any time an Officer seizes any item or takes into custody an item for Safekeeping the Officer will complete a Property Custody for and give a copy for the owner.
   ~~a.~~**b. The collection or disposition of questionable items will be at the discretion of the Lead or Designee.**
3. Storage of Weapons on Medical Center Campus.
   a. Anytime a request is made to secure a weapon by a registered and legal carrier, the Security Officer will make sure that the weapon is made safe and secure the weapon in the Emergency Department locked cabinet. The Officer will complete a Property Custody form and give a copy to the owner.
4. Returning Property in Custody of the Security Department.

a. When property in custody of the Security Department is requested to be returned the Officer will only return the item if the requester is ready to leave the Medical Center.

b. The Officer will ensure that the person requesting the property is the owner or has been authorized by the owner to retrieve the property in custody. The requester should have a copy of the Property Custody form.

c. The Officer will have the receiving party sign the original copy of the Property Custody form indicating that they are retrieving all the property.

D. FORM(S):

~~c.~~**1. Property Custody Record**

Tri-City Medical Center
Security Department

Property Custody Record

Notice to Property Owner: Upon release from the Tri-City Medical Center it will be your responsibility to make arrangements to pick up the hereon-listed items from the Security Department. Any items not picked up within thirty(30) days will be destroyed.

Officer Receiving Property:	Date Received:	Time Received:

Property Received from:

❑ Owner: _____

❑ Other: _____

Location / Reason Property Obtained:

_____

_____

_____

❑ Property Received for Safekeeping

Item #	Qty	Description / Condition:	SN / Tag #

Property Disposition:

❑ Property Returned to Owner
❑ Property Returned to Other Reason: _____
❑ Property Destroyed After Thirty(30) Days
❑ Property Destroyed Before Thirty(30) Days Reason: _____

Property Returned By:		
Officer:	Badge:	Date:

Property Received By:	
Signature:	Date:

White: Security Department - Yellow: Person Receiving Property - Pink: Receipt

Tri-City Medical Center
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SECURITY
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~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: September 05, 2000~~ ~~Reviewed: 8/01, 7/03, 11/06, 3/09, 6/11~~ ~~Revision: 8/01, 6/11~~ ~~Approvals: Director of Security~~	~~Subject: Psychiatric Patient Escorts~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 216~~

SUBJECT: Psychiatric Patient Escorts

ISSUE DATE: September 05, 2000 **POLICY NUMBER:** 216
REVIEWED DATE(S): 8/01, 7/03, 11/06, 3/09, 6/11
REVISION DATE(S): 8/01, 6/11

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To establish guidelines for Security Department personnel when conducting escorts for psychiatric patients.

B. **POLICY:**
1. It is the policy of the Security Department to ensure the safety, security, and welfare of all involved parties when conducting an escort of any psychiatric patients upon the Medical Center campus.

C. **PROCEDURE:**
1. Prior to any escorts involving a Psychiatric Patient regardless of voluntary/involuntary status, the Officer must complete a safety search of the ~~Patient's~~ **patient's** belongings to assure no weapons or dangerous items are brought with the patient.
   a. If an item is identified as dangerous, the Officer will take custody of the item and secure it for safe keeping in the locked cabinet in the Emergency Department Security Office.
   b. The item will be inventoried and a receipt will be given to the patient.
   c. Upon the patient's discharge, the item will be returned to the patient.
2. All Security Department escorts involving psychiatric patients shall be conducted with the accompaniment of at least one of the following Medical Center personnel.
   a. Registered Nurse (RN)
   b. Licensed Vocational Nurse (LVN)
   c. Emergency Medical Technician (EMT)
   d. Psychiatric Liaison
   ~~d.~~**e. Acute Catre Technician (ACT)/Nursing Assistant**

3. Security Department escorts involving psychiatric patients on a Psychiatric/5150 Hold will be conducted by a minimum of two (2) Security Officers if the escort meets at least one of the following criteria:
   a. Family members or a visitor are present at the time of escort.
   b. The patient has demonstrated or verbalized the desire to elope during his or her contact with Medical Center personnel.
   c. The patient is a danger to self or others.
   d. The Security Officer involved has made the determination that the patient may be a flight risk, or may pose a physical threat
4. Security Department escorts involving psychiatric patients on a Psychiatric /5150 Hold will be conducted by a minimum of one (1) Security Officer if the escort meets at least one of the following criteria.
   a. No family members or visitors are present at the time of escort.
   b. The patient has not demonstrated of verbalized the desire to elope during his or her contact with Medical Center personnel.
   c. The patient is gravely disabled and unable to elope during the escort.
5. Security Department escorts involving psychiatric patients not on a Psychiatric /5150 Hold will require the presence of one (1) Security Officer unless the escort meets one of the following criteria.
   a. The patient is not on a Psychiatric /5150 Hold at the time of the escort, but if the patient attempts to elope he/she **may**~~will~~ be placed on a Psychiatric /5150 Hold.
   b. The patient has demonstrated or verbalized the desire to elope and at the time of the escort if the patient attempts to elope he/she will be placed on a Psychiatric /5150 Hold.
   c. Medical Center personnel due to the patients' potential of becoming violent or a danger to self or others during the escort request security.
6. Security Department personnel shall be able to react in a quick and professional manner in the event that it is necessary to control a situation that may arise during an escort. To ensure that Security Officer's may safely and quickly react in the event of a situation the following will be followed by all Security Department personnel.
   a. No Security Officer shall be required to push a wheelchair during an escort.
   b. No Security Officer shall be required to carry any large objects that may inhibit him/her from a quick reaction.
   c. If the patient has multiple bags of belongings, the Security Officer shall ask for assistance from another Officer, or another member of Medical Staff.

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Oceanside, California

SECURITY
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~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: September 05, 1991~~ ~~Reviewed: 4/94, 10/97, 5/03, 11/03, 11/06, 3/09, 6/11~~ ~~Revision: 7/03, 11/03~~ ~~Approvals: Director of Security~~	~~Subject: Security Alarm Systems Response~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 220~~

SUBJECT: Security Alarm Systems Response

ISSUE DATE: September 05, 1991 **POLICY NUMBER:** 220
REVIEWED DATE(S): 4/94, 10/97, 5/03, 11/03, 11/06, 3/09, 6/11
REVISION DATE(S): 7/03, 11/03

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. In order to ensure the safety and security of sensitive and off-site locations the Security Department continually evaluates all locations and properties of the Medical Center for the need of a Security Alarm System to detect unauthorized or unlawful entry into an area of the Medical Center

B. **POLICY:**
1. Currently the Security Department utilizes Security Alarm Systems to detect Unauthorized or Unlawful entry into a Medical Center location. It is the responsibility of each Security Officer to know the location and disarm code for each Security Alarm System in the Medical Center and in all of the off-site locations.

C. **PROCEDURE:**
1. Currently Security Signal Devices Incorporated **(SSD)** is the Installer, Maintainer, and Monitor of the Medical Center Security Alarm Systems.
2. In the event of an Unauthorized or Unlawful entry into an area of the Medical Center protected by a Security Alarm System the Security Department will receive a call from SSD's Central Monitoring Station informing the Security Department of the location of the activated alarm.
3. The Security Department is the first responder to the activation of all areas of the Medical Center protected by Security Alarm Systems. Security Department personnel will respond to the location of the alarm and determine if an Unauthorized or Unlawful entry has indeed been committed of if the alarm activation was accidental or a system malfunction. Security Department personnel will respond to the alarm in accordance with all applicable Security Department Policies. If necessary Security Department personnel will summon the San Diego

Sheriffs Department or the Oceanside Police Department for assistance depending on the location of the alarm activation.

D. **~~ATTACHMENT~~FORM(S):**

1. Security and Panic Alarm Locations

Attachment 1

Silent / Panic Alarm System ~~Locations~~ as of August 2015

On Campus (4002 and 4010 addresses) Number of Alarms per Location =

Administration: 3 alarms
Behavioral Health Unit Building: 2 alarms
Business Management Services Building: 6 alarms
Cafeteria: 3 alarms
Emergency Department [E.D.]: 13 alarms
Fast Track [next to the E.D. area]: 2 alarms
Human Resources: 2 alarm
Labor and Delivery: 1 alarm
Magnetic Resonance Imaging Building: 3 alarms
Main Admitting or Registration: 8 alarms
Main Lobby's Volunteer Information Desk and Gift Shop: 3 alarms
Maternity Lobby: 1 alarm
Medical Records Department: 1 alarm
Medical Staffing Office: 2 alarms
Neonatal Intensive Care Unit or N.I.C.U. [3 West / Telemetry Tower location]: 1 alarm
N.I.C.U. Overflow: 3 alarms
Nurse Staffing Office: 1 alarm
Patient Financial Services or Cashier: 3 alarms
Patient Representative Office: 2 alarms
Pharmacy: 2 alarms [1 operational]
Postpartum: 1 alarm
Postpartum Overflow: 1 alarm

Off Campus (2095 address) Alarms =

Suite 111 Bldg. 2095 Outpatient Imaging: 1 alarm
Suite 214 Bldg. 2095 Marketing: 1 alarm
Suite 217 Bldg. 2095 Clinical Research / Statistics: 1 alarm

Tri-City Medical Center
Oceanside, California

SECURITY
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~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: August 06, 1997~~ ~~Reviewed: 5/03, 11/06, 5/09, 7/11~~ ~~Revision: 7/03, 6/09~~ ~~Approvals: Director of Security~~	~~Subject: Security Department VIP Policy~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 235~~

SUBJECT: Security Department VIP Policy

ISSUE DATE: August 06, 1997
REVIEWED DATE(S): 5/03, 11/06, 5/09, 7/11
REVISION DATE(S): 7/03, 6/09

POLICY NUMBER: 235

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**

1. To establish guidelines to assist Security Department personnel with the effective and efficient handling of VIP persons entering the Medical Center seeking medical treatment.

B. **POLICY:**

1. The "Very Important Patient" **(VIP)** policy has been established to expedite the handling of those classification persons entering the Medical Center for medical treatment.

C. **PROCEDURE:**

1. The Security Officer responsible for the area that a VIP Patient will be admitted to will immediately respond to that location and check in with the person in charge of that area.
2. The responding Security Officer will be responsible for notifying the Security **Manager,** Supervisor, ~~Designee,~~ or Shift Lead Officer of the VIP Patient's location within the Medical Center. The Security **Manager,** Supervisor, ~~Designee,~~ or Shift Lead Officer will be responsible for notifying the ~~Hospital Safety Officer~~ **Director of Safety** of the VIP Patient's location. The ~~Hospital Safety Officer~~ **Director of Safety** will notify the Chief Operating Officer and the Chief Nurse Executive of the VIP's location, and an appropriate area will be discussed to relocate the VIP to ensure privacy measures are implemented.
3. The responding Security Officer, Security **Manager,** Supervisor, ~~Designee,~~ or Shift Lead Officer will insure that all applicable Administrative and Patient Care Policies regarding VIP Patients are followed.

D. **~~ATTACHMENT~~RELATED DOCUMENTS:**

1. **Patient Care Services**~~Administrative~~ Policy **(formerly** #374**: Unidentified or Confidential Patient**
2. Administrative Policy #524**: Disclosure of Information to Public and Media**
3. Administrative Policy #526**: Rights to Request Privacy for Protected Health Information**

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SECURITY
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~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: May 01, 1994~~ ~~Reviewed: 1/97, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Security Incident Notification~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 208~~

SUBJECT: Security Incident Notification

ISSUE DATE: May 01, 1994
REVIEWED DATE(S): 1/97, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 7/03

POLICY NUMBER: 208

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To establish guidelines for Security Department personnel for the proper Incident Notification whenever a Security Incident occurs.

B. **POLICY:**
1. It is the responsibility of all Security Officers to properly notify the appropriate ~~people~~ **individuals** whenever a Security Incident occurs. Reference Administrative Policy #234 Security Department Incident Notification.

C. **PROCEDURE:**
1. Security Department personnel are required to notify the Security **Manager,** Supervisor, ~~Designee~~, or Shift Lead Officer anytime a Security Incident occurs on the Medical Center campus.
2. The following ~~are~~ **is** a list of ~~example~~ Serious Security Incidents that would require the immediate Security Department Incident Notification to be executed including but not limited **to:**
   a. Armed and Strong Armed Robbery.
   b. Homicide or Suspected Homicide.
   c. Kidnap or Suspect**ed** Kidnap.
   d. Rape.
   e. Serious Assault or Battery.
   f. Theft of Narcotics.
   g. Any Arrest made by or to a Security Officer.
   h. Natural Disaster.

i. Fire.
j. Flood.
k. Any Incident involving a Medical Center employee and requiring an immediate follow up investigation by the Security **Manager,** Supervisor~~, Designee~~, or Shift Lead Officer.
l. Death or Serious Injury to any Visitor or Staff Member.
m. Removing a Parked Vehicle from the Medical Center.

3. All notifications will be properly documented, in detail, on the Security Officer's DSR, including the time and type of contact.
4. Once the Security **Manager,** Supervisor, ~~Designee~~ or Shift Lead Officer has been notified they will make the proper notifications to any appropriate Administrative or Medical Center personnel.

D. **~~ATTACHMENT~~RELATED DOCUMENTS:**

1. Administrative Policy #234**: Security Department Incident Notification**

Tri-City Medical Center
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SECURITY
SECURITY OPERATIONS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: May 23, 2012~~ ~~Reviewed:~~ ~~Revision:~~ ~~Approvals: Director of Security~~	~~Subject: Security Officer Documentation~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM - # 238~~

SUBJECT: Security Officer Documentation

ISSUE DATE: May 23, 2012 **POLICY NUMBER:** 238
REVIEWED DATE(S):
REVISION DATE(S):

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To develop uniform documentation requirements for all Safety and Security related events.

B. **POLICY:**
1. All TCMC Security Officers are required to submit appropriate documentation. Security documentation includes the following: DSR's, Incident Reports, Enforcement Reports, Missing Patient Checklists and any other equipment or detail log. All Security officer field notes are to be destroyed upon submission of reports and documents.

C. **PROCEDURE:**
1. DSR (Daily Security Report)
   a. The Officer's DSR needs to be completed at the end of the Officer's shift. The DSR is to be chronological with accurate times and complete details of all the Officer's activities for that day. This information will include times spent in each location, and every assignment the Officer completes. All room numbers, points of contact, employee and patient names are to be included. In addition, if the officer has any involvement with lost and found or control of another person's belongings, the contents and the disposition will be documented as well as any bag, name or identification number. DSR's are not to be used in lieu of an Incident Report unless directed by the Security Supervisor, Shift Lead, or designee. If the Security Officer is assisting another officer, he will still include all details in his own DSR as if he were the Primary Officer involved.
2. Crime / Incident Reports
   a. Crime / Incident Reports need to be completed (draft) within the first 24 hours of the incident, with final copy within 48 hours. All fields (boxes) need to be completely filled

out with the proper information unless the information is not applicable in which N/A will be used. All known and investigated information will be included in the narrative section utilizing the questions (who, what, when, where, why and how) with full attention to detail, accuracy, consistency, and format. All appropriate attachments are to be included behind the narrative portion of the report (picture and video attachment sheets, witness statements, driver license and insurance information). All points of contact will be identified with title, name, department, phone numbers and their relation to the incident. A report will be generated for all risk management or liability issues regardless of the level of cooperation from witnesses or complainants. The final decision will be at the discretion of the Security Supervisor, Shift Lead, or designee.

3. Enforcement Reports
   a. Enforcement Reports need to be written with attention to filling out all the details (patient name, time 5150 was written or discontinued, whether restraints were used and at what time, all parties involved (Police Officer, Doctor, Nurse, Behavioral Health Liaison), and a synopsis written for each major Security intervention or event. (Not to include any medical procedure or non-security related event). Each detail will have a new entry added to the narrative.
4. Missing Patient Checklist
   a. A missing patient checklist will be utilized any time a patient is known to be missing from the unit. The checklist locations will be divided up by the available officers, and every area of the hospital will be searched as per the form. The original form with the areas checked by each officer will be placed in the "Submitted Reports" box, and a copy will be placed on the back of the Officer's DSR.
5. Equipment and Detail Logs
   a. The Security Department Equipment and Detail Logs need to be updated and completed by the end of the officer's shift. These logs include: Cart Maintenance Log, Crime / Incident Report Log, Fire Safety Check, Flashlight Log, Floor Check Log, Main Lobby Post Log, Risk Management Log, Safety Infractions and Work Order Log. Accurate times and complete details are to be denoted in the logbooks.

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SECURITY
SECURITY OPERATIONS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: January 15, 2003~~ ~~Reviewed: 5/03, 11/03, 11/06, 3/09, 6/11~~ ~~Revision: 7/03, 11/03~~ ~~Approvals: Director of Security~~	~~Subject: Security Panic Alarm System Response~~ ~~Page 1 of 1~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM - # 221~~

SUBJECT: Security Panic Alarm System Response

ISSUE DATE: January 15, 2003
REVIEWED DATE(S): 5/03, 11/03, 11/06, 3/09, 6/11
REVISION DATE(S): 7/03, 11/03

POLICY NUMBER: 221

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**

1. In an ongoing effort to provide a safe working environment to ensure the best possible patient care for the patients of the Medical Center the Security Department continually evaluates all areas of the Medical Center to determine if an area is deemed a high-risk area.

B. **POLICY:**

1. The Security Department has established a Panic Alarm system with activation switches in areas of the Medical Center that are determined to be a high-risk area.

C. **PROCEDURE:**

1. Each Security Officer is responsible for knowing the location of each Panic Alarm location within the Medical Center and at all off site locations.
2. Attached is a list of all Panic Alarm location within the Medical Center and all off site locations ~~of the Medical Center~~ with Panic Alarm activation switches.
3. When a Panic Alarm is activated an alarm will sound in the PBX/Operator Office indicating which location has activated the alarm. The PBX Operator will call the On-Duty Security Department personnel and inform them of silent alarm activation at location _____.
4. All On-Duty Security Department personnel will respond to the location of the activated alarm, assess the situation, and take the necessary action in accordance with Medical Center and Security Department policies.

D. **FORMS:**

~~4.~~1. **Security and Panic Alarm Locations**

~~Attachment 1~~

Silent / Panic Alarm System ~~Locations~~ as of August 2015

On Campus (4002 and 4010 addresses) Number of Alarms per Location =

Administration: 3 alarms
Behavioral Health Unit Building: 2 alarms
Business Management Services Building: 6 alarms
Cafeteria: 3 alarms
Emergency Department [E.D.]: 13 alarms
Fast Track [next to the E.D. area]: 2 alarms
Human Resources: 2 alarm
Labor and Delivery: 1 alarm
Magnetic Resonance Imaging Building: 3 alarms
Main Admitting or Registration: 8 alarms
Main Lobby's Volunteer Information Desk and Gift Shop: 3 alarms
Maternity Lobby: 1 alarm
Medical Records Department: 1 alarm
Medical Staffing Office: 2 alarms
Neonatal Intensive Care Unit or N.I.C.U. [3 West / Telemetry Tower location]: 1 alarm
N.I.C.U. Overflow: 3 alarms
Nurse Staffing Office: 1 alarm
Patient Financial Services or Cashier: 3 alarms
Patient Representative Office: 2 alarms
Pharmacy: 2 alarms [1 operational]
Postpartum: 1 alarm
Postpartum Overflow: 1 alarm

Off Campus (2095 address) Alarms =

Suite 111 Bldg. 2095 Outpatient Imaging: 1 alarm
Suite 214 Bldg. 2095 Marketing: 1 alarm
Suite 217 Bldg. 2095 Clinical Research / Statistics: 1 alarm

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SECURITY
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~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: April 20, 1994~~ ~~Reviewed: 10/97, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 10/97, 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Vehicle Jumpstart~~ ~~Page 1 of 1~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM - # 234~~

SUBJECT: Vehicle Jumpstart

ISSUE DATE: April 20, 1994 **POLICY NUMBER:** 234
REVIEWED DATE(S): 10/97, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 10/97, 7/03

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To set guidelines for Security Department personnel to utilize when a request for assistance for a dead battery is made.

B. **POLICY:**
1. It is the policy of the Security Department to follow the procedures of this policy while providing requested services with assistance for a dead battery.

C. **PROCEDURE:**
1. Security Officers will not leave Medical Center owned or operated property to assist with a dead battery.
2. All Jump Starts will be conducted on an "as- available" basis **by mobile patrols** and will not be performed if the Security Department has higher priority calls for service, duties, activities, or assignments pending.
3. Security Officers will not be authorized to attempt to push or tow a vehicle in an attempt to start the vehicle.
4. Security will only make a reasonable attempt to Jump Start a vehicle.
5. Security Officers will only be authorized to utilize the provided Jump Start Battery Pack; no other Jump Start methods will be utilized.

Tri-City Medical Center
Oceanside, California

SECURITY
PERSONNEL

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: June 15, 1992~~ ~~Reviewed: 6/94, 10/97, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Departmental Personnel Issues~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM - # 307~~

SUBJECT: Departmental Personnel Issues

ISSUE DATE: June 15, 1992 **POLICY NUMBER:** 307
REVIEWED DATE(S): 6/94, 10/97, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 7/03

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To provide a set of guidelines for all Security Department personnel, to assist with the proper procedure for document an issue involving another member of the Security Department.

B. **POLICY:**
1. When an interdepartmental incident occurs involving Security Department personnel, or when an Officer feels that an interdepartmental issue should be brought to the attention of the Security ~~Supervisor~~**Manager**, the following process will be utilized. Reference Administrative Policy #428 Fair Treatment for Non-Management Employees

C. **PROCEDURE:**
1. The reporting Officer will immediately complete an Incident Report or complete a Memo to the Security ~~Supervisor~~ **Manager** including but not limited to the following information:
   a. The Date, Time and Day of Week the incident took place.
   b. The names and post assignments of all involved Officers.
   c. A detailed description of all related information, this information may have been observed by the reporting Officer or information reported to the Officer by another source outside the Security Department.
   d. A complete statement by any available witnesses.
2. The completed Incident Report or Memo will be immediately forwarded to the Security ~~Supervisor~~ **Manager** or Designee, or if after hours, placed into an interdepartmental envelope and sealed. The envelope will then be placed in the Security ~~Supervisor's~~ **Manger's** In-Box.
3. The Security ~~Supervisor~~ **Manager** or Designee will then investigate the issue if deemed necessary and take the necessary action if any.

D. **~~ATTACHMENT~~ RELATED DOCUMENTS:**

1. Administrative Policy #428: **Fair Treatment of Non-Management**

Tri-City Medical Center
Oceanside, California

SECURITY PERSONNEL

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: April 2, 1991~~ ~~Reviewed: 6/94, 12/96, 3/02, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 3/02, 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Hair and Grooming Standards for Security Officers~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 302~~

SUBJECT: Hair and Grooming Standards for Security Officers

ISSUE DATE: April 2, 1991 **POLICY NUMBER:** 302
REVIEWED DATE(S): 6/94, 12/96, 3/02, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 3/02, 7/03

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. The Medical Center has a right to expect Security Department Officers to present a neat, clean, and well-groomed appearance, whether in uniform or civilian attire. Both hairstyle and civilian dress style are recognized as an individual matter, however when an Officer interacts on or off duty they will follow the below criteria.

B. **POLICY:**
1. All Security Officers, whether on or off duty will conform to the hair and grooming guidelines while they are on the Medical Center Campus.

C. **PROCEDURE:**
1. Regardless of style, the Officer's hair shall not in any way interfere with proper and efficient performance of their duties.
2. Male Grooming Standards.
   a. Front and side hair length: Hair may be worn at any length on the front and sides as long as it can't be extended into eyes and interfere with the Officer's vision.
   b. Back: Hair may be worn at any length and style as long as it doesn't extend below the top of the shirt collar.
   c. Hair shall be kept neat, clean, and well groomed at all times.
   d. Sideburns shall be trimmed so that they don't extend below the mid-ear. The bottom portion of the sideburn will be trimmed and at no time wider than one inch in width.
   e. Facial hair in the form of a mustache is permitted, but will be kept neat, clean, and well trimmed at all times. The mustache will not exceed lower than one-quarter inch past the smile crease line.
   f. Beards are not permitted at any time.

3. Female Grooming Standards.
   a. Hair shall be kept in a neat, clean and well-groomed manner and will either be cut in length or worn in a style, which doesn't extend below the top of the collar. The length or style also pertains to the hair extending in the Officer's eyes in such a manner as to interfere with their vision.

Tri-City Medical Center
Oceanside, California

SECURITY PERSONNEL

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: September 30, 1994~~ ~~Reviewed: 1/97, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: New Officer Training Check List~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM - # 301~~

SUBJECT: New Officer Training

ISSUE DATE: September 30, 1994 **POLICY NUMBER:** 301
REVIEWED DATE(S): 1/97, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 7/03

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To ensure proper training of newly hired Security Officers while in the new employee orientation and training phase of employment.

B. **POLICY:**
1. It is the policy of the Security Department that all newly hired Security Officers will be thoroughly trained and oriented to all duties, activities, assignments, and locations, which are pertinent to proper job performances.

C. **PROCEDURE:**
1. On the first day of employment, every newly hired Security Officer will receive a "Training Check List".
2. The Security Supervisor will assign a Field Training Officer to assist in the training of the new Officer.
3. The Field Training Officer will explain each listed item in the Training Check List. The Field Training Officer will then demonstrate the proper procedure to be followed for each task. The Field Training Officer will then observe the new Officer perform the duties of each task.
4. Once the Field Training Officer is satisfied that the new Officer can successfully perform each task, they will sign and date the Training Check List item.
5. It is expected that each new Officer will complete this phase of training within thirty days of the first day of employment.
6. The completed Training Check List will be submitted to the Security Supervisor for review and placed in the employee's Security Department Personnel File.

D. **~~ATTACHMENTS~~FORMS:**
1. ~~Training Check Lists~~**New Officer Training Check 30 Day**
~~1.~~**2. Department Orientation Checklist (Administrative 400s Form)**

Tri-City Medical Center
SECURITY DEPARTMENT

~~Officer Evaluation~~**New Officer Training Check – 30 Day**

Officer: _____ **Employee Number:** _____

Task:	Pass / Fail				Evaluator:	Officer:	Date:
How to Arrange Additional Security Coverage		Pass		Fail			
Duress Alarm Response (Panic Alarms)		Pass		Fail			
Duress Alarm Locations (Panic Alarms)		Pass		Fail			
Animal In Medical Center		Pass		Fail			
Announced Fire Alarm Response		Pass		Fail			
Appearance and Uniforms		Pass		Fail			
Powers of Arrest		Pass		Fail			
Service of an Arrest Warrant		Pass		Fail			
Attendance and Punctuality		Pass		Fail			
CCTV Locations		Pass		Fail			
Civil Disturbance		Pass		Fail			
Communications		Pass		Fail			
Crime Scene Protection		Pass		Fail			
Critical Incident Response Plan		Pass		Fail			
Detention By Security		Pass		Fail			
Disaster Preparedness		Pass		Fail			
Discovered Fire Response		Pass		Fail			
5150 Control		Pass		Fail			
Door Unlock Request		Pass		Fail			
Security Officer Job Description		Pass		Fail			
Employee Contacts		Pass		Fail			
Equipment/Gauge Checks		Pass		Fail			
Nursing/Security Relationship		Pass		Fail			
Facility Doors		Pass		Fail			
Security Sensitive Areas		Pass		Fail			
Forensic/Prisoner Training For Custody Officer		Pass		Fail			
Lost and Found Property		Pass		Fail			
Aero Medical Detail (Mercy Air)		Pass		Fail			
Hostage Situation		Pass		Fail			
Injured Person Contact		Pass		Fail			
Meal and Rest Periods		Pass		Fail			
Missing Property		Pass		Fail			
Morgue Detail/Duties		Pass		Fail			
Emergency Department Duties		Pass		Fail			
On-The-Job Injury or Illness		Pass		Fail			
Patrol/Inspection		Pass		Fail			
Parking Control		Pass		Fail			

Behavioral Health Department STAT Response		Pass		Fail			
Traffic Control		Pass		Fail			
Patient Contacts		Pass		Fail			

Tri-City Medical Center
SECURITY DEPARTMENT

Officer Evaluation

Officer: _____ **Employee Number:** _____

Task:	Pass / Fail				Evaluator:	Officer:	Date:
Persons Needing Non-Emergency Police Assistance		Pass		Fail			
Restraint Training		Pass		Fail			
Security At Shift Change		Pass		Fail			
Police Contacts		Pass		Fail			
Property Removal		Pass		Fail			
Request for Sensitive or Confidential Information		Pass		Fail			
Search by Security after an Arrest		Pass		Fail			
Security Alarm Locations		Pass		Fail			
Security Key Ring		Pass		Fail			
Security Mission Statement		Pass		Fail			
Security Lead Job Description		Pass		Fail			
Security Surveillance		Pass		Fail			
Security Report Forms		Pass		Fail			
Security Staffing Plan		Pass		Fail			
Lock/Unlock Schedules		Pass		Fail			
Seizure of Property By Security		Pass		Fail			
Serious Incident Notification		Pass		Fail			
Sexual Harassment		Pass		Fail			
Solicitation & Distribution of Literature		Pass		Fail			
Timed Duties		Pass		Fail			
Tobacco Use		Pass		Fail			
Use of Appropriate Force		Pass		Fail			
Valuables Escort		Pass		Fail			
Vehicle Accident on TCMC Property		Pass		Fail			
Vehicle Battery Jump (Battery Pack to Vehicle)		Pass		Fail			
Vehicle Battery Jump (Car to Car)		Pass		Fail			
Vehicle Door Unlock		Pass		Fail			
Vehicle Lights On		Pass		Fail			
Vehicle Re-Park		Pass		Fail			
Vehicle Tire Change		Pass		Fail			
Vehicle Use		Pass		Fail			
Very Important Patient (VIP)		Pass		Fail			
Visitor Contacts		Pass		Fail			
Weapons On Campus		Pass		Fail			

Officer: _____ Date: _____

Evaluator: _____ Date: _____

Supervisor: _____ Date: _____

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Department Orientation Checklist

EMPLOYEE NAME _____ **EID** _____

Hiring Managers:

Please complete this checklist with all new employees and transfers into your department within the first week of employment. **This completed form should be kept in the employee's departmental file and a copy sent to the**

Employee Name:	_____	Position/Dept:	_____
Manager Name:	_____	Date:	_____

Staffing Department for scanning into personnel file Additional department-specific information or checklists may be also completed

Thank you for your help to ensure that all new employees are orientated effectively and completely!

EMPLOYEE INITIALS	DATE	INFORMATION TO BE DISCUSSED WITH NEW EMPLOYEE:
		Job Description, Performance Standards, Performance Objectives & Merit Awards
		Hospital and Departmental Organization Chart and Leadership Structure
		Introduction to coworkers and key internal and/or external customers
		Location of nearest fire alarm pull and fire extinguisher to assigned work area
		Role of employee in disaster plan, fire, or other emergency and code situation
		Time Card completion, procedures, and overtime authorization/scheduling/pay checks
		Departmental policies discussed and copies provided to employee (or how to access)
		Department Forms
		Telephone and Pager systems, policies and training
		Departmental and/or hospital dress code
		Training on departmental equipment and machines, and procedure for reporting problems
		Resource manuals/hazardous materials in department and location of MSDS's
		Holidays – Departmental procedures and observances
		Process for requesting time off and reporting absences
		Procedures for breaks and meal periods
		Location of break rooms, cafeteria, restrooms and other facilities
		Annual physical requirement / Employee Health Services Department
		Department & hospital required training, mandatory requirements, and expectations on completion of NetLearning
		Hours and schedule
		Hospital policies and how to access on the TCMC intranet
		Departmental communication methods, tools, and processes
		Regular scheduled meetings employee must or should attend
		Staff meetings
		Security services offered to employee
		Employee parking

My signature indicates that the information listed above has been discussed with me, and that I understand this information.

Signature of Employee: _____ **Date:** _____

Signature of Manager: _____ **Date:** _____

***Submit to Staffing Department within one (1) month of hire date.**

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ATTACHMENT 3

Tri-City Medical Center
SECURITY DEPARTMENT

Officer Evaluation

Officer: _____ Employee Number: _____

Task:	Evaluator:	Officer:	Date:
Vision, Goals and Officer Conduct			
Security Department Vision, Goals, and Team Building			
7 Standards of Service Excellence			
TCHD Code of Conduct			
Security Officer Expectations			
Lead Security Officer Expectations			
AP&P #436: Photo Identification and Enforcement			
SDP&P #202: Security Post and Positions			
AP&P #415: Dress and Appearance			
SDP&P #302: Hair and Grooming Standards			
Hospital and Personal Liability			
Detailed Documentation / Using a Witness (Security Officer)			
AP&P #317: Patient Valuables Liability and Control			
SDP&P #230: Lost and Found Procedures			
SDP&P #216: Psychiatric Patient Escorts			
PCS #II.I: Service Animals in Medical Center			
SDP&P #211: Protocol When Interacting With Medical Center			
SDP&P #224: Morgue Releases			
SDP&P #234: Vehicle Jump Starts and Assistance			
SDP&P #209: Use of Force Policy			
SDP&P #210: Arrest and Detention Policy			
When To Notify Oceanside Police Department (Arrest)			
Patient Search For Weapons (After Arrest/Detention)			
If Contraband (Drugs etc.) is Found, Leave On Person, Tell OPD			
Legal Arrest vs Probable Cause and Legal Search			
Search Types and when used: Standing, Kneeling, Prone			
Restraint types: Hard, Soft, Vests, Handcuffs			
Video: Legal Liability			
Report Writing (Expectations of Report Quality)			
Importance of an Immediate and Detailed Field Investigation			
What Information is needed to be in a Detailed Field Investigation			
Quality Reports include: Facts, Detail, Accuracy, Consistency			
Reports to be written in Passed Tense only			
Write Person's Title, First Name, Last Name, then only last			
Write report so average person can read (no acronyms, spell out			

Emergency Preparedness Policy and Procedures			
Safety Policy #3005: Code Red (General Staff Response), Evacuation types Lateral, Horizontal, and Complete. Smoke Rises First.			
SDP&P #504: Security Code Red Response and Post Positions			
RACE= Rescue, Alarm / Activate, Contain, Extinguish / Evacuate			
PASS= Pull, Aim, Squeeze, Sweep (To extinguish a Fire)			
Fire Doors: Locations, Purpose, and Not Propped Open or Blocked			

Tri-City Medical Center
SECURITY DEPARTMENT

Officer Orientation

Officer: _____ Employee Number: _____

Task:	Evaluator:	Officer:	Date:
Emergency Preparedness Policy and Procedures (Cont)			
AP&P #234: Security Department Incident Notification			
SDP&P #803: Emergency Situation Officer Recall: All Officers are required to maintain phone or message system and call back in 2 hours			
SDP&P #801: Security Department Disaster Plan (Alert and Activation Phase)			
AP&P #221: DR Strong (BHU / ER Staff will have 1 person as Team Leader for their units, all other units, Security is in command). When Security goes "Hands On", will not let go until			
SDP&P #505: Code Gray (Contain, Control, Communicate)			
SDP&P #503: Code Adam Security Response (monitor all exits, check bags and suspicious people, Call OPD)			
AP&P #369: Code Adam Staff Response (All people with bags and bundles will be detained and Security called STAT)			
MCH Policy Infant Security: Staff ID's worn at **ALL** Times, Doors not Propped Open, Numerical Code changed every 90 days, Infants escorted only in open crib or isolette by MCH staff only.			
Abductor's Behavior: Asks questions about Security, Baby Schedules, Emergency Exits, Visitations, Baby locations, Large Packages/coats.			
Emergency Preparedness #4013: Bomb Threat (PBX calls 7575 and Location, turn radios and cell phones off in immediate area (300ft), report to Incident Commander any suspicious packages,			
SDP&P #502: Security Sensitive Areas (Hot Spots)			
SDP&P #107: Responsibility and Accountability of Authority			
SDP&P #509: High Risk Security Patients and Visitors			
SDP&P #219: Security Precautions for Custody Patients			
Safety Policies and Procedures #2000: Security Management Plan			

~~Officer:~~ _____ ~~Date:~~ _____

~~Evaluator:~~ _____ ~~Date:~~ _____

~~Supervisor:~~ _____ ~~Date:~~ _____

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Tri-City Medical Center
Security Department

~~Training Check List~~

~~Task~~	~~Trainers Initials:~~	~~Officers Initials:~~	~~Date Completed:~~
~~***Supervisor Training:***~~			
~~The role of a Healthcare Security Officer~~			
~~Security Department Organizational Structure~~			
~~Customer Relations and Service~~			
~~Patrol Techniques and Procedures~~			
~~Critical Incident Response~~			
~~Fire Prevention and Control~~			
~~Use of Basic Equipment~~			
~~Basic Safety~~			
~~Preliminary Investigation Procedures~~			
~~Forensic "In-Custody Prisoner" Training~~			
~~***Field Training Officer Training:***~~			
~~Orientation Manual / Policy and Procedure Manual~~			
~~New Employee Orientation~~			
~~Administrative Policy Manual~~			
~~Patient Care Policy Manual~~			
~~Patient Care Procedure Manual~~			
~~Patient Care Guidelines Manual~~			
~~Safety and Disaster Manual~~			
~~Infection Control Manual~~			
~~Security Management Plan~~			
~~Security Management Manual~~			
~~Time Card Procedure~~			
~~Two-Way Radio Procedure~~			
~~Shift Change Briefing~~			
~~Department Forms~~			
~~Emergency Codes~~			
~~Crime/Incident/Enforcement Report Process~~			
~~Property Custody Record~~			
~~Pager System~~			

~~PTO Request Process~~
~~Panic Alarm System~~
~~Security Alarm System~~
~~Key Control and Key Rings~~
~~Building Locations~~
~~Emergency Department Officer~~
~~Mental Health Department Response~~
~~Off Site Locations~~
~~Business and Management Services Building~~
~~Card Access System (open/close procedures)~~

~~Classroom Annex~~
~~Central Plant~~

~~Pavilion~~
~~North Wing~~
~~Center Tower~~
~~South Tower~~

~~Ancillary Building~~
~~Emergency Department~~
~~Mental Health Unit~~
~~Dialysis Building~~
~~Surgery~~
~~Woman's Center~~
~~Warehouse Locations~~
~~Special Projects Building~~

~~Information Systems~~
~~MRI Building~~

~~Electrical Services Building~~
~~Security Office~~
~~Lock and Unlock Procedures~~
~~CCTV System~~
~~Security Vehicles~~
~~Jump-Start Procedures~~
~~Foot Patrol Procedures~~
~~Mobile Patrol Procedures~~

~~Morgue Details~~
~~Dr. Strong Response Procedures~~

~~STAT Response Procedure~~
~~Restraint Procedures~~
~~5150 / ETOH / OD / Medical Hold Procedures~~
~~Missing Patient Procedures~~
~~Life Medical Detail (Mercy Air)~~

~~Restricted Parking Areas~~
~~Infant Security~~

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Tri-City Medical Center
Oceanside, California

SECURITY PERSONNEL

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: June 11, 1991~~ ~~Reviewed: 4/94, 10/97, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Outside Employment~~ ~~Page 1 of 1~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 306~~

SUBJECT: Outside Employment

ISSUE DATE: June 11, 1991 **POLICY NUMBER:** 306
REVIEWED DATE(S): 4/94, 10/97, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 7/03

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

~~A. **PURPOSE:**~~
~~1. To establish the responsibility of all Security Department personnel regarding outside employment.~~

~~B. **POLICY:**~~
~~1. Security Department employees shall not engage in outside supplemental employment, which may conflict with their Security Department employment, Schedule, or the mission of the Security Department.~~

~~C. **PROCEDURE:**~~
~~1. Security Department employees shall not engage in outside employment that would conflict with their Security Department schedule or the needs of the Security Department.~~
~~2. All Per Diem Security Department employees will furnish a written schedule of availability to the Security Supervisor, Designee, Shift Lead Officer, or Scheduling Officer prior to the start of the new schedule. Shifts will be assigned based on the current needs of the Security Department.~~
~~3.~~**1.** ~~Any changes in availability of Per Diem employees will be immediately submitted in writing to the Security Supervisor, Designee, Shift Lead Officer, or Scheduling Officer. These changes will be immediately forwarded to the Scheduling Officer to implement any changes necessary to the Security Department Schedule.~~

Tri-City Medical Center
Oceanside, California

SECURITY
PERSONNEL

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: June 01, 1994~~ ~~Reviewed: 1/97, 7/03, 11/06, 3/09, 6/11~~ ~~Revision: 7/03, 2/11~~ ~~Approvals: Director of Security~~	~~Subject: Payroll Timecard~~ ~~Page 1 of 1~~
~~Submitted By: Security Supervisor~~	~~Procedure Manual: Security Department SDPPM - # 305~~

SUBJECT: Payroll Timecard

ISSUE DATE: June 01, 1994 **POLICY NUMBER:** 305
REVIEWED DATE(S): 1/97, 7/03, 11/06, 3/09, 6/11
REVISION DATE(S): 7/03, 2/11

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To set forth guidelines for all Security Department personnel to utilize for timecard processing.

B. **POLICY:**
1. Pursuant to District guidelines, Security Department personnel will utilize the proper format (KRONOS) when processing their payroll timecard.

C. **PROCEDURE:**
1. ~~When processing a District payroll timecard (KRONOS), all Security Department personnel will utilize the following authorized Program "Genie".~~ All Officers are to punch in accurately and no more than 6 minutes before the beginning or end of their shift. If an Officer punches in 1 or more minutes after the start of the shift, the Officer will be in violation of Administrative Policy 8610-408 Part B #3: Absences and Tardiness, and subject to Administrative Policy 424 Coaching and Counseling #2.3.1.2: Performing duties in an unsatisfactory or unacceptable manner.
   a. All KRONOS timecards are to be "Approved" and printed by the last day of the pay period, with an explanation of any punches outside the scheduled shift written on the timecard. If an Officer fails to complete the timecard with corrections by the end of the pay period, the officer will be in violation of this policy, and subject to Administrative Policy 424 Coaching and Counseling #2.3.1.2: Performing duties in an unsatisfactory or unacceptable manner.

D. **RELATED DOCUMENTS:**
1. **Administrative Policy: 408 Absences and Tardiness**
~~1.~~**2. Administrative Policy: 424 Coaching and Counseling**

Tri-City Medical Center
Oceanside, California

SECURITY
PERSONNEL

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: April 18, 1991~~ ~~Reviewed: 4/94, 10/97, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 7/03, 7/09~~ ~~Approvals: Director of Security~~	~~Subject: Scheduled Time Off~~ ~~Page 1 of 1~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 303~~

SUBJECT: Scheduled Time Off

ISSUE DATE: April 18, 1991 **POLICY NUMBER:** 303
REVIEWED DATE(S): 4/94, 10/97, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 7/03, 7/09

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To provide a uniform procedure for the request of Scheduled Time Off (Vacation, Holiday, Excused Time Off, Etc.) by Security Department personnel

B. **POLICY:**
1. All Security Officers shall follow the below listed procedure for requesting of excused time off.

C. **PROCEDURE:**
1. Due to the necessity of providing coverage for patient care twenty-four hours a day, seven days a week, it is necessary to set guidelines for submission of scheduled time off requests. These are guidelines only and special circumstances will be handled on an individual basis as they arise.
2. Employees wishing scheduled time off must complete the proper request form no less than two weeks (14 days) prior to the requested start date.
3. Employees wishing to trade shifts must complete the proper request form and notify the Security ~~Director~~ **Manager** no less than two weeks (14 days) prior to the requested start date, and will be subject to the ~~Director's~~ **Manager's** approval. If the shift trade is due to an emergency, documentation of the emergency will be required for verification purposes.
4. Urgent and Emergency situations will be handled on an individual basis.

Tri-City Medical Center
Oceanside, California

SECURITY
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~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: April 18, 1991~~ ~~Reviewed: 6/94, 10/97, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Unplanned Time Off (Unscheduled Absence/Tardy)~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 304~~

SUBJECT: Unplanned Time Off (Unscheduled Absence/Tardy)

ISSUE DATE: April 18, 1991 **POLICY NUMBER:** 304
REVIEWED DATE(S): 6/94, 10/97, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 7/03

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To provide a uniform procedure for unplanned time off (sick leave, absence, tardy) by Security Department personnel.

B. **POLICY:**
1. All Security Department personnel shall follow and be aware of the following procedure for an unplanned time off. Reference Administrative Policy #408 Absences and Tardiness

C. **PROCEDURE:**
1. Sick Leave
   a. While it is impossible to predict illness, the fact that an employee is taking sick leave and will not be able to report to work should be conveyed by telephone to the Security Supervisor or Shift Lead Officer on-duty at least Three (3) hours prior to the beginning of the shift or the absence will be treated as an unexcused absence. An Unscheduled Absence for will be completed by the Security Supervisor or Shift Lead Officer upon receipt of the call for absence or tardy by any Officer.
   b. If an employee's illness extends beyond one day, the employee must continue to ensure that notification is made of this fact on a daily basis. An unscheduled absence/tardy form will be completed by the employee receiving the call and forwarded to the Security Supervisor or Designee.
   c. Any absence of three days or more due to illness will require an Employee Health or Doctor's release before an Officer may return to work. This requirement may also be applied to less that three days if the Employee Health Nurse believes it is necessary

for any reason or it is determined the employee has had a documented unsatisfactory absence record.

2. Absences and Tardiness:
   a. As per Administrative Policy, employees are expected to be on-duty the hours and days assigned. Employees should report promptly at their assigned starting time in order to be ready for duty at the beginning of their shift.
   b. While it is impossible to predict most situations that may cause tardiness, as much advanced notification as possible needs to be conveyed, by telephone to the Security Supervisor or Shift Lead Officer and inform them of an estimated time of arrival. The Security Supervisor or Shift Lead Officer will then complete the Unscheduled Absence / Tardy form.
   c. An employee is considered tardy when the employee reports to their work area after their regular scheduled starting time. Working late to make up for tardiness will not be authorized without prior approval of the Security Supervisor or Designee.
   d. Absenteeism or Tardiness in excess of Tri-City Medical Center Administrative Policy or Security Department Policy may result in disciplinary action up to and including termination.

D. **~~ATTACHMENT~~RELATED DOCUMENTS:**
1. Administrative Policy #408**: Absences and Tardiness**

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY EQUIPMENT

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: November 18, 1993~~ ~~Reviewed: 12/95, 10/97, 6/00, 2/01, 5/03, 6/09, 6/11~~ ~~Revision: 2/01, 7/03, 6/09~~ ~~Approvals: Director of Security~~	~~Subject: Authorized Security Department Uniforms and Safety Equipment~~ ~~Page 1 of 3~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 401~~

SUBJECT: Authorized Security Department Uniforms and Safety Equipment

ISSUE DATE: November 18, 1993 **POLICY NUMBER:** 401
REVIEWED DATE(S): 12/95, 10/97, 6/00, 2/01, 5/03, 6/09, 6/11
REVISION DATE(S): 2/01, 7/03, 6/09

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date (s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To establish guidelines for the wearing and issuing of approved Security Department Uniforms and Safety Equipment by all Security Personnel.

B. **POLICY:**
1. All on duty Medical Center Security Department Personnel will wear only approved uniforms and safety equipment items while acting in the capacity of Security Officer. In addition all uniform items are to be issued in accordance with this policy.

C. **APPROVED UNIFORM APPAREL:**
1. Required Uniform Items (Department Issue)
   a. Uniforms will be clean and pressed with visible vertical creases on the pant legs and on the shirt sleeves.
   b. Boots will be clean and polished and all equipment will be maintained.
   c. A supervisor will routinely check uniforms and equipment to verify compliance.
   d. Flying Cross Uniform Trousers.
   e. Flying Cross Short Sleeve Shirt.
   f. Flying Cross Long Sleeve Shirt.
      i. Long sleeve shirts are to be worn with a solid Blue Break-away tie and plain silver tie bar.
   g. Quartermaster brand "Law Pro" Law Enforcement Jacket.
   h. All-American Military Style pull over v-neck type sweater.
   i. Department patches are to be worn on both sleeves of any approved shirt, sweater, jacket, and in the center of management approved ball cap.
   j. Department issued Security badge will be displayed in plain sight in an appropriate manner.

k. Medical Center Photographic Identification Badge will be worn in plain sight with the photograph showing.

2. Required Uniform Items (Officers expense).
   a. Duty Belt will be made of Nylon with plastic buckle and black in color.
   ~~b. At least one handcuff case and set of handcuffs. Case to match the duty belt.~~
   ~~c.~~**b.** Four Belt keepers matching duty belt.
   ~~d. One OC Pepper case matching duty belt.~~
   ~~e.~~**c.** One Key Ring matching duty belt.
   ~~f.~~**d.** Footwear will consist of any of the following and will be maintained in a clean and neat condition.
   ~~g.~~**e.** Military style boots, with plain toe, and full leather upper, black in color, and having plain type sole.
   ~~h.~~**f.** High Tech brand (or equivalent) style uniform boot, black in color with standard sole.
      i. All low cut style footwear will be worn with plain black or dark blue colored socks. High top boots may be worn with white, black, or blue socks (Sock color will not be visible while wearing boots).
      ii. 3.2.6.2 Prior approval from the Security Supervisor must be obtained for the wearing of any other style of footwear.

3. Optional Uniform Items (Officers expense)
   a. Approved plain Navy Blue or Black ball cap style Security Hat with approved Security patch centered on the front.
   b. Crew style tee shirt. Color will be Black, White, or Blue only.
   c. The wearing of appropriate insignias. Insignias must be approved by the Security Supervisor prior to being worn and can only be worn in a manner displaying proper respect and protocol.

4. Required Safety Equipment (Department Issue)
   a. ~~One canister of 10% OC Pepper Foam~~
   b. One, Nylon pouch to carry personal protective equipment.
      i. Nylon pouch to carry the following items. A) Blue non-latex medical exam gloves (or equivalent). B) Safety glasses. C) Spit sock.
   c. Department furnished Two Way Motorola Radio.
      i. Officer will be issued his own personal radio for use while on duty. **T**he Officer will be solely responsible for maintaining his issued radio and keeping it in good operating condition. Any damage to the Officer's radio must be immediately reported to his supervisor. Damage due to neglect will be the responsibility of the assigned Officer.

5. Optional Safety Equipment (Officer expense)
   a. Mini style flashlight with case matching duty belt.
   b. EM**T** style equipment holder, matching duty belt.
   c. Plain black colored gloves. Gloves will only be worn with uniform during night shifts or inclement weather.

6. While on duty Security Officers will only wear the appropriate uniform items as described.

7. While on duty Security Department Personnel will only be allowed to wear the following personal affects. Appropriate wristwatch. Ring(s), to be limited to wedding band or one ring per hand. **T**he wearing of any necklaces will be done in such a manner to be kept from plain sight. Earrings to be limited to stud type and one per ear (Females Only).

D. **ISSUANCE OF UNIFORMS:**

1. Full Time New-Hire
   a. Number of issued uniforms to be received by Full Time New-Hire Security Department Officers will be determined by the Security ~~Director~~ **Manager** -based on Department needs.

2. Per Diem New-Hire

a. Number of issued uniforms to be received by Per Diem New-Hire Security Department Officers will be determined by the ~~Security Director~~ **Manager** based on Department needs.

3. Annual Full Time Replacement
   a. Number of annual issued uniforms to be received by Full Time Security Department Officers will be determined by the Security ~~Director~~ **Manager** based on Department needs.
4. Annual Per Diem Replacements
   a. Number of annual issued uniforms to be received by Per Diem Security Department Officers will be determined by the Security ~~Director~~ **Manager** based on Department needs.

E. **REPLACEMENT OF DAMAGED UNIFORMS:**

1. Any replacement of required Security Department uniform items that have sustained work-related damage will be subject to approval and will be replaced in accordance with the Uniform Procedure to be determined by the Security ~~Director~~ **Manager**.

F. **NON-COMPLIANCE:**

1. Non-Compliance with any portion of this policy may result in disciplinary action leading to, and or including termination.

DELETE from Security Department Manual per J. Piearson.

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY EQUIPMENT

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: April 16, 1991~~ ~~Reviewed: 4/94, 1/97, 6/00, 7/01, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 7/03, 6/11~~ ~~Approvals: Director of Security~~	~~Subject: Chemical Agent~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 402~~

SUBJECT: Chemical Agent

ISSUE DATE: April 16, 1991 **POLICY NUMBER:** 402
REVIEWED DATE(S): 4/94, 1/97, 6/00, 7/01, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 7/03, 6/11

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

~~A. **PURPOSE:**~~
~~1. To establish guidelines for the use of a Chemical Agent by a Security Officer.~~

~~B. **POLICY:**~~
~~1. The use of a Chemical Agent by a Tri-City Medical Center Security Officer will only be utilized after it has been determined by the responding Officer that a real and imminent danger is present and that this is the appropriate response level in the use of force continuum to ensure the safety, security, and welfare of all patients, visitors, and staff members.~~

~~C. **PROCEDURE:**~~
~~1. Only Security Department personnel, who have received the appropriate training and instruction in the use of a chemical agent, will be authorized to possess and utilize a chemical agent during the course of their assigned duties and responsibilities.~~
~~2. In the event that it is determined that the use of a chemical agent is necessary to deescalate a violent incident from occurring; the following process will be utilized only as a last resort and only if the subject can not be deescalated any other way.~~
~~a. The first responding Security Officer on scene will assume the responsibility of Team Leader.~~
~~i. The Lead Officer or Security Supervisor will assume this role when they arrive if they feel it necessary.~~
~~b. The Team Leader will be the only Officer having direct verbal contact with the subject.~~

~~c. The Team Leader will advise all other officers that they intend to use the Chemical Agent by stating "OC" to all officers who will then position themselves to prevent them from being exposed to the Chemical Agent.~~

~~d. After the Chemical Agent has been administered, all Security Officers will assist in subduing the subject and placing the subject into handcuffs if necessary.~~

~~e. If required the subject will receive the appropriate level of first-aid if necessary.~~

~~i. Place the subject into an area with continuous flow of air. Note that water can reactivate the agent on the affected area.~~

~~f. At the conclusion of the incident, the primary Officer or Team Leader will complete a Primary Incident Report detailing the incident; ALL other Officers involved will write a supplemental incident report.~~

~~g. Under no circumstances will the O.C. agent be used in the following areas:~~

~~i. Emergency Room or waiting areas~~
~~ii. Fast Track~~
~~iii. N.I.C.U.~~
~~iv. I.C.U. / C.C.U~~
~~v. Surgery~~
~~vi. Nursery~~
~~vii. Labor and Delivery~~

~~h.~~**a.** ~~Use extreme caution in other areas of the Hospital with O.C. agent use.~~

Tri-City Medical Center
Oceanside, California

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~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: May 05, 2003~~ ~~Reviewed: 11/06, 3/09, 6/11~~ ~~Revision:~~ ~~Approvals: Director of Security~~	~~Subject: Security Department Key Rings and Department Key Control~~ ~~Page 1 of 1~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 406~~

SUBJECT: Security Department Key Rings and Department Key Control

ISSUE DATE: May 05, 2003 **POLICY NUMBER:** 406
REVIEWED DATE(S):
REVISION DATE(S):

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To establish a set of guidelines for Security Department personnel to utilize in the performance of their assigned duties related to Key Control.

B. **POLICY:**
1. It is the Policy of the Security Department to maintain a department set of keys that are not to be removed from the Medical Center campus.

C. **PROCEDURE:**
1. The Security Department Supervisor will be responsible for maintaining a predetermined number of sets of Medical Center key rings for use by Security Department personnel.
   a. One Master Key set will be maintained for the 1-Post Position.
   b. One Master Key set will be maintained for the 2-Post Position.
   c. One Master Key Set will be maintained for the 3-Post Position.
   d. One Master Key Set will be maintained for the 4-Post Position.
   e. At least 2 sets of Cart Keys will be maintained within the Security Department.
   f. One Shred-~~it~~-**PHI Bin** key will be maintained within the Security Department.
   g. One Card Access Key will be maintained within the Security Department for access into the Business and Management Services building.
2. At no time will any Security Department personnel for any reason remove any Security Department maintained sets of keys from the Medical Center without prior approval from the Security Supervisor or Designee.

Tri-City Medical Center
Oceanside, California

SECURITY
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~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: September 06, 1991~~ ~~Reviewed: 6/94, 10/97, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Security Vehicles~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 405~~

SUBJECT: Security Vehicles

ISSUE DATE: September 06, 1991 **POLICY NUMBER:** 405
REVIEWED DATE(S): 6/94, 10/97, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 7/03

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To establish a uniform procedure for the use of the Security Vehicles by Security Department personnel

B. **POLICY:**
1. It is the policy of the Security Department to maintain and supply Security Vehicles for the use by all Security Department personnel in the course of their assigned duties. In order to maintain these vehicles in proper working order, it will be the responsibility of each Security Officer to follow the established procedures.

C. **PROCEDURE:**
1. All Security Officers will be able to demonstrate their proficiency in the proper operation of all Security Vehicles.
2. Prior to the use of any Security Vehicle it will be the responsibility of each Officer to ensure that the Vehicle is in proper working order.
3. Any conditions that may contribute to the failure of the vehicle or any unsafe or unsatisfactory conditions will be reported to the Security ~~Supervisor~~ **Manager** or Designee immediately in order to call the appropriate company for any necessary repairs.
4. Eating will not be permitted in any security vehicle. Drinks may be stored in a vehicle, and any spills will be immediately cleaned up. Each Officer is responsible for keeping all Vehicles in a Safe and Clean working order.
5. All Security Department personnel utilizing any Vehicle will operate the Vehicle in a Safe and Proper manner, observing all Medical Center and Traffic rules and regulations.
6. Security Carts are not permitted off property unless authorized by Shift Lead or Security ~~Supervisor~~**Manager**.

DELETE from Security Department Manual per J. Piearson.

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY EQUIPMENT

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: April 16, 1991~~ ~~Reviewed: 5/94, 1/97, 5/03 , 11/06, 3/09, 6/11~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Use of Handcuffs~~ ~~Page 1 of 1~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 403~~

SUBJECT: Use of Handcuffs

ISSUE DATE: April 16, 1991
REVIEWED DATE(S): 5/94, 1/97, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 7/03

POLICY NUMBER: 403

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date (s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

~~A. **PURPOSE:**~~
~~1. To establish guidelines as to when Security Officers will be authorized to utilize handcuffs.~~

~~B. **POLICY:**~~
~~1. It is the policy of the Security Department to utilize the following procedure as a guideline for the use of Handcuffs.~~

~~C. **PROCEDURE:**~~
~~1. The authorized use of handcuffs by any Officer will be utilized under the following criteria.~~
~~a. When in the Security Officer's determination, handcuffs are necessary to effectively control an individual, who has been placed under arrest.~~
~~b. When directed by a Doctor to physically restrain a combative or violent patient and the utilization of leather restraints are not available.~~
~~c.~~**a.** ~~When it is determined that the use of handcuffs is necessary to physically control a person who has become violent or combative in order to ensure the safety, security, and welfare of all patients, visitors, and staff members.~~

Tri-City Medical Center
Oceanside, California

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SECURITY EQUIPMENT

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: November 12, 2010~~ ~~Reviewed:~~ ~~Revision:~~ ~~Approvals: Director of Security~~	~~Subject: Use Of Recording Device~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 408~~

SUBJECT: Use of Recording Device

ISSUE DATE: November 12, 2010 **POLICY NUMBER:** 408
REVIEWED DATE(S):
REVISION DATE(S):

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To establish guidelines for the use of a Recording Device by a Security Officer.

B. **POLICY:**
1. **T**he use of a Recording Device defined as any device designed to or has the capabilities to capture sound, for example but not limited to audio recorder, cell phone, video recorder, or hand-held computer, by a **T**ri-City Medical Center Security Officer will only be utilized after it has been approved through the ~~Tri-City Medical Center Safety Officer~~ **Director of Safety/EOC, Director of Risk Management, Legal or Chief Compliance Officer** and only if all parties in the area defined as a 30 foot radius from the device or anyone who may not be physically present but would be heard by the Recording Device would have given expressed written consent approving their voice to be recorded by the Security Officer prior to recording.

C. **PROCEDURE:**
1. Only Security Department personnel, who have received the appropriate approval through the Safety Officer, and by Tri-City Healthcare District ~~Legal Affairs an~~d Compliance Officer, with instruction in the laws and use of a Recording Device will be authorized to utilize a Recording Device during the course of their assigned duties.
2. In the event that it is determined that the use of a Recording Device is necessary and approved, the Officer will obtain a written consent from the parties within the defined 30 foot radius or anyone who may not be physically present but would be heard by the Recording Device before the recording can begin. This consent will acknowledge that the parties understand their voice will be recorded for a single session only.

3. If it is determined that the use of a Recording Device is necessary after the initial recording session, the Officer using the Recording Device will obtain a new consent form, even if the parties involved approved a prior session to be recorded and signed a consent form.

Tri-City Medical Center
Oceanside, California

SECURITY
SAFETY

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: March 19, 1997~~ ~~Reviewed: 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: After Action Incident Review and Debriefing~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 511~~

SUBJECT: After Action Incident Review and Debriefing

ISSUE DATE: March 19, 1997 **POLICY NUMBER:** 511
REVIEWED DATE(S): 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 7/03

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To establish an action review process that will assist the Security Department in the formal review of all critical response situations or incidents involving Medical Center Security Officers.

B. **POLICY:**
1. In an on-going effort for continual improvement on the overall efficiency and effectiveness of services provided by the Security Department, an informal process for action review has been developed. This process will assist the Security Department in the identification, tracking, and trending of areas of service that are in need of improvement or modification. **The Security Department will review all incident reports with Administration.**

C. **PROCEDURE:**
1. Critical Situation/Incident – Any response by Security Department personnel, which include but are not limited to the following circumstances:
   a. Involving the Use of Force.
   b. Involving the arrest of an individual upon the Medical Center campus.
   c. Multiple Security Officer response or involvement
   d. Involvement of personnel from multiple Medical Center departments.
   e. Disaster (Drill/Actual)
   f. Any unusual event when it is determined by Security personnel that there is a need for documentation and additional review.

D. **ATTACHMENTS:**

1. Security Department **After Action Incident Review** form.

Tri-City Medical Center
Security Department

After Action Incident Review

The *After Action Incident Review* form is to be completed by Security Department personnel anytime a Security Officer feel that there is a process or incident that needs to be reviewed for the purposes of improvement within the Security Department.

Complete all applicable sections of this form and submit the completed *After Action Incident Review* with the completed Security Department Incident/Crime report. Use an additional continuation sheet if necessary.

1. Problem/Concern Identified including a Description of the Incident:

2. How was the Problem/Concern Identified?

3. Action Taken to resolve the Problem/Concern:

Recommendations:

Submitted By: _____ Date: _____ Received By: _____ Date: _____

Tri-City Medical Center
Oceanside, California

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~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: April 03, 1991~~ ~~Reviewed: 5/94, 12/96, 6/03, 11/06, 3/09, 6/11~~ ~~Revision: 6/03~~ ~~Approvals: Director of Security~~	~~Subject: Conflict Resolution~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 510~~

SUBJECT: Conflict Resolution

ISSUE DATE: April 03, 1991 **POLICY NUMBER:** 510
REVIEWED DATE(S): 5/94, 12/96, 6/03, 11/06, 3/09, 6/11
REVISION DATE(S): 6/03

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To establish guidelines, which Security Officers can utilize in the performance of their duty regarding a conflict resolution

B. **POLICY:**
1. It is the policy of the Security Department to employ a safe, nonviolent management system when confronted with a situation involving the need for a conflict resolution. This system has been designed to offer the Officer and those involved the best possible care, safety, and welfare in a crisis situation. Reference Administrative Policy #463 Work Place Violence

C. **PROCEDURE:**
1. When a Security Officer is confronted with a crisis situation the Officer will always utilize the ~~team~~ **contact / cover** concept before initiating contact.
2. The Contact Officer will approach the individual to within three to four feet and slightly to the side. The Officer will maintain a non-threatening stance with one foot in front of the other.
3. The Officer will attempt to initiate a verbal intervention contact utilizing a calm, understanding approach, and trying to determine the precipitating factors, in an effort to reduce the level of anxiety on the part of the individual. The Officer should avoid any outward display of emotion and should listen and not offer any options or comments during this period.
4. After the individual has explained, the Officer should repeat back the main points and offer any assistance available.
5. If the situation escalates the Officer must advise the individual that a confrontation is not the Officer's objective and attempt to obtain voluntary compliance from the individual.
6. If the individual is not willing to voluntary comply, the Officer will advise the individual of the other actions which may be utilized to neutralize the situation.

7. The Officer will only utilize physical force as a last resort and will only use reasonable force or that force which is necessary to neutralize the situation. Any force utilized should always be the least restrictive method and only as a last resort.
   a. Any force used will be in compliance of Security Department Policy #209 regarding the Use of Force.
8. All Officers will be responsible for their own actions and shall not shift to others the burden or responsibility for their own actions.

D. **~~ATTACHMENT~~ RELATED DOCUMENTS:**
1. Administrative Policy #463:**Workplace Violence**

Tri-City Medical Center
Oceanside, California

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~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: November 1990~~ ~~Reviewed: 4/94, 11/96, 10/01, 06/03, 11/06, 3/09, 6/11~~ ~~Revision: 07/03~~ ~~Approvals: Director of Security~~	~~Subject: Disposal of Drugs and Drug Paraphernalia~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 506~~

SUBJECT: Disposal of Drugs and Drug Paraphernalia

ISSUE DATE: November 1990 **POLICY NUMBER:** 506
REVIEWED DATE(S): 4/94, 11/96, 10/01, 06/03, 11/06, 3/09, 6/11
REVISION DATE(S): 07/03

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To set forth the District's procedure for handling and disposing confiscated and/or discovered drugs and/or drug-use paraphernalia.

B. **DEFINITIONS:**
1. Drugs:
   a. Substances recognized as drugs in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States or the official National Formulary or any supplement to any of them.
   b. Substances intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or animal.
   c. Substances (other than food) intended to affect the structure or any function of the body of man or animal.
2. Drug-Use Paraphernalia:
   a. All equipment, products, and materials of any kind which are designed for use or marked for use in planting, propagating, cultivation, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, injecting, ingesting, inhaling, or otherwise introducing into the human body a controlled substance.

C. **POLICY:**
1. Any District employee who finds or confiscates any drug or drug paraphernalia on District property shall immediately notify the Security Department. Reference Administrative Policy #217 Disposal of Drugs and Drug Paraphernalia.

D. **PROCEDURE:**

1. Upon receiving information of found drugs or drug paraphernalia, the Security Department will immediately dispatch a Security Officer to the location ~~and~~, take possession of such items **and establish a chain of custody**. **T**he Security Officer will then obtain the necessary information needed to complete the appropriate Security Department report.
2. The collecting Security Officer will then immediately notify the Security ~~Director~~ **Supervisor and / or the Lead Security Officer** and/~~or~~ the Oceanside Police Department**.** ~~and~~ **The officer will** request that ~~a patrol officer~~ **O.P.D.** be sent to retrieve the discovered or confiscated drugs ~~or drug~~ / paraphernalia, **or the officer will request disposition instructions from O.P.D**. Upon the arrival of the Oceanside Police Department, the Security Officer will turn over all seized items and inform the Police Officer of all pertinent facts involved with the seizure. The Security Officer will be responsible for obtaining the Police Officer's name, badge number, and the time the items were released.
3. The collecting Security Officer will be responsible for the proper completion of all necessary reports. The Security Officer will further be responsible for noting all facts in his/her Daily Security Report.

E. **~~ATTACHMENT~~ RELATED DOCUMENTS:**

1. Administrative Policy #217:**Disposal of Drugs and Drug Paraphernalia**

Tri-City Medical Center
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~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: June 02, 1995~~ ~~Reviewed: 7/97, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 7/97, 7/03~~ ~~Approvals: Director of Security~~	~~Subject: High Risk Patient or Visitor~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM - # 509~~

SUBJECT: High-Risk Patient or Visitor

ISSUE DATE: June 02, 1995 **POLICY NUMBER:** 509
REVIEWED DATE(S): 7/97, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 7/97, 7/03

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To identify Patients or Visitors which, due to circumstances, may be a high-risk to the Safety, Security, and Welfare of Medical Center Patients, Visitors, and Staff Members.

B. **POLICY:**
1. It is the policy of the Tri-City Medical Center Security Department to **immediately** identify any Patient or Visitor, which may place the Safety, Security, and Welfare of Medical Center Patients, Visitors, or Staff Members in jeopardy and to take the appropriate level of intervention.

C. **PROCEDURE:**
1. When any Tri-City Medical Center Security Officer observes, detects, or is otherwise notified of any Patient or Visitor who has arrived at the Medical Center and who due to ~~cretin~~ **certain** factors would place Patients, Visitors, or Staff Members at a risk for the potential of harm, the Officer will immediately evaluate the situation.
   a. **Examples of high risk behaviors include but are not limited to anger, aggression, verbal or physical threats or inappropriate response to situation**
2. The Security Officer will be responsible for notifying all other Officers of the situation and request the necessary level of assistance to effectively and efficiently control the individual. In addition the Officer will immediately notify the Security Supervisor and/or Shift Lead Officer.
3. The Security Supervisor or Shift Lead Officer will then notify the appropriate Administrator, ~~Director~~ **Manager**, or Administrative Coordinator of the situation and any action taken if necessary.
4. High Risk Patients

a. To ensure the Safety, Security, and Welfare of all Patients, Visitors, and Staff Members, the primary responding Security Officer will ensure that all Clinical Staff responsible for the patients care are informed of all available information pertaining to this patient. Any Security Officer who interacts with a high-risk patient will follow the guidelines of Security Department policies pertaining to conflict resolution.
   i. **T**he Security Supervisor or Lead Security Officer will assume the responsibility of Primary Officer if they feel it necessary to intervene.

b. **T**he primary Security Officer will be responsible for ensuring that the high-risk patient is continually monitored and, if necessary, escorted within the Medical Center.

c. Unless otherwise directed, patient visitation privileges will be restricted to two immediate family members only **as per the direction of a Charge Nurse and / or an Administrator.**

d. In the event that the high-risk patient is involved in an incident that would adversely jeopardize the Safety, Security, and Welfare of the Patients, Visitors, or Staff Members at Tri-City Medical Center, the patients will be registered into the patient tracking system with a no-information/confidential status.

e. In the event that a large crowd, ten or more individuals, associated with the high-risk patient who is in the Emergency Department, and there is a strong possibility of a disruption of normal operating procedures, the Primary Security Officer will immediately implement the following.
   i. Notify the Oceanside Police Department of the situation and need for assistance if necessary.
   ii. Remove the crowd to the outside triage patio area.
   iii. If necessary, close down the Emergency Department registration area and restrict all access into the patient care area.
      ~~1) Redirect all Patients and Visitors to the Urgent Care registration area.~~
      ~~2)~~**1)** Use the North/East Ancillary entrance for access into the Emergency Department **via the Registration Hallway.**~~.~~
   iv. Position the CCTV system to record all crowd and parking locations adjacent to the Emergency Department and other areas if necessary.
   v. If Necessary, the primary Officer will utilize the Security Department "Emergency Situation Officer Recall"

5. High Risk Visitor
   a. **T**o ensure the Safety, Security, and Welfare of all Patients, Visitors, and Staff Members the primary Security Officer will be responsible for ensuring that any high-risk visitors are continually monitored and evaluated for signs of escalating or disruptive behavior.
   b. All Security Officers who interact with high-risk visitors will follow Security Department policies pertaining to conflict resolution. In addition the Officer will utilize all available Medical Center resources to assist in the successful resolution of the incident.
   c. If all proactive efforts are unsuccessful, the high-risk visitor will be advised to exit the Medical Center and advised that if they refuse to comply the Oceanside Police Department will be called for assistance in the removal of the high-risk visitor.
   d. The Primary Security Officer will be responsible for ensuring that all departmental documentation is completed and submitted in accordance with Medical Center and Security Department policies.

Tri-City Medical Center
Oceanside, California

SECURITY
SAFETY

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: January 25, 1994~~ ~~Reviewed: 10/97, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Personal Safety Escort for Visitors and Staff~~ ~~Page 1 of 1~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 514~~

SUBJECT: Personal Safety Escort for Visitors and Staff

ISSUE DATE: January 25, 1994 **POLICY NUMBER:** 514
REVIEWED DATE(S): 10/97, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 7/03

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To establish guidelines for all Security Department personnel while conducting an escort Medical Center Patients, Visitors, and Staff Members.

B. **POLICY:**
1. Whenever possible, it is the policy of the Security Department, that all ON-Duty Security Officers will perform personal safety escorts for Patients, Visitors, and Staff Members from the Medical Center to their vehicle or other means of transportation.

C. **PROCEDURE:**
1. If Possible, all On-Duty Security Officers will be available to provide personal safety escorts when requested for Patients, Visitors, and Staff Members.
2. If an escort request is received over the Security Department radio system, the Officer having responsibility for the escort request area will, if possible, respond and make personal contact with the requesting party.
3. If the responsible Officer is unable to respond, PBX will be immediately notified and advised of the Officers estimated time of arrival.
4. If during any escort, the Officer receives an emergency or high priority call, the Officer will immediately terminate the escort and respond to the location of the call.
5. All escorts will be performed in a timely, polite, and professional manner.
6. All escorts will be documented on the Officer's Daily Security Report.

Tri-City Medical Center
Oceanside, California

SECURITY
SAFETY

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: April 04, 1996~~ ~~Reviewed: 2/97, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 2/97, 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Security Sensitive Areas~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM - # 502~~

SUBJECT: Security Sensitive Areas

ISSUE DATE: April 04, 1996 **POLICY NUMBER:** 502
REVIEWED DATE(S): 2/97, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 2/97, 7/03

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date (s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**

1. To provide for the Safety, Security, and Welfare of all Patients, Visitors, and Staff Members of Security Sensitive Areas.

B. **POLICY:**

1. It is the goal of this policy to be proactive and not reactive in the Security Management for all Security Sensitive Areas of Tri-City Medical Center. By the nature of their existence, the areas listed below are considered to be Security Sensitive Areas. **T**he patients contained within each of the Security Sensitive Area units, as a result of their condition, are totally dependent upon the staff working within these units. This dependency is illustrated through constant one-on-one care being administered. The clinical staff is normally considered the first line of defense, however should a situation occur where a Patient, Visitor, or Staff Member has been victimized, threatened, or injured, Security assistance should be requested immediately by calling the Medical Center Code Phone by dialing "66".

C. **PROCEDURE:**

1. **T**he Security Department **working with the Environmental Health and Safety Committee have** ~~has~~ identified the following Medical Center departments, Security Sensitive.
   a. Emergency Department ED
   b. **Behavioral** ~~Mental~~ Health Unit ~~M~~**B**HU
   c. **Women and Newborn Services**~~Maternal Child Health~~ **WNS**~~MCH~~
   d. ~~Adult Critical~~ **Intensive** Care Unit ~~A~~CICU
   e. Pharmacy Department
   f. Business Office PFS / BAMS
   g. Human Resources Department HRD

h. Neonatal Intensive Care Unit NICU
i. Medical Records Department
j. Information Technology Departments I.T.
k. Nuclear Medicine or Hot Lab
l. Central Plant infrastructure
m. Forensics Services [Out and In-Patient]
n. Administration Department
~~h.~~**o. Risk Management/ Regulatory**
~~i.~~**p. Closed Units**

2. The department staff of each of these areas is charged with the responsibility of providing the initial line **of safety** for their patients or staff members, the Security Department will provide back up as requested unless the Security Supervisor, designee, or Shift Lead Officer feels that a Security Intervention is required to provide for the Safety, Security, and Welfare of all Patients, Visitors, and Staff Members.
3. The typical situations that could occur include but not limited to the following:~~.~~
   a. Disruptive Patient, Visitor, or Staff Member.
   b. Visitor Control Issue.
   c. Child Custody Issue
   d. Criminal Activity
      i. Theft
      ii. Trespass
      iii. Assault
      iv. Battery
   e. Emergency Situation
   f. Emergency Preparedness
4. In any of the above situations if it can not be controlled or resolved by appropriate staff member then the Security Department should be immediately notified by utilizing the Code Phone by dialing "66" and following the procedures outlined in Administrative Policy #221 related to reporting a Dr. Strong.

Tri-City Medical Center
Oceanside, California

DELETE – no longer required

SECURITY
EMERGENCY PREPAREDNESS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: April 15, 1991~~ ~~Reviewed: 5/94, 1/97, 7/03, 11/06, 3/09, 6/11~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Disaster Manual~~ ~~Page 1 of 1~~
~~Submitted By: Security Supervisor~~	~~Procedure Manual: Security Department SDPPM - # 802~~

SUBJECT: Disaster Manual

ISSUE DATE: April 15, 1991 **POLICY NUMBER:** 802
REVIEWED DATE(S): 5/94, 1/97, 7/03, 11/06, 3/09, 6/11
REVISION DATE(S): 7/03

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

~~A. **PURPOSE:**~~
~~1. To establish Security Officers responsibility regarding the Medical Center's Disaster Manual.~~

~~B. **POLICY:**~~
~~1. It is the policy of the Security Department that all Security Officers will be familiar with and have a working knowledge of the Medical Center's Disaster Manual and all appropriate forms.~~

~~C. **PROCEDURE:**~~
~~1. The Security Department copies of the Medical Center Safety and Disaster Manual will be kept in the following locations:~~
~~a. One copy in the Main Security Department Office.~~
~~b. One copy in the Emergency Department Security Office.~~
~~2.~~**1.** ~~It will be the responsibility of every Security Officer to maintain a continual familiarization of the contents, policies, and procedures of this manual.~~

Tri-City Medical Center
Oceanside, California

SECURITY
EMERGENCY PREPAREDNESS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: January 29, 1993~~ ~~Reviewed: 4/94, 12/96, 12/01, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 12/01, 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Disaster Plan for the Security Department~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 801~~

SUBJECT: Disaster Plan for the Security Department

ISSUE DATE: January 29, 1993 **POLICY NUMBER:** 801
REVIWED DATE (S): 4/94, 12/96, 12/01, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 12/01, 7/03

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To assure adequate security during a disaster. Proper departmental procedures are to be initiated for the safety of all staff, visitors, and patients at the Medical Center.

B. **PERSONNEL:**
~~B.~~**1.** **Security Manager**
~~1.~~**2.** Security Supervisor
~~2.~~**3.** Lead/Charge Security Officer(s)
~~3.~~**4.** Security Officers

C. **PROCEDURE:**
1. In the event of a Disaster Alert Phase, the Security ~~Supervisor~~ **Manager** of his/her designee will be notified by Administration and advised of the circumstances. It is the responsibility of the Security ~~Supervisor~~ **Manager** or his/her designee to:
   a. Review the Security Department Disaster Plan, and Call Back Protocol.
   b. Verify all disaster supplies and equipment, which are currently stored in the Disaster Storage Shed, north of the Security Department Office.
2. In the event of a Disaster Activation Phase.
   a. The Lead/Charge Security Officer on duty will initiate the department call back process and notify the respective Law Enforcement agencies, which are appropriate.
   b. All Security Department personnel will be instructed to report to the Security Department Office or other location within the Medical Center.

c. The on-duty Lead/Charge Security Officer will assume the position of Duty Officer in the Command Center (HEICS) until such time as he/she is relieved of duty by the Security ~~Supervisor~~ **Manager** or his/her designee.

d. The on-duty Lead/Charge Security Officer will assign Security Officers to provide traffic control for the Triage area, utilizing the placement of signage and any other additional personnel that are deemed necessary.

e. A Security Officer with two-way radio capabilities will be assigned to the main southern access into the Medical Center (Vista Way entrance). This Officer will have available appropriate traffic control equipment to include but not limited to emergency road flares, signal light, traffic cones, barricades, and caution tape, in order to ensure an orderly ingress and egress into and out of the Medical Center grounds. If necessary additional personnel from this location will also be assigned to monitor any vehicular activity at the ~~Dialysis Center~~**Human Resources Building** entrance.

f. One Officer and any needed additional personnel, with two-way radio communications will be assigned to the northern and southern entrances into the Medical Center grounds from Thunder Drive. These Officers will also be in possession of traffic control devices to control the traffic flow at these locations.

g. During this Disaster Activation Phase, no individual will be allowed entry into the Medical Center unless they are in possession of their issued Tri-City Medical Center photo identification badge.

h. As the situation permits any or all access ways may be allowed opened by the authority of Administration.

i. All other assignments will be at the direction of the Security ~~Supervisor~~ **Manager** or his/her designee.

D. **AUTOMATIC REVIEW:**

1. This policy/procedure will be annually reviewed and updated as needed. It is the responsibility of the Security ~~Supervisor~~ **Manager** to:
   a. Orient and educate all Security Officers to the Disaster Plan.
   b. Maintain an updated version of the Disaster Plan and Call Back Roster.

Tri-City Medical Center
Oceanside, California

SECURITY
EMERGENCY PREPAREDNESS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: April 16, 2003~~ ~~Reviewed: 12/96, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 7/03, 7/10, 10/10~~ ~~Approvals: Director of Security~~	~~Subject: Emergency Situation Officer Recall~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 803~~

SUBJECT: Emergency Situation Officer Recall

ISSUE DATE: April 16, 2003 **POLICY NUMBER:** 803
REVIEWED DATE(S): 12/96, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 7/03, 7/10, 10/10

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To establish guidelines to be utilized in the event of an Emergency Situation or Disaster Alert, or for the immediate recall of additional Security Department personnel due to Emergency or staffing need.

B. **POLICY:**
1. All Medical Center Security Officers are required to maintain in good working order a telephone or telephone message system that allows for contact within 2 hours, in the event of an emergency or Security Department need.

C. **PROCEDURE:**
1. In the event of an emergency situation or Department need requiring the recall of additional Security Department personnel during off hours, the Shift Lead Officer or Designee will use the chain of command to notify the Security Supervisor prior to activating the Officer Recall chart.
2. The Security Shift Lead Officer or Designee will go down the list calling each Officer starting with the Officers on the shift needing to be filled first, followed by other shift Officers as needed and recording the results of each call. If necessary the Security Supervisor, Designee, or Shift Lead Officer will appoint another Security Officer or Medical Center Employee call each Officer.
3. Each Officer called will be informed of the need for additional Security Department personnel, and that he is being recalled. The Officer will be briefed on his duties for the situation or Emergency when he arrives on post.
4. Each Officer called is required to respond or return the phone call no later than 2 hours from the time the message was left and documented.

Tri-City Medical Center
Oceanside, California

SECURITY
DISASTER PREPAREDNESS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: March 25, 1991~~ ~~Reviewed: 9/94, 7/97, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 9/94, 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Medical Center Power Outage~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM - # 804~~

SUBJECT: Medical Center Power Outage Response

ISSUE DATE: March 25, 1991 **POLICY NUMBER:** 804
REVIEWED DATE(S): 9/94, 7/97, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 9/94, 7/03

Department Approval Date(s): **07/15**
Environmental Health and Safety Committee Approval Date(s): **08/15**
Professional Affairs Committee Approval Date(s): **09/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To set fourth guidelines to be utilized by Security Officers when confronted with a power outage at the Medical Center.

B. **POLICY:**
1. It is the policy of the Security Department to maintain a well-lighted environment in all areas of the Medical Center in order to ensure the Safety, Security, and Welfare of all Patients, Visitors, and Staff Members.

C. **PROCEDURE:**
1. Upon either notification or observation of any type of power outage, the Security Officer will immediately notify the Security Supervisor, Designee, or Shift Lead Officer of the power outage. The Security Officer will also ensure that the on-duty Engineer and Administrator or Administrative Coordinator are also informed of the power outage.
2. The Security Department will provide safety escorts to Patients, Visitors, and Staff Members throughout the Medical Center Campus Parking Areas if the power outage occurs during dark hours.
3. All Security Officers on-duty during a power outage during dark hours will maintain a high visibility, conducting frequent and random patrols of the parking areas ensuring the Safety, Security, Welfare of all Patients, Visitors, and Staff Members, including all Medical center, and Personal Property.

Tri-City Medical Center	Distribution:	Women and **Newborn** ~~Children~~'s Services
PROCEDURE:	**BALLOON CERVICAL RIPENING CATHETER**	
Purpose:	To outline the nursing care for the patient with an unfavorable cervix, undergoing placement of a mechanical dilator (~~foley~~ balloon catheter) **through**~~in~~ the ~~uterine~~ cervical os.	
Supportive Data:	Mechanical methods **for**~~of~~ cervical ripening **is indicated prior to labor induction at term when the cervix is unfavorable for induction.** ~~have been used for hundreds of years.~~ Balloon catheters are a current method used to soften the cervix, and ~~facilitate amniotomy when compared with no treatment.~~ **m**May be appropriate for women for whom pharmacologic agents for cervical ripening are contraindicated.	
Equipment:	1. **18**~~14-26~~ gauge ~~foley~~ (balloon) catheter a. **40-80** ~~30~~ ml balloon ~~or~~ ~~b. 60 ml balloon or~~ ~~c. Cook Foley (double balloon)~~ 2. Vaginal speculum, if requested by p**rovider**~~hysician~~ 3. Sterile normal saline or sterile water for injection 4. **(2)** 30**- 60** mL syringe**s** ~~(2)~~ 5. Tape/stabilizing device	

A. **INDICATIONS AND CONTRAINDICATIONS:**

1. Indications for cervical ripening
   a. Unfavorable cervix\
   b. Induction of labor indicated for:
      i. Chorioamnionitis
      ii. Fetal demise
      ~~iii. Pregnancy induced hypertension~~
      ~~iv.~~**iii.** Post-term pregnancy
      ~~v.~~**iv.** Fetal compromise (oligohydramnios, intrauterine growth restriction (IUGR) or isoimmunization)
      ~~vi.~~**v.** Preeclampsia or eclampsia
      ~~vii.~~**vi.** Maternal medical condition such as diabetes mellitus, renal disease, chronic pulmonary disease or chronic hypertension
      ~~viii.~~**vii.** Psychosocial indication
      ~~ix.~~**viii. Trial of labor after Cesarean (TOLAC)**
2. Contraindications:
   a. Vasa previa.
   b. Complete placenta previa.
   c. Fetal malpresentation (transverse lie, breech).
   d. Umbilical cord prolapse.
   e. ~~Non-reassuring FHR tracing~~.
   f. Unexplained heavy vaginal bleeding in third trimester.

B. **PROCEDURE:**

1. RN shall verify physician/**Allied Health Professional (AHP)** order.
2. RN shall verify prenatal record on patient's medical chart.
3. Prior to placement of the ~~foley~~ balloon catheter, the RN shall initiate continuous electronic fetal monitoring to obtain a ~~reassuring~~ fetal heart rate (FHR) tracing **predictive of fetal well being at the time of observation, Category I tracing.** ~~and/or reactive non-stress test (NST)~~.
   a. Notify physician/**AHP** for ~~non-reassuring~~ FHR tracing **displaying Category II or Category III criteria**.

~~R~~eview/Revision Date	**Department of OB/Gyn Review**	**~~Clinical Policies & Procedures~~**	**~~Nurse Executive Committee~~**	**Department of Pediatrics**	**Pharmacy and Therapeutics**	**Medical Executive Committee**	**Professional Affairs Committee**	**Board of Directors Approval**
7/03; 5/09	01/13, 06/15	~~02/13~~	~~02/13~~	n/a	n/a	05/13, 08/15	06/13, 09/15	06/13

4. Position patient per physician/**AHP request**~~order~~ **for catheter placement**, care should be taken to minimize effects of supine hypotension~~n.~~
   a. **Physician/AHP may place balloon catheter, manually if stylet is available with catheter set up for directed placement or provider may request a speculum to help visualization for catheter placement.**
5. After the ~~foley~~ **balloon** catheter has been placed in the cervical os and the balloon inflated with sterile water or normal saline by the physician/**AHP**, tape or use stabilizing device to secure the catheter to the patient's medial thigh.
   a. Caution: do not overfill ~~foley~~ balloon beyond manufacturer's guidelines.**(Balloon usually inflates with 40mL of fluid, with a maximum of ~~-~~80 mL)**
6. Reposition the patient in a lateral position as soon as possible following insertion.
7. Document the type, size and placement of the transcervical ~~foley~~ balloon catheter with the amount of fluid instilled in the balloon **in the patient's electronic ~~medical~~health record (EHR~~EMR~~).** ~~on the patient care record~~.
8. Continue to electronically monitor the fetal heart rate for a minimum of 30 minutes after placement of transcervical ~~foley~~ **-balloon** catheter to ob**serve for fetal response.**~~tain a reactive/reassuring FHR tracing~~ (NST)
9. Patient activity/ambulation is per physician/**AHP** order.
10. Document the time and notify the physician/**AHP** when the balloon extrudes (falls out), as this usually indicates that the cervix is beginning to dilate.
    a. The balloon catheter should be removed when an active labor pattern is established

~~10.~~**11.** Document the onset of regular painful contractions, maternal fever, and continuous uterine pain.

~~11.~~**12.** Document ongoing maternal-fetal assessments per W**NS**~~CS~~ procedure: "Fetal Surveillance –
   a. Interpretation and Documentation of FHR" in the patient**'s EHR~~EMR~~.**~~t care record~~.

C. **REFERENCES:**

1. AAP & ACOG. (200**12**~~7~~). -Guidelines for Perinatal Care, **7**~~6~~th Edition
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8. ~~8.~~**4.** Simpson, K. R., & Creehan, P. A. (200**14**~~8~~). ~~AWHONN's~~ Perinatal **N**~~n~~ursing **(4th Ed.)**~~.~~ Philadelphia, PA: Wolters Kluwer / Lippincott Williams & Wilkins
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Tri-City Medical Center	Distribution: Women's & Children's Services/NICU
PROCEDURE:	**BREASTMILK MISADMINISTRATION**
Purpose:	To provide guidelines for action when an infant is fed "unprocessed" human milk from a mother in the NICU other than his/her own mother.
Supportive Data:	Despite significant prevention effort, infants may inadvertently be fed another mother's milk in error. This misadministration of human milk results in anxiety for both family and staff. Much of this anxiety is the result of misinformation about the potential infectious risks to the recipient infant and uncertainty as to how to evaluate the risk. In most cases, the risk of transmission of infectious disease is extremely low. With increasing Joint Commission ~~on Accreditation of Health Care Organizations (JCAHO)~~ focus on patient safety and medical error reporting by hospital systems, a plan of care should be available in the (hopefully) rare instance when a mother's milk is given to the wrong infant. It is imperative that the confidentiality of the donor mother be maintained.

A. **DEFINITIONS:**

1. **Misadministration** – an infant given the wrong mother's milk, "i.e., any mother's milk other than his/her own mother's milk.
2. **Recipient Infant** – The infant given the wrong mother's milk.
3. **Source Mother** – Mother whose milk is fed to the wrong infant.
4. **Recipient Mother** – Mother of infant who receives the wrong milk.

B. **PROCEDURE:**

1. If an infant receives the wrong breast milk:
   a. The RN/LVN will notify the shift supervisor and the physician of both the source and the recipient infant's identity.
   b. The shift supervisor will notify the source and recipient parents or legal representatives. The recipient parents are informed and counseled regarding the possible risks from the exposure, including assessment of the donor mother's STD status drawn at delivery. Both the donor and recipient mother are tested for HIV, HBV, HCV, HTLV1/11, and CMV.
   c. The physician will review the source mother's chart for maternal history and order appropriate lab work on the source mother which includes:
      i. HIV 1 and 2 antibody
      ii. Hepatitis C antibody
      iii. Hepatitis B surface antigen
      iv. Additional lab work may include:
         1) HTLV 1 and 2 antibody
         2) Syphilis Serology (RPR or VDRL)
         3) CMV antibody screen
2. The physician will obtain source mother's informed consent for HIV test and authorization of disclosure of the results if the results are not available in the source mother's chart.
3. If the source mother refuses to consent to testing, the recipient newborn, with the parent's consent, should be followed up with the appropriate tests for HBV, HBC, HIV, HTLV I/II, and CMV at three months and six months after the incident.
4. If the source mother is HbsAg positive, the newborn is to receive HBV immunoglobulin and HBV vaccine immediately. The HbsAg status of the mother should be available on the prenatal record; if not available, it should be done as an immediate (STAT) test.
5. If the donor is positive for HIV, a decision needs to be made immediately regarding antiretroviral prophylaxis, as it should start within 1 to 2 hours after the exposure.

Department Review/Revision	~~Clinical Policies & Procedures~~	~~Patient Care Quality Committee~~	Department of Pediatrics	~~Medical~~ Department of OB/GYN ~~Review~~	Medical Executive Committee	Professional Affairs Committee	Board of Directors Approval
10/06, 05/08, 4/09, 6/11, 12/14	~~7/07, 4/09~~	~~8/07, 5/09~~	03/15	8/07, 06/15	8/07, 8/15	9/07, 6/09, 09/15	9/07, 6/09

6. If the donor mother is CMV positive and the recipient mother is CMV negative, the recipient newborn's urine is to be tested for CMV no sooner than eight weeks post exposure.
7. The physician will notify the primary physician of the recipient infant to provide follow-up care as needed. Refer to UCSD mother/child and adolescent HIV program, (619) 543-8080 as resource, if appropriate.
8. The RN will complete and obtain signature on the consent for HIV test form and authorization for disclosure of the results of HIV test form if needed.
9. The RN/shift supervisor will process any ordered lab tests on the source mother on recipient with a universal requisition form marked, "no charge to patient" – charge to infection control shared service account.
10. Note on the recipient infant's chart, the date of the occurrence and lab studies that were ordered. Also indicate which follow-up labs may be needed.
11. The infection control practitioner will notify the appropriate state agencies of the test results where applicable.

C. **REFERENCES:**

1. Lawrence R. & Lawrence R. (2005). Breastfeeding: a guide for the medical profession, 6th Ed. Mosby, Inc., pp. 761-776.
2. Human Milk Banking Association of North America. Best practice for expressing, storing and handling human milk in hospital, homes and child care settings.
3. APIC Test of Infection Control and Epidemiology, (2005). Association for Professionals in Infection Control and Epidemiology, Inc.
4. Warner, B.B. & A. Sapsford. Misappropriated Human Milk. Fantasy, Fear and Fact Regarding Infections Risk. www.medscape.com/viewarticle/472406.

Tri-City Medical Center	Distribution:	Women's & Children's Services, ~~NICU, Nursery~~
PROCEDURE:	**BREAST MILK, PUMPING, HANDLING, AND STORAGE OF**	
Purpose:	To provide a standardized process for collection, storage and handling of maternal breast milk in the hospital setting.	
Supportive Data:	Mothers giving their babies pumped milk in the hospital setting is part of a wellness program that hospitals support. If circumstances such as separation of mother and baby occur then the staff is to provide for and educate the mother in proper pumping, handling and storing of human milk.	
~~Equipment:~~	~~1. **Fresh/Raw Milk** – Expressed breast milk~~ ~~2. **Fresh/Frozen Milk** – Freshly expressed breast milk that has been frozen and kept at approximately less than or equal to -20°C (-4° F)~~ ~~3. **Thawed Milk** – Breast milk that has been previously frozen. Thawed milk must be used within 24 hrs.~~ ~~4. **Heat Processed Milk** – Fresh raw and/or fresh frozen milk that has been heat-treated as per milk banking guidelines.~~	

A. **CRITERIA FOR BREAST MILK STORAGE:**

1. Gloves should be worn when preparing breast milk or when spillage may occur. General guidelines for determining which breast milk to use, unless otherwise ordered:
   a. ~~1st two weeks of M~~milk in chronological order
   b. Fresh expressed milk
   c. Refrigerated milk
   ~~d. Oldest dated frozen milk~~
2. At all times, all containers shall be labeled with patient identification label including **mother or** infant's name~~, and~~ medical record number**, date and time.**.
3. ~~Syringes for feedings shall be changed every 4 hours.~~

B. **BREAST MILK STORAGE GUIDELINES:**

1. Breast milk shall be stored as follows in a designated refrigerator/freezer:

Breast Milk Storage Guidelines		
Method	Term Infant	Pre-Term or Sick Infant
Room temperature less than or equal to 25° C (77° F)	6-8 hours	4 hours
Refrigeration of Fresh Milk less than or equal to 4° C (39° F)	3-5 days	~~48~~**96** hours
~~Completely Thawed & Placed in Refrigerator (plain or fortified)~~	~~24 hours~~	~~24 hours~~
~~Deep Freezer less than or equal to -20° C (-4° F)~~	~~6-12 months~~	~~6 months~~

C. **PROCEDURE:**

1. Collection
   a. Provide instruction to MOB on "Pumping, Storing & Transporting Breast Milk for hospitalized infants. Parent information sheet given **by lactation consultant**.
   b. Direct parent to a pump rental facility and use of in-house pump when parent is at hospital with baby.
   c. Instruct mother of baby in hand expression and manual pumping as alternative ways of collecting milk.
   d. Provide individualized labels with the ~~infant's~~ **mother's** name and medical record number, containers and lids**, and NICU will provide infant labels on initial NICU visit.**

Review/Revision Date	~~Clinical Policies & Procedures~~	~~Patient Care Quality Committee~~	~~Medical~~ Department of "OB/GYN	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors ~~Approval~~
7/03, 5/06, 6/07, 05/08, 4/09, 6/11, 12/14	~~7/07, 4/09~~	~~8/07, 5/09~~	8/07, 6/15	n/a	8/07, 08/15	9/07, 6/09, 09/15	9/07, 6/09

~~d.~~**e. When giving or receiving milk from the refridgerator the identification band will be checked with the milk label.**

~~e. When receiving breast milk from babies that are back transferred from other facilities, a TCMC patient label must be applied to all containers received.~~

f. Instruct mother to write the date and time of collection.

g. Instruct mother in hand washing before and after pumping.

h. Instruct mother in cleaning collection bottles and flange.

i. Educate mother in how to store breast milk in small volumes to minimize waste.

2. Hospital Pump Care:
   a. Breast pumps shall be wiped down with a hospital approved germicide as follows:
      i. Prior to each use in the NICU.
      ii. Prior to each new patient use in areas other than NICU.
      iii. If a spill occurs.
   b. If internal contamination is noted, take the pump out of service and send to Biomed for deep cleaning.

~~3. Handling:~~
~~a. Breast milk may be delivered to NICU fresh or frozen.~~
~~b. To thaw frozen breast milk;~~
~~i. Fill container with warm water. Place frozen milk container in warm water. Do not let the level of water in the bowl from the tap touch the mouth or top lid of the container.~~
~~ii. Do not place in boiling water or microwave.~~
~~iii. Milk may be thawed in the refrigerator~~
~~iv. Swirl the container of milk to mix the cream back in, and distribute the heat evenly. Do not stir the milk. Do not shake the milk.~~
~~v. Measure volume of breast milk required for feeding into appropriate feeding container. Promptly refrigerate unused portion of thawed breast milk, Label as follows: Date & time thawed; date & time of expiration of thawed breast milk.~~
~~vi. In the NICU, when breast milk is transferred from one container to another for administration, a patient label must be affixed to either the new container or the warming cup it is placed in.~~
~~1) The re-labeling will be done at the preparation area and will be double-checked by two personnel.~~
~~c. Warming Breast milk:~~
~~i. At bedside, prior to transfer of breast milk to any other feeding container (i.e., syringe, volufeed) and before administration, infant's name and medical record number shall be double checked between original container label and infant band by two personnel attending MOB and baby (LC, RN, LVN, MD).~~
~~ii. In the NICU, prior to administration, the infant's name and medical record number must be double-checked between the labeled container at the bedside and the infant band, by two personnel.~~
~~iii. Breast milk may be warmed in a container of warm tap water.~~
~~iv. When warming breast milk, follow the same procedure as when thawing breast milk.~~
~~v. Do not use microwave oven in warming breast milk.~~
~~vi. Any warmed breast milk that is not used must be discarded.~~
~~d. Transporting Breast Milk:~~
~~i. Breast milk must be kept cold/frozen during transport. An insulated cooler or freezer bag with a frozen gel pack or ice is recommended.~~
~~ii. Liquid milk must remain cold~~
~~iii. Frozen milk must not be allowed to thaw. If milk has thawed, do not refreeze.~~
~~iv. Mothers shall be instructed to bring no more than 48 hours worth of breast milk at one time if possible. Extra milk can be brought in from home as needed. Mothers are educated about proper storage of milk at home.~~

4. Following the infant feeding, discard any unused breast milk from feeding container
5. Fortification of EBM:
   a. Wash hands prior to preparing fortified breast milk.
   b. Combine fortifier with EBM according to manufacturer's recommendations.
   c. The combination should be refrigerated and used within 24 hours once prepared.
   d. Fortifiers are to be added to human milk at room temperature.
6. Continuous Infusion Feeding:
   a. Wash hands prior to preparing the feeding.
   b. Milk that has been checked for correct milk/correct infant is placed in labeled syringes. Gently agitate syringe to dispense fat into the solution.
   c. To minimize fat loss during gavage feedings use milk infusion systems with syringe tip pointed up.
   d. Hang times for continuous feedings of EBM should be limited to four hours to reduce bacterial growth.
   e. Syringes should be changed with each feeding.
   f. Enteral extension tubing shall be changed with each feeding.

D. **DOCUMENTATION:**

1. Document handling of breast milk (refrigeration, freezing,
2. Document parent education in patient record.
3. Document identification of breast milk. (See handling #3)
4. Document administration of breast milk in the patient's medical record.
5. Discard any expired breast milk
   5.

E. **CROSS-REFERENCE:**

1. See Breast **Milk Misadministration procedure**
   1.

F. **REFERENCES:**

1. Human Milk Banking Association of North America, Inc. Best Practice for Expressing, Storing and Handling Human Milk in Hospitals, Homes and Child Care Settings. 2005. Raleigh, NC: HMBANA.
2. *Infant Feedings: Guidelines for Preparation of Formula and Breast milk in Health Care Facilities*. American Dietetic Association. Copyright – 2004
3. Meirer, P.P. (1997). **Professional Guide to Breastfeeding Premature Infants**. Ross Products Division, Abbott Laboratories.
4. Pardou, A., et al. (1994) Human Milk Banking: Influence of storage process and of bacterial contamination on some milk constituents. Biol Neonate; 65; 302-309.
5. Pierce, K.Y. & Tully M.R. (1992). Mother's Won Milk: Guidelines for storage and handling. Journal of Human Lactation; 8 (3); 159-160.
6. The Academy of Breastfeeding Medicine Protocol Committee; Caroline J. Cantry, MD, FABM; Cynthia R. Howard, MD, MPH, FABM. Protocol #7: Model Breastfeeding Policy. Approved 2/20/2004.
7. Lawrence, Ruth & Lawrence Robert (2005). Breastfeeding – A Guide for the Medical Profession. Elsevier Mosby. 761- 778, 1081 –1093.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 1/07	SUBJECT: ~~Ongoing Professional Practice Evaluation /~~ **Peer Review Process: OPPE and FPPE**
REVISION DATE: 3/08, 5/08, 06/08**, 7/2015**	POLICY NUMBER: 8710 – 509

Medical Executive Committee Approval:	~~06/08~~07/27/15
Professional Affairs Committee Approval:	09/17/2015
Board of Directors Approval:	~~06/08~~

A. **POLICY:**

~~The Medical Staff has the responsibility to protect patients by ensuring that all practitioners can carry out the privileges they request in a competent, safe manner. There may be times when quality of care or behavioral concerns is not identified during the initial credentialing process. Detailed information, such as numbers of procedures performed, complication rates, and behavioral aspects of performance, are difficult to obtain. Focused professional practice evaluation compels the medical staff to evaluate these aspects in more detail. Focused professional practice evaluation pertains to those who currently have privileges on the medical staff. This policy outlines how the medical staff evaluates the credibility of reported concerns regarding the clinical practice or competence of a privileged practitioner.~~ Medical Staff members, departments, divisions and committees participate in peer review activities in accordance with this policy as well as the Medical Staff Bylaws, Medical Staff Rules and Regulations, Department/Division Rules and Regulations, and as required by licensure regulations, accreditation standards and conditions of participation in Federally funded programs. Peer review includes all evaluation activities involving members of the Medical Staff ~~and other individuals holding privileges~~ ("Practitioners"), including quality improvement, utilization review, monitoring, proctoring, focused review, Focused Professional Practice Evaluation (FPPE), On-going Professional Practice Evaluation (OPPE) and medical record review. The results of peer review activities are utilized to assess a Practitioner's professional practice as part of the credentialing, privileging, and corrective action processes.

~~B. DEFINITION:~~

~~1. Peer: Refers to physicians of like education and specialty. These physicians are licensed independent practitioners privileged through the Medical Staff who are subject to the Medical Staff Bylaws.~~

~~2. Within the Standard of Care: means that care was provided in accordance with contemporary standards of the specialty and department.~~

~~3. Focused Professional Practice Evaluation ("FPPE"): Time limited evaluation of a practitioner(s) competence in performing a specific privilege. This process is implemented for all initially requested privileges and whenever a question arises regarding a practitioner's ability to provide safe, high quality patient care.~~

~~4. Ongoing Professional Practice Evaluation ("OPPE"): A documented summary of ongoing data collected for the purpose of assessing a practitioner's clinical competence and professional behavior. The information gathered during this process is factored into decisions to maintain, revise or revoke existing privilege(s) prior to or at the end of the two-year medical staff membership and privilege renewal cycle.~~

~~C.~~B. ~~CRITERIA FOR~~ ONGOING PROFESSIONAL PRACTICE EVALUATION ("OPPE"):

~~1.~~ Ongoing Evaluation: ~~Except as otherwise determined by the department/divisions/Medical~~

~~Executive Committee, the medical staff shall regularly monitor all members' privileges in accordance with the provisions set forth in their respective rules and regulations and such performance monitoring is not viewed as a disciplinary measure, but rather as an information gathering activity. Performance monitoring does not give rise to the procedural rights described in Tri-City Medical Center's Bylaws, Article VI.~~ At eight (8) month intervals, every Practitioner will undergo Ongoing evaluation. ~~A~~as defined by each Department/Division., ~~applicable~~ Relevant data is collected and assembled for review by the applicable Department Chair/Division Chief, who shall determine whether the ~~p~~Practitioner is performing: 1) well/within desired expectations and that no further action is warranted;, or 2) that an issue exists that requires a focused evaluation,; or 3) recommending revocation of a privilege because it is no longer required, recommending suspension of a privilege,; or 4) that there has been zero performance of a privilege thereby triggering focused review (proctoring) whenever the practitioner performs the privilege,; or 5) determining that a privilege should be continued without change because the organization's mission is to be able to provide the privilege to its patients. Ongoing evaluations shall be ~~collated by Practitioner and~~ included in the Practitioner's credential file as part of the reappointment process.

~~2.~~1. This process will evaluate a ~~physician's~~ Practitioner's professional performance on an on-going basis, utilizing the following six (6) areas of General Competencies:

i. Patient Care
ii. Medical / Clinical Knowledge
iii. Practice-based learning and Improvement
iv. Interpersonal and communication skills
v. Professionalism
vi. Systems / Based Practice

~~3. Each Department / Division will select and approve their OPPE monitoring indicators. Relevant information for these indicators will be integrated, and reviewed quarterly by the designated Medical Staff leadership position. The data will be presented as confidential and protected as such.~~

~~4. System-Based Practice Criteria for OPPE may include but is not limited to the Following:~~

~~a. review of operative and other clinical procedure(s) performed and their outcomes;~~
~~b. pattern of Blood blood and pharmaceutical usage;~~
~~c. morbidity and mortality data;~~
~~d. infection control rates;~~
~~e. length of stay as compared to other practitioners within the same specialty treating patients with same procedures/diagnosis;~~
~~f. sedation reversals for GI compared to other practitioners performing the same procedure;~~
~~g. cesarean rates for OB as compared to other practitioners performing the same procedure;~~
~~h. peer review organization denials~~
~~i. demographic information, such as number of admissions/consults/surgeries;~~
~~j. other relevant criteria as determined by the organized medical staff;~~

~~5. Methods used for Ongoing Professional Practice Evaluation may include but is not limited to:~~

~~a. periodic chart review;~~
~~b. monitoring of diagnostic and treatment techniques;~~
~~c. direct observation;~~
~~d. discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing and administrative personnel;~~

~~The medical staff leadership use the information they receive from OPPE in their determination as whether to continue, limit, or revoke any existing privileges.~~

2. Routine Individual Case Review is initiated based on department/division established criteria, reported deviations from expected care, statistical analysis showing (i) important single events, levels of performance, or patterns or trends varying significantly from expected; (ii)

performance varying significantly from other organizations; (iii) performance varying significantly from recognized standards, variances from utilization practices, (iv) risk management concerns involving quality of care, complaints from patients/family or staff relating to quality of care, (v) notices from regulatory bodies, accreditation agencies or third party payors involving quality of care, or if an appropriate, (vi) medical staff officer determines a need.

~~e.~~a. Initial Review: will be performed by the applicable department, division or committee (or designee thereof in accordance with the Medical Staff Bylaws or Rules and Regulations). Review findings will be documented and rated in accordance with a system established by the Medical QA/PI Committee.

b. Review Timelines: Peer review of a particular matter shall be conducted as soon as reasonably possible based on when the matter is discovered and the complexity of the matter to be reviewed. In general, initial review of those circumstances identified herein should be carried out within thirty (30) days of discovery. Completion of the peer review process of a particular circumstance should occur within ninety (90) days of discovery, unless unusual events interceded, include but not limited to, focused review or referral to another department/division. Delays in review shall be reported to the Medical Executive Committee. Expedited reviews are appropriate in the event there may be an imminent threat to the health or safety of an individual.

c. Reporting Findings: The findings of peer review activities are reported through the department/division/quality review committee to the QA/PI/PS Committee and on to the Medical Executive Committee within forty-five (45) days of completion.

~~6.~~d. Action: Consistent with the provisions of the Medical Staff Bylaws, the department/division/quality review committee/chair/chief may take action or make recommendations for action, including implementation of monitoring, proctoring and focused evaluation activities. Any recommendations for corrective action which may give rise to hearing rights shall be processed in accordance with the Medical Staff Bylaws.

~~D.~~C. ~~CRITERIA FOR INITIATION OF~~ FOCUSED PROFESSIONAL PRACTICE EVALUATION("FPPE"):

1. FPPE includes monitoring, proctoring and focused review activities. These activities are intended to evaluate the privilege-specific competence of a practitioner granted new/initial privileges, where activity is insufficient to evaluate competence at time of privilege renewal, or when questions arise regarding a practitioner's ability to provide quality care.
2. Monitoring: Monitoring shall consist of the on-going scrutiny of a Practitioner's practice without limitations or obligations on the monitored Practitioner. Examples include, but are not limited to, retrospective chart review, concurrent chart review, and concurrent observation.
3. Proctoring:
   a. Concurrent proctoring is when a Practitioner is obligated to arrange for another Practitioner to be present during a patient care episode and, except in the case of an emergency, when the Practitioner may not proceed with the specific patient care unless the proctor is present.
   b. Retrospective proctoring is when a Practitioner's provision of care and treatment is evaluated through review of the medical record. In the case of newly or initially granted privileges, all Practitioners shall be subject to such proctoring requirements as set for the in the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department/Division Rules and Regulations. In addition, in cases where a Practitioner has insufficient activity in a particular privilege to evaluate competence at time of renewal, the proctoring process may be utilized.
   c. The provisions of the Bylaws and Rules and Regulations shall be followed with regard to the methods of proctoring, duration of proctoring, criteria for conclusion of proctoring, process for conclusion of proctoring, etc.
4. Focused ~~Professional Practice Evaluation~~Review: In case where, based on the evaluation of a ~~p~~Practitioner's current clinical competence, compliance with standards, or ability to perform

requested privileges, questions arise regarding a Practitioner's ability to provide quality care, focused review may be initiated. Circumstances which may give rise to focused professional practice evaluation include, but are not limited to, provision of inappropriate care, including a single egregious incident or a clinical practice trend; mortality/morbidity complication rates at variance with applicable standards; failure to comply with hospital or medical staff policies, procedures, rules, regulations, bylaws, laws, regulations or standards; action by a licensing agency or other governmental entity; a significant pattern of malpractice claims; and a significant number or dollar amount of malpractice settlements, judgments or arbitration awards.

~~1. The Medical Staff may but is not limited to evaluating specific aspects of a physician's performance when the following circumstances are triggered:~~

~~a. when a physician has the credentials to suggest competence, but additional information or a period of evaluation is needed to confirm competence in the organization's setting (Initial appointee);~~

~~b. when / if questions arise regarding a physician's practice during the course of the OPPE;~~

~~c. any confirmed /valid issues that may arise that affect the provision of safe, high quality care have been identified;~~

~~d. two (2) consecutive quarters of the OPPE below threshold;~~

~~e. any sentinel event that occurred as a direct result of physician practice;~~

~~f. unexpected deaths;~~

~~g. unexpected surgical deaths;~~

~~h. severe transfusion reactions;~~

~~i. certain compensable events identified by the risk manager.~~

a. INITIATION PROCESS: Request for a FPPE must be in writing, submitted to the MEC, with supported reference to the specific activities or conduct alleged. Monitoring for the FPPE may include but is not limited to periodic chart review, concurrent chart review, direct observation, monitoring diagnostic and treatment techniques, interviews with staff.

~~E.~~

~~1. Request for a FPPE must be in writing, submitted to the MEC, with supported reference to the specific activities or conduct alleged.~~

~~2. Monitoring for the FPPE may include but is not limited to the following:~~

~~a. periodic Chart chart Reviewreview;~~

~~b. concurrent chart review~~

~~c. direct Observationobservation;~~

~~d. monitoring of Diagnostic diagnostic and Treatment treatment Techniquestechniques;~~

~~e. interviews with staff as indicated;~~

~~f. proctoring; Level II as defined in the Medical Staff Policy "Focused Professional Evaluation" Policy # 8710-542;~~

~~3.~~b. Time frame for the FPPE: The Medical Executive Committee will approve the time frame required for monitoring

~~a.~~c. ~~The Medical Executive Committee will approve the time frame required for monitoring. The anticipated time frame will be at least four (4) conservative months. This time frame may be extended at the discretion of the department division chair/chief, or any other Medical Staff leadership position.~~

~~4.~~d. Monitoring Plan: If the MEC initiates the request for an FPPE, the ~~physician~~Practitioner will be notified in writing within five business days. The initial written notice shall include a statement of facts demonstrating the request for FPPE was reasonable and warranted. This communication must also include what is wrong with the performance and what improvements are expected.

~~a. If the MEC initiates the request for an FPPE, the physician will be notified in writing within one workingfive business days week. The initial written notice shall include a statement of facts demonstrating that the request for a FPPE was reasonable and~~

~~warranted. This communication must also include what is wrong with the performance and what improvements are expected.. Possible aspects of the monitoring will include but is not limited to the following:~~

~~i. specific areas in which practitioner's performance is an unsatisfactory and specific example(s) of the deficiencies;~~

~~ii. what improvements are expected and the specific period of time the practitioner is being given to demonstrate acceptable performance;~~

~~iii. what assistance is available to help practitioner improve performance;~~

~~iv. a statement that if performance does not improve to a minimally acceptable level further action may be taken.~~

~~b. External Sources sources may be used but are not limited to the following:~~

~~i. conflict of interest is identified and confirmed;~~

~~ii. Medical Executive Committee or other departmentDepartment/division Division request;~~

~~iii. no other practitioner on-staff credentialed within specialty.~~

~~F.~~D. GENERAL RULES SURROUNDING PEER REVIEW ~~PROCESS~~ ACTIVITIES

1. ~~PROCEDURES FOR PEER REVIEW~~Participants in the Peer Review Process:

a. Peer: Within the context of this policy, a "peer" is one with similar clinical competence and scope of responsibility, and to the extent possible, in the same or related specialty, with the experience to render technically sound judgment of the clinical circumstances under review.

b. Reviewer(s): The Department/Division/Committee Chair/Chief shall appoint Practitioners to perform case screening. The reviewer shall not be personally involved in the care of the patient, and to the extent possible should not be a member of the same practice group or have other personal or professional conflicts.

c. Affected Practitioner: A Practitioner whose practice is being reviewed shall participate in the peer review process at the earliest reasonable time to afford the affected Practitioner with an opportunity to provide additional information or obtain education regarding the particular circumstances. This participation may include, but is not limited to, written response or attendance at a meeting, as determined by the Department/Division/Committee. In cases where the peer review process advances to the investigation for corrective action stage, the process shall comply with the provisions of the Medical Staff Bylaws.

~~1.~~d. Support Staff: Employees of the hospital may be designated to assist the Medical Staff with its peer review activities. Employees acting in such roles shall be under the direction and supervision of the Medical Staff, and shall comply with all Medical Staff confidentiality requirements with regard to peer review materials.

~~a.~~e. Data Sources/Collection: The cases for peer review are derived from quality review form, patient satisfaction surveys, department specific criteria and reports generated from coded medical records.

~~b.~~f. Criteria shall be reviewed by each department/committee/ annually. The criteria can be changed before the annual review with request from Department Chair.

~~c. A Physician whose case is being reviewed may not peer review his/her own case. The case will be referred to the appropriate physician screener. The Physician, whose case is being reviewed, may have the option of attending the meeting if the problem case involves discussion; otherwise communication is obtained through correspondence~~

~~d.~~g. Cases involving more than one discipline are referred to other areas for additional input or action. These are tracked in the original committee until completed.

~~e.~~h. Incomplete case reviews are referred to the next scheduled meeting.

~~f.~~i. Cases referred for review shall be reviewed by the ~~physician~~ Practitioner screener of each committee (or designee), who shall determine whether to refer the case to the full committee for discussion, and make the preliminary assignment of category.

~~g.~~j. Cases referred for discussion shall be summarized in sufficient detail to ascertain the

salient facts of the case, the issue under discussion, and the reasoning underlying the committee(s) decision.

~~h.~~k. Peer Review results are used in the reappointment process and in ongoing performance improvement activities for all members of medical staff.

~~i. External peer review is an option used in extreme circumstances for cases that an impartial review could not be performed or the involved physician is the only physician credentialed in this specialty. (Pursuant to § 3.8-2 Medical Staff Bylaws)~~

~~j.~~l. Cases requiring immediate action or intervention are shared directly from Risk Manager to Department Chairman or Chairman of Quality Assurance/Performance Improvement/Patient Safety Committee and may require direct intervention.

~~k.~~m. For cases of ~~physician~~ Practitioner comportment, refer to Medical Staff Policy 511.1, Physician Behavior Policy.

~~l. Provision of participation in the review process by the physician whose performance is being reviewed is pursuant to § 2.5 Basic Responsibilities of Medical Staff Membership~~

~~G.~~E. CATEGORY OF ASSIGNMENTS:

1. Not Physician Related
   a. These events are casually related to the patient, to support care provided within the hospital, or care provided outside the hospital. Trending data from this category would not enhance or identify opportunities to improve physician-specific performance but may demonstrate trends useful for departmental or hospital wide management.
2. Within The Standard of Care
   a. These events reflect care that is within the contemporary standards of the specialty or expected standards of the department.
   b. These events reflect care that resulted in a complication and or prolonged clinical course, but the care remained within the contemporary standards of the specialty or the department.
3. Departure From The Standard of Care
   a. In each occurrence below, the physician will be notified:
      i. Minimal Variance
         a. These events reflect care that is minimally outside the contemporary standards of the specialty or expected standards of the department, and which might be to the detriment of the patient. There could be review, response or further study by the committee.
      ii. Moderate Variance
         a. These events reflect care that is clearly outside the contemporary standards of the specialty or expected standards of the department to the detriment of the patient. There must be review, response, trending, or further study by the committee.
      iii. Significant Variance
         a. These events represent gross departures from expected standards, raise immediate questions about judgment or technique and require an immediate response from the committee or department. In each occurrence, the physician will be notified.
      ~~b.~~iv. Violation of Hospital Policy ~~(~~Includes poor communication or inadequate documentation~~)~~.
      ~~c.~~v. Violation of Physician Code of Conduct ~~(~~These behavioral events will initiate an immediate response. The physician will be notified~~)~~.

~~f.~~F. APPEAL PROCESS:

1. ~~Physician~~Practitioner(s) asked for information by a reviewing committee with regard to quality events of a particular case(s) must respond within 30 days of receipt of such request. If no response is received within 30 days, the committee will make its determination without that physician(s) input.

2. If the ~~physician~~ Practitioner disagrees with the category assigned, he/she may request appeal from the committee where the assignment is made. If the appeal is not resolved to the satisfaction of the ~~physician~~Practitioner, the Medical Executive Committee shall serve as the final appeal body.
3. The Medical Staff member may review his/her file on request.
4. Quality Assurance/Performance Improvement/Patient Safety Committee ~~(whose chairman shall be a active member of the medical staff and be appointed by the chief of staff)~~ oversees and supervises all medical staff peer review activity. When a subsidiary peer review body is not performing appropriately, the Quality Assurance/Performance Improvement/Patient Safety Committee is responsible for resolving issues.
5. When the Quality Assurance/Performance Improvement/Patient Safety Committee disagrees with an assigned significance category, the case will be referred back to the Department Quality Peer Review Committee for reconsideration. If no agreement is reached, referral will be made to the Medical Executive Committee for final arbitration.
6. Any evaluation of a quality event that is not completed within six (6) months of initial review will be assessed by the Chairman of the Quality Assurance/Performance Improvement/Patient Safety Committee.

~~I. Other:~~

~~1. At the discretion of the Medical Executive Committee physicians who perform peer review functions above and beyond their basic responsibilities as members of the Medical Staff wi receive a stipend.~~ See attachment A ~~for rate.~~

References:

Medical Staff Standards, Joint Commission 2008
The compliance Guide to JC~~AHO~~ Medical Staff Standards.
Effective Peer Review A Practical Guide to Contemporary Design, 2nd Edition, Robert Marder, May 2008

Tri-City Medical Center

Attachment A

CRITERIA FOR ~~PHYSICIAN~~ PRACTITIONER PEER REVIEW
ALL RECORDS FOR ALL DIVISION/DEPARTMENTS ARE REVIEWED FOR:

GENERIC SCREENING

- Re-admission with 30 days (usually 7 days or less unless significant related event)
- Death with code, unexpected, ~~coroner's~~ Medical Examiner's case
- Patient complaints (Incident reports, patient surveys)
- Complications CVA, MI
- Delay in service, physician not being available
- Transfusion reactions, major blood loss requiring unplanned transfusion
- Drug reaction
- Unplanned transfer to ICU
- CPR
- Nosocomial infection
- Random review
- Quality Review Reports

SURGICAL CASES
(GVS, UROLOGY, OB/GYN, ORTHOPEDICS, NEUROSURGERY, SUB SPECIALITY)

- Unexpected return to OR
- Unexpected peri-operative injury
- Excessive blood loss
- Death in OR
- Wound dehiscence
- Intra-operative complication

CARDIOTHORACIC

Mortality
New renal failure requiring Dialysis
Stroke
Deep Sternal Wound Infection
Peri op MI

~~Neurosurgery~~EUROSURGERY

CNS Leak following surgery
Worsening neuro-logical symptoms following surgery
All generic sSurgical criteria

~~**(This data comes from the Cardiothoracic Clinical Outcomes Manager)**~~

ANESTHESIA

PACU stay over 4 hours
Anesthesia related event: Pneumothorax, aspiration, esophageal intubation, cardiac arrest, MI, seizure, malignant hyperthermia, transfusion reaction, neurological deficit
Death in OR or within 48 hours of surgery
Injury

EMERGENCY ROOM

Re-admission to ER within 72 hours
Patient complaints
Deaths (coded within the ED)
EMTALA concerns

OBSTETRICS

Apgar less than 4 at 5 minutes
Eclampsia
LOS over 3 days Vaginal Delivery
LOS over 5 days Cesarean Section
Injury to infant
Transfer to ICU
Stillborn or neonatal deaths greater than 2500 grams

~~PEDIATRICS~~NEONATAL

LOS over 5 days ~~pediatric patient~~
Apgar less than 5 at 5 minutes
Injury
Seizures within first 24 hours
Meconium aspiration resulting in NICU stay
Neonatal deaths over 2500 grams
Neurological deficits

Readmissions within 72 hours.

UTILIZATION REVIEW

PRO denial
Discharge planning
Referral by UR physician advisor
Admission denial
Continued stay denial

TISSUE REVIEW:

There are three broad categories into which all surgical pathology and cytophology cases will be reviewed, A, B, or C. The pathologists will assign all cases to one of these classes at the time of microscopic sign-out. The case definitions are as follows:

Group A:

Gross exam only
A diagnostic procedure for clinical workup only, (e.g. no specimen)
The tissue pathology substantiates the clinical impression and / or the operative diagnosis
The tissue pathology does not confirm or support the clinical diagnosis, but significant pathology is present to justify the surgical procedure.

Group B:

All cases with normal tissue removed as identified by the pathologist, excluding appropriate incidental organ removal.

Group C:

All cases where the pathologic findings do not appear to justify removal of tissue
All cases where the pathologic diagnosis differs from pre- or post-op diagnosis, and does not fit –under A-4.
All cases where the pre-op clinical diagnosis differs greatly from the post-op diagnosis.
The pathology findings suggest either too little or too much tissue was removed by the surgical procedure.
The tissue pathology does not support the clinical diagnosis.
The pathology and / or operative procedure warrants review for reasons other thean those stated above.

All cases falling into group ~~A,~~ B, and C will be referred to the Tissue Committee. Bases on its review of the cases, the Tissue Committee will have the option of disposing of cases at its level, or referring them back to the appropriate Divisions or departments, with a report of their findings to Tissue Committee.

PEER REVIEW SUMMARY

Most ~~physicians~~ Practitioners will have sufficient cases reviewed through the above generic screen fall out to meet credentialing requirements. Random reviews are also done to supplement those physicians who have not had enough case review generated to adequately demonstrate their management of patient care. Random reviews are also generated to intensify review of ~~physicians~~ Practitioners who have demonstrated some area of concern to

their department or division quality review committees.

Tri-City Medical Center

~~Attachment A~~

~~Stipend Schedule~~:

~~A. Judicial Review Committee will receive $150 per hour.~~
~~B. The Medical Staff Office will keep track of the hours performed and provide such documentation for payment to the involved Medical Staff member.~~

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Governance & Legislative Committee Meeting Minutes
Tri-City Healthcare District
September 1, 2015

Members Present: Larry W. Schallock, Chairperson; Director Ramona Finnila; Director RoseMarie V. Reno; Blake Kern, Community Member; Eric Burch, Community Member; Al Memmolo, Community Member; Dr. Paul Slowik, Community Member; Dr. Marcus Contardo, Physician Member; Dr. Henry Showah, Physician Member; Dr. Gene Ma, Chief of Staff

Non-Voting Members: Greg Moser, General Counsel; Jody Root, General Counsel; Tim Moran, CEO; Kapua Conley, COO; Cheryle Bernard-Shaw, CCO

Others Present: Teri Donnellan, Executive Assistant; Sherry Miller, Manager, Medical Staff Office; Esther Beverly, VP/Human Resources; Robin Iveson, Community Member; Jane Dunmeyer, League of Women Voters, James J. Dagostino, DDP, PT Board Member

Absent:

	Discussion	Action Follow-up	Person(s) Responsible
1. Call To Order/Introduction	The meeting was called to order at 12:30 p.m.in Assembly Room 3 at Tri-City Medical Center by Chairman Schallock, Committee Chairman.		
2. Approval of Agenda	**It was moved by Director Reno to approve today's agenda as presented. Dr. Slowik seconded the motion. The motion passed unanimously.**	Agenda approved.	
3. Comments from members of the public	Chairman Schallock read the Public Comments announcement as listed on today's Agenda.	Information only	
4. Ratification of prior Minutes	**It was moved by Director Reno and seconded by Dr. Slowik to ratify the minutes of the August 4, 2015 Governance & Legislative Committee. The minutes were approved unanimously.**	Minutes ratified.	
5. Old Business – a. Review and discussion of amendments to new Board Policy 15-027 Solicitation and Distribution of Literature on District Properties	In follow-up to discussion at last month's meeting, General Counsel reviewed the changes that included a policy name change to include not only distribution of literature but any goods that might be sold. Mr. Moser stated the policy as presented is consistent with the Auxiliary's "no sales" philosophy that excludes bake	Recommendation to be sent to the Board of Directors to approve Board Policy 15-027 Prohibition on Political Activities, Solicitation Distribution of Literature and Goods on District Properties; item to appear on next	Ms. Donnellan

Topic	Discussion	Action Follow-up	Person(s) Responsible
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	sales. Ms. Beverly stated she agrees that the policy includes all changes as previously recommended. **It was moved by Director Finnila to recommend approval of Board Policy 15-027 Prohibition on Political Activities, Solicitation, Distribution of Literature and Goods on District Properties. Director Reno seconded the motion. The motion passed unanimously**.	Board agenda and included in Board Agenda packet.	
b. Medical Staff Rules & Regulations 1) Division of Neurosurgery	Ms. Miller stated per the committee's direction at last month's meeting the Division of Neurosurgery Rules & Regulations were brought back to the Division and their minor revisions are included in today's agenda packet. It was noted that the Medical Quality Peer Review Committee technically does not exist until the Medical Staff Bylaws are approved and he recommends that the existing committee reference will continue until the Medical Staff and Board approve modification to the Medical Staff Bylaws. He further explained that when the modifications are approved that creates the Medical Quality Peer Review Committee and the Rules and Regulations will be amended to conform with the Bylaws. **Mr. Root stated this language appears in virtually all Rules & Regulations and the same recommendation applies to all applicable Rules & Regulations.** Dr. Contardo stated with regard to Proctoring there are at least 32 categories and 64 should be proctored. He also noted a contradiction in the language "six cases, at least two cases must be proctored for each category…" It was also suggested the number 4 be stricken on page 5 of the policy. Dr. Contardo also commented on the revisions wherein some are listed in red while others are in blue and underlined. Mr. Root also noted his concern with section VII B. related to the physician's ability to order tests by virtue	**The existing committee reference will continue until the Medical Staff and Board approve the modification to the Medical Staff Bylaws. When the modifications are approved that creates the Medical Quality Peer Review Committee and the Rules and Regulations will be amended to conform with the Bylaws.**	Medical Staff Office

Topic	Discussion	Action Follow-up	Person(s) Responsible
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	of appointment to the Medical Staff and recommended this section be removed. **Mr. Root stated this language appears in virtually all Rules & Regulations and the same recommendation applies to all applicable Rules & Regulations.** It was recommended the Division of Neurosurgery Rules and Regulations be referred back to the Division for further clarification.	**Recommendation to remove section VII B applies to all applicable Medical Staff Rules & Regulations.** Division of Neurosurgery Rules & Regulations will be sent back to the Division for clarification and brought back for review at the October committee meeting.	Medical Staff Ms. Miller/ Ms. Donnellan
2) Division of Psychiatry	Ms. Donnellan stated the Division of Psychiatry Rules & Regulations were pulled at the Board meeting due to changes that were made at the August Medical Executive Committee. It was not known at this time what the revisions were. Dr. Ma stated he would inquire as to what the "minor" revisions were made to the Rules and Regulations at the Medical Executive Committee meeting. Mr. Root also suggested that Dr. Ma discuss section XV Restraint Assessment with the Psychiatry Division and clarify due to the fact that under the hospital's restraint policies only the physician can perform the assessment.	Division of Psychiatry Rules & Regulations to be sent back to the Division for clarification and brought back for review at the October committee meeting.	Dr. Ma/ Ms. Donnellan
6. New Business a. Medical Staff Rules & Regulations 1. Allied Health Professionals	Ms. Miller stated the Allied Health Professionals Rules & Regulations are brought forward today per discussion at last month's meeting. She noted Certified Neurophysiologic Intraoperative Monitor was added as a category of privileges; however it is misspelled as written and will be corrected. Mr. Root suggested section II A. #5 be revised to strike Board Policy 14-038 as it does not apply to Allied Health Professionals. Mr. Root suggested Board Policy 14-038 Liability Insurance Requirements be placed on the agenda for next month's meeting to provide clarification as to liability insurance requirements. It was recommended section IV. A. be modified to strike the word "currently".	Allied Health Rules & Regulations will be sent back to Allied Health for review and clarification and brought back for review at the October committee meeting. Board Policy 14-038 Liability Insurance Requirements be placed on next month's agenda.	Ms. Miller/ Ms. Donnellan Ms. Donnellan

Topic	Discussion	Action Follow-up	Person(s) Responsible

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	Extensive discussion was held regarding section VII. Definition of Physician Supervision A. numbers 1-5. Dr. Contardo commented that it would be impossible to effectively monitor the various levels as listed. Ms. Miller agreed that it would be difficult to monitor and recommended the Rules and Regulations be brought back to Allied Health for discussion on this section in particular. Discussion was held regarding Midwives which was the intent of bringing the Allied Health Rules & Regulations to the Committee. Mr. Moran explained midwives are hired by North County Health Services. Mr. Moran further explained that all Allied Health Professionals are independent contractors.		
2. Department of Obstetrics & Gynecology	Chairman Schallock stated the Department of Obstetrics & Gynecology Rules & Regulations was placed on today's agenda related to Director Reno's questions regarding Midwives. Ms. Miller clarified all categories of privileges are not included however the Rules and Regulations reflects the highlights. Dr. Contardo noted this department will no longer exist as presented upon approval of the Medical Staff Bylaws and will be a Division of Women's & Children's Services. Discussion was held regarding the tracking of vaginal births after C-section for Midwives. Dr. Ma explained the screening for a vaginal birth versus C-Section is done by North County Health Services. Dr. Ma stated he will have discussion with North County Health Services and bring information back to the committee. It was noted that the Department of Obstetrics & Gynecology Rules & Regulations are not due for approval but were brought to the committee for information only at the request of the committee last month.	Information only. Upon approval of Medical Staff Bylaws, the Rules and Regulations will be modified to reflect the current Bylaws. Dr. Ma to report back on discussion with North County Health Services.	Ms. Miller Dr. Ma

Topic	Discussion	Action Follow-up	Person(s) Responsible

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3. Department of Pathology	Dr. Contardo stated the Pathology Rules & Regulations have been thoroughly reviewed and there are no substantive changes. **It was moved by Dr. Contardo to recommend approval of the Department of Pathology Rules & Regulations. Director Reno seconded the motion. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve Department of Pathology Rules & Regulations; item to appear on next Board agenda and included in Board Agenda packet.	Ms. Donnellan
b. Review of Amendments to Medical Staff Bylaws	General Counsel Mr. Jody Root stated the Bylaws contained in today's meeting packet have been approved by the Medical Staff which presents a problem due to the fact that they have not been reviewed by the Governance Committee or the Board of Directors. Mr. Root further explained that the committee cannot modify the Bylaws due to the fact that they have already been approved by the Medical Staff. He noted the approval process was accelerated to satisfy the Joint Commission however he still recommends that the committee not recommend that the Board approve the Bylaws as presented due to a number of changes that are not beneficial to the Medical Staff or the District. Mr. Root pointed out several of these provisions to the Committee. Mr. Moser explained that if the Board does not take action the Bylaws are deemed approved which is a problem and a legal issue. Mr. Root explained the Governance Committee's Charter was revised to ensure the Bylaws came to the committee for consensus prior to Board or Medical Staff approval. Dr. Ma and Ms. Miller stated they were not aware of this process and do not believe the Charter accurately reflects the approval steps. Dr. Ma stated many of the issues referred to by Mr. Root have already been addressed in the latest edition of the Bylaws and Dr. Ma was under the impression that the modified version would be presented today. Mr. Root explained and clarified that the version of the Bylaws that the Medical Staff approved is the version before us today. Dr. Ma stated he believed the amendments were editorial in nature and believed it was under his purview	Amended Bylaws to be sent out to the Medical Staff for approval. Pending approval by the Medical Staff item will be placed on the September Board agenda for Board approval.	Dr. Ma Ms. Donnellan

Topic	Discussion	Action Follow-up	Person(s) Responsible

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	as Chief of Staff to bring those amendments forward without further approval from the Medical Staff. Mr. Root disagreed and stated he believes the changes are more substantive in nature. The committee recognized the timing issue but also the need for Bylaws that accurately reflect the needs of the Medical Staff as well as the District. Mr. Moran suggested that the revisions that have been discussed by the Bylaws Committee be professionally translated into a modified set of Bylaws and be resent to the Medical Staff for consideration. Dr. Ma recognized that further work will be needed on the Bylaws; however that work will be set aside and addressed going forward. Dr. Ma agreed with this approach and will send a modified set of Bylaws with a memorandum of explanation and request a vote within thirty (30) days. Pending approval by the Medical Staff, approval of the modified Bylaws will be placed on the Board's Regular September meeting agenda.		
c. Review and discussion of Board Policy #14-042 – Duties of Board of Directors	Chairman Schallock stated Board Policy 14-042 was placed on today's agenda at the request of Director Reno to consider including reference to the fact that the Board retains responsibility for hiring General Counsel. General Counsel Mr. Moser stated Board Policy 14-023 Responsibility for Decision-Making on Legal Matters was adopted last year and speaks to the Board's responsibility in the hiring of General Counsel. Mr. Moser suggested Board Policy 14-023 be cross-referenced in Board Policy 14-042. In addition, Director Reno questioned if there is a Board Policy that provides oversight of the District's Mission Statement. Mr. Moser responded that there currently is not a policy and a policy is not legally required. Director Finnila suggested this issue be addressed at the Board's retreat. Director Reno reiterated the importance of the Board's oversight of the Mission Statement when approving a new service or program to ensure the	General Counsel to amend Board Policy 14-042 Duties of Board of Directors as described and bring back to the committee for consideration at the October meeting. The Board's role in oversight of the District's Mission Statement will be addressed at the Board's Workshop.	General Counsel Board

Topic	Discussion	Action Follow-up	Person(s) Responsible

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	program meets the mission of the District.		
d. Review and Discussion of Board Policy #14-039 Comprehensive Code of Conduct	Chairman Schallock stated Board Policy 14-039 Comprehensive Code of Conduct was placed on today's agenda at the request of Director Reno to ensure all Board members know their legal rights on a quasi-judicial matters. Mr. Moser stated the only quasi-judicial matter that the Board may be involved in would relate to the Medical Staff appeals process. Mr. Moser suggested the language in section II. 2 b. be revised to accurately explain quasi-judicial matters.	General Counsel to amend Board Policy #14-039 Comprehensive Code of Conduct as described and bring back to the committee for consideration at the October meeting.	General Counsel
e. Re-evaluation of pilot program wherein the Finance, Operations & Planning Committee agenda will post as a potential Board Meeting to allow limited participation by all Board Members	Chairman Schallock reported this item relates to a pilot program wherein Board members who are not members of the Finance, Operations & Planning Committee can attend the entirety of the committee meetings, but may not actively participate in the discussion of agenda items. Chairman Schallock explained this was a pilot program in which a statement was included on the Finance, Operations & Planning Committee agenda allowing Board members to attend the entire meeting including closed session but not participate in discussions. Director Reno stated she is in favor on continuing with this practice however Board members may need to be re-educated on their allowable level of participation. Director Finnila stated she is not a proponent to act on every contract that comes through for approval; however she feels strongly that major issues that affect the District should be brought directly to the Board so that the entire Board is given the same information at the same time. Discussion was held regarding the practice of placing the majority of Finance, Operations & Planning agenda items on the Board's Consent Agenda which may appear to minimize the importance of the agenda item. Chairman Schallock explained a Board member has the right to request any agenda item be placed under New Business rather than the Consent Agenda. Mr. Burch questioned whether it would be helpful to require agenda items of a certain dollar threshold automatically be placed under New Business. Chairman Schallock explained many	Recommendation to continue to post Finance, Operations & Planning Committee as a potential Board Meeting to allow attendance by all Board members with limited participation; item to be appear on next Board agenda and included in agenda packet.	Ms. Donnellan

Topic	Discussion	Action Follow-up	Person(s) Responsible

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	contracts that come forward to the committee have an extremely high dollar value due to the nature of the business and it would be difficult to come up with a fixed threshold. It was recommended that the Board continue with the current practice and Chairman Schallock will remind Board members to follow the rules of limited participation and adhere to the Brown Act requirements.		
7. Discussion regarding Current Legislation	There was no discussion regarding current legislation.	None.	
8. Review of FY2016 Committee Work Plan	The FY2016 Committee Work Plan was included in today's meeting packet for reference. Director Reno suggested the Work Plan be amended to reflect that the Medical Staff Bylaws are brought forward for consideration in April or May, rather than the first quarter of the year.	Work Plan will be revised as discussed.	Ms. Donnellan
9. Committee Communications	There were no committee communications.		
10. Community Openings – None	There are currently no openings on the committee.		
11. Confirm date and time of next meeting	The committee's next meeting is scheduled for Tuesday, October 6, at 12:30 p.m.		
12. Adjournment	Chairman Schallock adjourned the meeting at 2:10 p.m.		

I. MEMBERSHIP

~~———~~The Department of Pathology consists of only physicians who have a contractual relationship with the existing pathology group and are board certified by the American Board of Pathology, or who are actively progressing towards ~~recently Board-eligible~~certification.~~, may be members of the Division, except in the circumstance of special skills or other attributes offered by a candidate that are necessary for the proper functioning of the Division.~~ Physicians who are actively progressing towards ~~B~~board-certification ~~eligible~~ must attain certification within two (2) years~~, unless the Division waives this requirement. All pathologists applying for Medical Staff membership or practicing in the Division must have a contractual relationship with the existing pathology group at that time.~~

II. FUNCTIONS OF THE DEPARTMENT

The general functions of the Department of Pathology shall include: ~~Pathology Division is a member of the Department of Hospital Based Physicians. It is represented through this Department on the Medical Executive Committee. The function of the pathologists is~~ the provision of comprehensive medical direction of all aspects of the Clinical Laboratory and its branches, and the provision of ~~the provision of~~ anatomic pathology, clinical pathology, and laboratory medicine services to the patients and physicians of the Tri-City HealthCare District. ~~Additional functions of the Division as an entity include, without limitation, the diligent surveillance of the quality of care rendered to its consumers, the implementation of the Quality Improvement Plan, and the issuance of periodic recommendations to other members, officials or entities of the Medical Staff or the District to maintain or improve service levels.~~ Specific functions of the Department shall include the following:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Department and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital;

C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Department clinical practice;

D. Review and evaluate Department member adherence to:
   1. Medical Staff policies and procedures;
   2. Sound principles of clinical practice.

E. Submit written minutes to the QA/PI Committee and Medical Executive Committee concerning:
   1. Department review and evaluation activities, actions taken thereon, and the results of such actions; and
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital.

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;

H. Recommend/Request~~The Division is responsible for recommending / requesting~~ Focused Professional Practice Evaluation as indicated ~~for Medical Staff members~~ (pursuant to Medical Staff Policy 8710-509);

I. Approve On-Going Professional Practice Evaluation Indicators; and

J. Formulate recommendations for Department rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to ~~and~~ approval of the Medical Executive Committee.

~~on-going professional practice evaluation indicators.~~

III. DEPARTMENT MEETINGS

The Department~~Division~~ of Pathology shall meet at the discretion of the Chair, but at least~~no less than~~ annually. The Department~~division chief. The division~~ will consider the findings from the ongoing monitoring and evaluation of the quality, safety, and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the ~~QA/PI/PS~~ QA/PI/PS Committee, and thence to the Medical Executive Committee.

Twenty-five percent (25%) of the Active Department ~~*Division*~~ members, but not less than two (2) members, shall constitute a quorum at any meeting.

From time to time, other laboratory professionals may be invited to participate in the discussions and deliberations in a non-voting capacity.

IV. DEPARTMENT OFFICERS

~~A.~~ The Department ~~*Division*~~ of Pathology shall have a Chair ~~*Chief*~~ who shall be~~is~~ a member of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in the clinical areas covered by the Department.

~~Pathology.~~

~~B.~~ The Department Chair ~~*Division Chief*~~ shall be elected ~~by division members~~ every year by the Active members of the Department who are eligible to vote. ~~Staff Members of the *Division*. If there are vacancies of any officer for any reason, the Chair shall designate a new officer(s), or call a special election.~~ The Chair~~chief~~ shall be elected by a simple majority of the members of the Department ~~*Division*~~.

~~C.~~ The Department Chair ~~*Division Chief*~~ shall serve a one-year term, which coincides with the Medical Staff ~~medical staff~~ year unless he/~~or~~ she resigns,~~or~~ is removed from office, or loses his/~~or~~ her Medical Staff~~medical staff~~ membership or clinical privileges in the Department~~that division. *Division*~~. Department officers shall be eligible to succeed themselves.

V. DUTIES OF THE DEPARTMENT CHAIR

The Department Chair shall assume the following responsibilities:

A. Be accountable for all professional and administrative activities of the Department;

B. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Department;

C. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form;

D. Recommend to the Medical Executive Committee the criteria for clinical privileges in the Department;

E. Recommend clinical privileges for each member of the Department;
F. Assure that the quality, safety and appropriateness of patient care provided by members of the Department are monitored and evaluated; and
G. Other duties as recommended from the Medical Executive Committee.

VI. PRIVILEGES

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office.
B. By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.
C. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified.
D. Privileges shall consist of the full breadth of anatomic and clinical pathology services, including surgical pathology, cytopathology, and autopsy pathology, as well as all the disciplines of laboratory medicine.~~,~~

~~, and other developing subspecialty areas of pathology or laboratory medicine.as may be defined by the Division in the future.~~

E. The role of the individual physician with clinical privileges will be:
   1. ~~(1)~~ the expert provision of all anatomic and clinical pathology services to patients and physicians of Tri-City HealthCare District;
   2. ~~(2)~~ providing appropriate consultations to members of the Medical Staff on a timely basis; ~~(3)~~
   3. participating in suitable teaching activities and patient management conferences; and, ~~(4)~~
   4. contributing to uninterrupted on-call coverage to the District and the Medical Staff.

~~V. GRANTING OF PRIVILEGES~~

~~Specific clinical privileges will be recommended for an applicant by the Pathology Division only upon providing, in the opinion of the Division, satisfactory evidence of appropriate training and / or experience. The awarding and continued exercise of such privileges shall b based upon the scope and currency of training and experience, demonstrated competence and sound professional judgment. Such recommendations shall be made to the Medical Executive Committee and the Governing Body of the District.~~

~~VI. APPOINTMENT/ REAPPOINTMENT/PROCTORING CRITERIA~~

Privileges~~**Criteria**~~	**Initial Appointment**	**Proctoring**	**Reappointment (every 2 years)**
Anatomic Pathology~~Surgical pathology cases~~	Training ~~Training~~	**Blend of ten (10)** representative cases~~15 10~~	~~5~~ ~~3~~Ten (10) cases
Laboratory Medicine (Clinical Pathology)~~Cytopathology~~			As attested by the Department Chair or designee.

~~Postmortem examinations~~	~~Training~~	~~1~~	~~0~~
~~Fine needle aspiration interpretation~~	~~Training~~	~~2~~	~~NA~~
~~Hematopathology~~			
~~Serology~~			
~~Immunopathology~~			
~~Hematology~~			
~~Venipuncture~~			
~~Arterial puncture~~			
~~Clinical chemistry~~			
~~Clinical microbiology~~			
~~Immunohematology~~			
~~Bone marrow interpretation~~			
~~Apheresis~~			
~~Skin testing~~			

VII. REAPPOINTMENT OF CLINICAL PRIVILEGES

Privileges may be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the practitioner will be required to undergo proctoring for all procedures that were not satisfied. The practitioner will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

VIII. PROCTORING OF PRIVILEGES

A. Each Medical Staff~~*new medical staff*~~ member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated ~~—~~until his or her privilege status is established by a recommendation from the Department Chair ~~*Division*~~to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

B. ~~.~~All Active ~~*active staff*~~ members of the Department ~~*Division*~~ will act as proctors and the Department Chair will make proctoring assignments. Additional cases may be proctored as recommended by the Department Chair ~~*and the Division Chief*~~. It is the responsibility of the Department Chair to inform the monitored member whose proctoring is being continued whether the deficiencies noted are on current clinical competence, practice behavior, or the ability to perform the requested privilege(s). ~~**THE MONITOR MUST BE PRESENT FOR**~~ The monitor must be present for a sufficient period of time to assure himself/herself of the member's competence, or may review the case documentation (i.e. H&P, OP note, or vides) entirely to assure himself/herself of the practitioner's competence. ~~*will make proctoring assignments.*~~ ~~**A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE MEMBER'S COMPETENCE, OR MAY REVIEW THE CASE DOCUMENTATION (I.E., H&P, OP NOTE, OR VIDEO) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE PRACTITIONER'S COMPETENCE.**~~

~~***record* shall be *kept of these reviews. If indicated,*** the~~

C. ~~The~~ When the required number of cases has been proctored, the Department Chair ~~*Division Chief*~~ must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports. ~~*period.*~~

~~*VII. CLINICAL PRIVILEGES*~~

~~*These shall consist of the full breadth of anatomic and* clinical pathology services, including surgical pathology, cytopathology, all the disciplines of laboratory medicine, autopsy pathology, and other developing subspecialty areas of pathology or laboratory medicine as may be defined by the Division in the future.~~

~~role of the individual physician with clinical privileges will be (1) the expert provision of all anatomic and clinical pathology services to patients and physicians of Tri-City HealthCare District; (2) providing appropriate consultations to members of the Medical Staff on a timely basis; (3) participating in suitable teaching activities and patient management conferences; and, (4) contributing to uninterrupted on-call coverage to the District and the Medical Staff.~~

D. ~~The~~ A form shall be completed by the proctor, and should include comments on procedural technique, and overall impression and recommendation (i.e., qualified, needs further observation, not qualified);~~.~~

E. Blank proctoring forms ~~will be~~ are available from the Medical Staff Office;~~.~~ ~~Forms will be made available to the member.~~

F. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Office.

~~VII.~~IX. PERFORMANCE IMPROVEMENT FUNCTIONS

In selecting performance improvement monitoring priorities, high-volume, high-risk, and problem-prone diagnoses and procedures are identified and considered as the foci of more intensive review.

The current primary performance improvement foci for this service include at least the following evaluations, some of which are interdepartmental and/or interdisciplinary in nature. Additional team members are involved in the improvement process as are deemed appropriate to the process(es) being reviewed, evaluated and addressed so ~~that~~ the most knowledgeable participants related to the focus are involved in its review and improvement.

The ~~Division~~ Department will maintain at all times a Quality Improvement Plan, which complies with the requirements of applicable accrediting and licensing agencies.

Performance Measure	Function
• Malignant Diagnosis Retrospective Review	Recredentialing, Competency/Proficiency, Improving Organizational Performance
• Non-Malignant Diagnosis Retrospective Review	Recredentialing, Competency/Proficiency, Improving Organizational Performance
• Tissue Review As Determined by the Pathologist	Improving Organizational Performance, Assessment Of Patients, Regulatory Requirement, Education
• Blood Usage Review – Usage Appropriateness, Informed Consent, Utilization, Outcomes	Improving Organizational Performance, Assessment Of Patients, Regulatory Requirement, Education
• Autopsy Review – See criteria below	Regulatory Requirement, Outcomes, Education

~~VIII.~~X. AUTOPSIES

Autopsies are secured pursuant to the guidelines outlined in the Medical Staff Rules and Regulations, and Patient Care Services Policy "Autopsy, Authorization of", IV.P.4.~~The hospital pathologists attempt to secure autopsies in all cases of unusual deaths and of medical-legal, educational interest and at the request of the attending staff member. The following criteria identify deaths in which an autopsy should be encouraged:~~

~~A. Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician.~~

~~B. Deaths in which autopsy may help to allay concerns of the family and/or the public regarding the death, and to provide reassurance to them regarding same.~~

~~C. Unexpected or unexplained deaths occurring during or following any dental, medical, or surgical diagnostic procedures and/or therapies. These are performed only if the Medical Examiner waives jurisdiction~~

~~D. Deaths of patients who have participated in clinical trials (protocols) approved by institutional review boards.~~

~~E. All obstetrical deaths.~~

~~F. All pediatric deaths.~~

~~Securing an autopsy will be performed according to the Patient Care Services policy manual.~~

XI. AUTOPSY NOTIFICATION GUIDELINES

The pathologist ~~will~~shall perform the autopsy in a timely manner. Before beginning an autopsy, the attending physician and pathologist should confer to achieve a maximum interchange of knowledge and to assure optimum results from the clinical history and histological examination. The ~~attending~~ requesting physician should be present at the autopsy. The pathologist performing the autopsy ~~will~~shall notify the ~~attending~~ requesting physician when an autopsy is to be performed. As relevant to their educational need, other providers may be requested or permitted to observe the gross examination.

APPROVALS:

Department of Pathology:	08/19/2015
Medical Executive Committee:	08/24/2015
Governance Committee:	09/01/2015
Board of Directors:	

~~Postmortem examinations~~	~~Training~~	~~1~~	~~0~~
~~Fine needle aspiration interpretation~~	~~Training~~	~~2~~	~~NA~~
~~Hematopathology~~			
~~Serology~~			
~~Immunopathology~~			
~~Hematology~~			
~~Venipuncture~~			
~~Arterial puncture~~			
~~Clinical chemistry~~			
~~Clinical microbiology~~			
~~Immunohematology~~			
~~Bone marrow interpretation~~			
~~Apheresis~~			
~~Skin testing~~			

VII. REAPPOINTMENT OF CLINICAL PRIVILEGES

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VIII. PROCTORING OF PRIVILEGES

A. Each Medical Staff~~*new medical staff*~~ member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated ~~——~~until his or her privilege status is established by a recommendation from the Department Chair ~~*Division*~~to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

B. ~~.~~All Active~~——*active staff*~~ members of the Department ~~*Division*~~ will act as proctors and the Department Chair will make proctoring assignments. Additional cases may be proctored as recommended by the Department Chair ~~*and the Division Chief*~~. It is the responsibility of the Department Chair to inform the monitored member whose proctoring is being continued whether the deficiencies noted are on current clinical competence, practice behavior, or the ability to perform the requested privilege(s).

~~——**THE MONITOR MUST BE PRESENT FOR**~~ The monitor must be present for a sufficient period of time to assure himself/herself of the member's competence, or may review the case documentation (i.e. H&P, OP note, or vides) entirely to assure himself/herself of the practitioner's competence.~~*will make proctoring assignments.*~~ ~~**A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE MEMBER'S COMPETENCE, OR MAY REVIEW THE CASE DOCUMENTATION (I.E., H&P, OP NOTE, OR VIDEO) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE PRACTITIONER'S COMPETENCE.**~~

~~——***record* shall be *kept of these reviews. If indicated,*~~ the

C. ~~The~~ When the required number of cases has been proctored, the Department Chair~~*Division Chief*~~ must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports. ~~*period.*~~

~~*VII. CLINICAL PRIVILEGES*~~

~~*These shall consist of the full breadth of anatomic and* clinical pathology services, including surgical pathology, cytopathology, all the disciplines of laboratory medicine, autopsy pathology, and other developing subspecialty areas of pathology or laboratory medicine as may be defined by the Division in the future.~~

~~role of the individual physician with clinical privileges will be (1) the expert provision of all anatomic and clinical pathology services to patients and physicians of Tri-City HealthCare District; (2) providing appropriate consultations to members of the Medical Staff on a timely basis; (3) participating in suitable teaching activities and patient management conferences; and, (4) contributing to uninterrupted on-call coverage to the District and the Medical Staff.~~

D. ~~The~~ A form shall be completed by the proctor, and should include comments on procedural technique, and overall impression and recommendation (i.e., qualified, needs further observation, not qualified);~~.~~

E. Blank proctoring forms ~~will be~~ are available from the Medical Staff Office;~~.~~ ~~Forms will be made available to the member.~~

F. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Office.

~~VII.~~IX. PERFORMANCE IMPROVEMENT FUNCTIONS

In selecting performance improvement monitoring priorities, high-volume, high-risk, and problem-prone diagnoses and procedures are identified and considered as the foci of more intensive review.

The current primary performance improvement foci for this service include at least the following evaluations, some of which are interdepartmental and/or interdisciplinary in nature. Additional team members are involved in the improvement process as are deemed appropriate to the process(es) being reviewed, evaluated and addressed so ~~that~~ the most knowledgeable participants related to the focus are involved in its review and improvement.

The ~~Division~~ Department will maintain at all times a Quality Improvement Plan, which complies with the requirements of applicable accrediting and licensing agencies.

Performance Measure	Function
• Malignant Diagnosis Retrospective Review	Recredentialing, Competency/Proficiency, Improving Organizational Performance
• Non-Malignant Diagnosis Retrospective Review	Recredentialing, Competency/Proficiency, Improving Organizational Performance
• Tissue Review As Determined by the Pathologist	Improving Organizational Performance, Assessment Of Patients, Regulatory Requirement, Education
• Blood Usage Review – Usage Appropriateness, Informed Consent, Utilization, Outcomes	Improving Organizational Performance, Assessment Of Patients, Regulatory Requirement, Education
• Autopsy Review – See criteria below	Regulatory Requirement, Outcomes, Education

~~VIII.~~X. AUTOPSIES

Autopsies are secured pursuant to the guidelines outlined in the Medical Staff Rules and Regulations, and Patient Care Services Policy "Autopsy, Authorization of", IV.P.4.~~The hospital pathologists attempt to secure autopsies in all cases of unusual deaths and of medical legal, educational interest and at the request of the attending staff member. The following criteria identify deaths in which an autopsy should be encouraged:~~

~~A. Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician.~~

~~B. Deaths in which autopsy may help to allay concerns of the family and/or the public regarding the death, and to provide reassurance to them regarding same.~~

~~C. Unexpected or unexplained deaths occurring during or following any dental, medical, or surgical diagnostic procedures and/or therapies. These are performed only if the Medical Examiner waives jurisdiction~~

~~D. Deaths of patients who have participated in clinical trials (protocols) approved by institutional review boards.~~

~~E. All obstetrical deaths.~~

~~F. All pediatric deaths.~~

~~Securing an autopsy will be performed according to the Patient Care Services policy manual.~~

XI. AUTOPSY NOTIFICATION GUIDELINES

The pathologist ~~will~~shall perform the autopsy in a timely manner. Before beginning an autopsy, the attending physician and pathologist should confer to achieve a maximum interchange of knowledge and to assure optimum results from the clinical history and histological examination. The ~~attending~~ requesting physician should be present at the autopsy. The pathologist performing the autopsy ~~will~~shall notify the ~~attending~~ requesting physician when an autopsy is to be performed. As relevant to their educational need, other providers may be requested or permitted to observe the gross examination.

APPROVALS:

Department of Pathology:	08/19/2015
Medical Executive Committee:	08/24/2015
Governance Committee:	09/01/2015
Board of Directors:	

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #15-027

~~ISSUE DATE: 4/83~~ ~~SUBJECT:~~ **POLICY TITLE: Prohibition on Political Activities, Solicitation ~~and~~, Distribution of Literature and Goods on District Properties**

~~REVISION DATE: 5/88, 11/94, 9/00, 2/03, 2/05; 02/09~~ ~~POLICY NUMBER: 8610-210~~

~~Administrative Policies & Procedures Committee Approval: 02/09~~
~~Operations Team Committee Approval: 02/09~~
~~Governance Committee Approval: 03/09~~
~~Board of Directors Approval:~~

A. **PURPOSE**

1. To avoid disruption of healthcare operations or disturbance of patients, and to maintain appropriate order and discipline, any solicitations or distribution of literature or goods on Tri-City Healthcare District (TCHD) managed properties~~y~~ shall be subject to this policy. In addition, this policy prohibits political activities on premises owned or controlled by TCHD.

B. **DEFINITIONS**

1. Working areas are all areas on TCHD property except cafeteria(s), employee lounges, physicians' lounge, medical staff office and other areas reserved for the exclusive use of the medical staff. Working areas include TCHD lobbies~~,~~ and ~~TCHD~~ parking areas.
2. Working time includes the shift of both the employee doing the soliciting or distributing and the employee to whom the soliciting or distributing is directed. This does not include rest periods or meal times.

C. **POLICY**

1. Any solicitation or distribution of literature or goods within TCHD-managed properties shall be limited to non-working areas, except scheduled uses of assembly rooms, classrooms and conference rooms per Board Policy #14-043, and shall be limited to those public agencies, nonprofit organizations, associations and other groups which further the health care needs of the public within the District, and those directly related to programs and operations which are supported, sponsored by, or affiliated with the District.
2. No person, including any officer or employee of TCHD shall engage in political activity during working hours on TCHD managed properties, including the solicitation of contributions regarding candidates or ballot measures, per Government Code sections 3205, 3507 and 3209.
~~1.~~3. Any and all solicitations and/or distributions of literature or goods among TCHD staff, patients, Medical Staff or~~and~~ the public ~~or~~ on TCHD Property and facilities are subject to the following rules:
   a. Solicitation or Distribution by non-employees: Persons and organizations not employed by TCHD may not solicit or distribute literature or offer goods~~,~~ on TCHD property, at any time, without prior written approval of the Human Resources Department for purposes consistent with this policy~~, for any purpose~~ provided that members of the Medical Staff may distribute literature in non-working areas reserved for their exclusive use.
   b. Solicitation by TCHD Employees or Medical Staff or Allied Health Professionals: ~~-~~TCHD employees and members of the Medical Staff and Allied Health Professionals may not solicit at any time, for any purpose, in any working areas that may ~~would cause disruption to~~affect patient care (e.g. patient rooms, operating rooms, treatment rooms, corridors in

patient treatment areas, family meeting rooms, and consultation rooms).

c. No Solicitations for Profit; by TCHD Employees: Solicitations or distributions in any way connected with the sale of any goods or services for profit (other than directly related to medical care to be provided) is strictly prohibited at any time among TCHD staff, patients, or visitors, in any working areasplace where TCHD services are performed.

d. TCHD Employees may not distribute literature, during working time for any purpose. Employees, members of the Medical Staff and Allied Health Professionals may not distribute literature, at any time, for any purpose in TCHD working areas.

e. Notice of Intent to Solicit or Distribute Literature: TCHD requires that prior to soliciting or distributing literature for any purpose an employee who intends to engage in solicitation and or distribution of literature must identify him or herself and notify the Human Resources Department of his or her intent before engaging in such activity.

f. Educational flyers and class materials will be reviewed and approved for posting by the Director of Education and Clinical Informatics.

g. Posting on TCHD Bulletin Boards: TCHD maintains bulletin boards located throughout its facilities for communicating with its employees.

i. Postings on these boards are limited to TCHD-related material including statutory and legal notices, safety and disciplinary rules and procedures, and other TCHD items. No postings shall be permitted for any other purpose.

ii. All postings require the approval of the Human Resources Department.

~~ii.~~4. Except as authorized by Government Code section 3507, nothing in this policy shall be construed to limit the provisions of any TCHD collective bargaining agreement or labor relations policy, including provisions regulating access of employee organization officers and representatives to work locations or the use of designated bulletin boards for communications related to the scope of representation.

Reviewed by the Gov/Leg Committee: 9/1/15
Approved by the Board of Directors:

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #15-027

POLICY TITLE: Prohibition on Political Activities, Solicitation, Distribution of Literature and Goods on District Properties

A. PURPOSE

1. To avoid disruption of healthcare operations or disturbance of patients, and to maintain appropriate order and discipline, any solicitations or distribution of literature or goods on Tri-City Healthcare District (TCHD) managed properties shall be subject to this policy. In addition, this policy prohibits political activities on premises owned or controlled by TCHD.

B. DEFINITIONS

1. Working areas are all areas on TCHD property except cafeteria(s), employee lounges, physicians' lounge, medical staff office and other areas reserved for the exclusive use of the medical staff. Working areas include TCHD lobbies and parking areas.

2. Working time includes the shift of both the employee doing the soliciting or distributing and the employee to whom the soliciting or distributing is directed. This does not include rest periods or meal times.

C. POLICY

1. Any solicitation or distribution of literature or goods within TCHD-managed properties shall be limited to non-working areas, except scheduled uses of assembly rooms, classrooms and conference rooms per Board Policy #14-043, and shall be limited to those public agencies, nonprofit organizations, associations and other groups which further the health care needs of the public within the District, and those directly related to programs and operations which are supported, sponsored by, or affiliated with the District.

2. No person, including any officer or employee of TCHD shall engage in political activity during working hours on TCHD managed properties, including the solicitation of contributions regarding candidates or ballot measures, per Government Code sections 3205, 3507 and 3209.

3. Any and all solicitations and/or distribution of literature or goods among TCHD staff, patients, Medical Staff or the public on TCHD Property and facilities are subject to the following rules:

a. Solicitation or Distribution by non-employees: Persons and organizations not employed by TCHD may not solicit or distribute literature or offer goods on TCHD property, at any time, without prior written approval of the Human Resources Department for purposes consistent with this policy, provided that members of the Medical Staff may distribute literature in non-working areas reserved for their exclusive use.

b. Solicitation by TCHD Employees or Medical Staff or Allied Health Professionals: TCHD employees and members of the Medical Staff and Allied Health Professionals may not solicit at any time, for any purpose, in any working areas that may affect patient care (e.g. patient rooms, operating rooms, treatment rooms, corridors in patient treatment areas, family meeting rooms, and consultation rooms).

c. No Solicitations: Solicitation or distribution in any way connected with the sale of any goods (other than directly related to medical care to be provided) is strictly prohibited at any time among TCHD staff, patients, or visitors, in any working areas.

d. TCHD Employees may not distribute literature during working time for any purpose. Employees, members of the Medical Staff and Allied Health Professionals may not distribute literature, at any time, for any purpose in TCHD working areas.

e. Notice of Intent to Solicit or Distribute Literature: TCHD requires that prior to soliciting or distributing literature for any purpose an employee who intends to engage in solicitation and or distribution of literature must identify him or herself and notify the Human Resources Department of his or her intent before engaging in such activity.

f. Educational flyers and class materials will be reviewed and approved for posting by the Director of Education and Clinical Informatics.

g. Posting on TCHD Bulletin Boards: TCHD maintains bulletin boards located throughout its facilities for communicating with its employees.

   i. Postings on these boards are limited to TCHD-related material including statutory and legal notices, safety and disciplinary rules and procedures, and other TCHD items. No postings shall be permitted for any other purpose.

   ii. All postings require the approval of the Human Resources Department.

4. Except as authorized by Government Code section 3507, nothing in this policy shall be construed to limit the provisions of any TCHD collective bargaining agreement or labor relations policy, including provisions regulating access of employee organization officers and representatives to work locations or the use of

designated bulletin boards for communications related to the scope of representation.

Reviewed by the Gov/Leg Committee: 9/1/15
Approved by the Board of Directors:

TRI-CITY HEALTHCARE DISTRICT
MEDICAL STAFF BYLAWS
~~January, 2014~~ August 2015

1. **Deletion/Addition: BYLAWS, "DEFINITIONS"**
~~**BOARD OF DIRECTORS**~~ ***GOVERNING BODY*** means the ~~**governing body**~~ District Board of Directors of the Hospital.

2. **Addition: BYLAWS, ARTICLE II, SECTION 2.1: NATURE OF MEMBERSHIP**
No physician, dentist, or podiatrist, including those in a medical administrative position by virtue of a contract with the Hospital, shall admit or provide medical or health-related services to patients in the Hospital or ***via telemedicine*** unless he or she is a member of the Medical Staff or has been granted temporary privileges in accordance with the procedures set forth in these Bylaws

3. **Addition: BYLAWS, ARTICLE II: MEMBERSHIP, SECTION 2.1-1 (a)& (c), QUALIFICATIONS FOR MEMBERSHIP**

Only physicians, dentists, or podiatrists who:

(a) Document their (1) current licensure, (2) adequate experience, education and training, (3) current professional competence, (4) good judgment, (5) adequate physical and mental health status, ***and (6) not currently excluded from any governmental healthcare program,*** so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent and that patients treated by them can reasonable expect to receive quality medical care.

c) Maintain ~~in force~~ **current** professional liability insurance coverage at a **minimum amount of *1 million per occurrence and 3 million aggregate*** with a carrier that is approved by the California State Insurance Commission.

4. **Addition: BYLAWS, ARTICLE II, SECTION 2.5 (b), (g), (i) (k) & (n-1) BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP**
Except for the honorary staff, the ongoing responsibilities for each member of the Medical Staff include:

(b) Abiding by the Medical Staff Bylaws, Medical Staff Rules and Regulations and Medical Staff Policies and Procedures, ***and Hospital policies and procedures approved by the Medical Staff.***

(g) ***Abide by the medical staff Code of Conduct, w***orking cooperatively with ***fellow medical staff*** members, ***Allied Health Professionals***, nurses, Hospital Administration, and others and refraining from any abusive or disruptive behavior, which could adversely affect the delivery of patient care.

(i) Refusing to engage in improper inducements ***or fee splitting***, for patient referral.

(k) Participating in such emergency service coverage or consultation panels as may be determined by the Medical Staff. ***Abide by EMTALA requirements***. Additional on-call coverage may be mandated only upon majority vote of the Medical Staff.

(n) Notify the Medical Staff Office upon notification of:

(1) Any past, ~~or~~ pending, or current sanctions by the ~~Medical Board~~ ***applicable licensing/certifying entity, the DEA***, or exclusions from a federal health care program;

5. **Addition/Deletion: BYLAWS, ARTICLE II, SECTION 2.6-1, 2.6-2 & 2.6-3 HARASSMENT PROHIBITED**

~~**HARASSMENT PROHIBITED**~~ ***STANDARD OF CONDUCT***

2.6-1 As a condition of membership and privileges, a Medical Staff member shall continuously meet the requirements for professional conduct established in these Bylaws and as further described in the Medical Staff's Professional Behavior policy and Code of Conduct policy.

2.6-2 Prohibited conduct affects or could affect the quality of patient care at the hospital and includes:

(a) ~~**Harassment**~~ ***Discrimination, which is defined as conduct*** by a Medical Staff member against any individual (e.g., against another Medical Staff member, house staff, hospital employee or patient) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender or sexual orientation ~~**shall not be tolerated**~~.

(b) "Sexual harassment", ***which*** is unwelcome verbal or physical conduct of a sexual or gender-based nature, which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings or posters). ***Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates and/or perpetuates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct, which indicates that employment, and/or employment benefits are conditioned upon acquiescence in sexual activities.***

(c) ***Behavior that undermines a culture of safety (also sometimes referred to as disruptive behavior), as described in the Medical Staff's Professional Behavior policy.***

~~2.6.3 Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates and/or perpetuates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct, which indicates that employment, and/or employment benefits are conditioned upon acquiescence in sexual activities.~~

All allegations of ~~**sexual harassment**~~ ***such prohibited conduct*** shall be immediately investigated by the Medical Staff and, if confirmed, will result in appropriate corrective action, from reprimands up to and including termination of Medical Staff privileges or membership, if warranted by the facts.

6. **ADDITION/DELETION: ARTICLE III: CATEGORIES OF MEMBERSHIP, SECTION 3.3 ~~CONSULTING~~ ACTIVE AFFILIATE STAFF:**

QUALIFICATIONS:

Any member of the ***Active Affiliate*** ~~Medical~~ Staff in good standing *may* ***admit or otherwise be involved in patient care or Medical Staff activities at TCMC, documenting a minimum of twelve (12) patient contacts in two (2) year period*** ~~may consult in his or her area of expertise; however, the consulting Medical Staff~~ ***and*** shall consist of such practitioners who:

(a) Are not otherwise members of the Medical Staff and meet the general qualifications set forth in Section 2.2. ~~except that this requirement shall not preclude an out-of-state practitioner from appointment as may be permitted by law if that practitioner is otherwise deemed qualified by the Medical Executive Committee~~.

(b) ***May provide Telemedicine services.***

(c) Possess adequate clinical and professional expertise.

(d) Are willing and able to come to the Hospital on schedule or promptly respond when called to render clinical services within their area of competence.

(e) Are members in good standing of the active Medical Staff of another health care facility.

(f) Have satisfactorily completed their designated term in the provisional category.

PREROGATIVES

~~The consulting~~ Active Affiliate staff shall be entitled to:

~~(a) Exercise such clinical privileges as are granted pursuant to Article V, but shall not admit patients.~~ ***May admit patients without limitation, except as otherwise provided in the Medical Staff Rules & Regulations, or by specific privilege restriction.***

(b) Attend meetings of the Medical Staff and the department/division of which that person is a member, including open committee meetings and educational programs, but shall have no right to

vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

~~Consulting~~ ***Active Affiliate*** staff members shall not be eligible to hold office in the Medical Staff organization, but may serve committees.

7. **ADDITION/DELETION: ARTICLE III: CATEGORIES OF MEMBERSHIP, SECTION 3.4 ~~ASSOCIATE~~ REFER AND FOLLOW STAFF:**

QUALIFICATIONS

The ~~associate~~ **Refer and Follow** staff shall consist of members who:

(a) Meet the general qualifications set forth in Section 2.2; and

~~(b)~~ Are ~~part-time Hospital based physicians~~ **are practitioners who maintain membership limited to contracted administrative processes without other obligations, or have an active community office practice and routinely utilize TCMC's outpatient and inpatient referral services and wish to maintain medical staff membership status**; ~~or~~

~~(c) Provide telemedicine services only; or~~

~~(d) Are physicians, dentists, or podiatrists who infrequently work for Medical Staff members. Physicians who regularly admit or treat patients on an ongoing basis at this medical center, as a part of the private medical practice, shall not be eligible for this status; or~~

~~(e) Are physicians functioning only as surgical assistants. The surgical assistants may not admit patients or write orders.~~

~~(f) Have satisfactorily completed appointment in the provisional staff category. Dues may be waived for associate staff members at the discretion of the Medical Executive Committee. Associate staff members are not required to attend meetings nor participate in emergency service coverage. However, such members are welcome to attend Medical Staff meetings in a non-voting capacity.~~

PREROGATIVES

(a) Refer and Follow staff members do not have privileges and are therefore exempt from the requirement to maintain malpractice insurance;

(b) Will be responsible to pay any annual or reappointment fees.

(c) Has "view only" access to their patient's Health information record, however, will not be allowed to enter orders in the patient's health record.

(d) Shall not nominate, vote on any matters presented at general or special meeting of the Medical Staff or any Committee or the Department of which they are members.

(e) May attend a General meeting of the Medical Staff and Department of which they are appointed and any Educational program offerings.

8. **DELETION: ARTICLE III: CATEGORIES OF MEMBERSHIP, SECTION 3.5 COURTESY STAFF:**

~~QUALIFICATIONS~~

~~The courtesy staff shall consist of members who:~~

~~(a) Meet the general qualifications set forth in Section 2.2.~~

~~(b) Are involved in not more than 12 patient care activities including admissions, assisting in surgeries, consultations, or other patient care procedures but at least two (2) patient care and/or Medical Staff activities as defined in Section 3.2-1 (c) per year.~~

~~(c) Are members in good standing of the active Medical Staff of another health care facility.~~

~~(d) Have successfully completed their designated term in the provisional staff category.~~

~~PREROGATIVES~~

~~Except as otherwise provided, the courtesy Medical Staff member shall be entitled to:~~

~~(a) Participate in the care of patients within the limitations of Section 3.5-1 (b) and exercise such clinical privileges as are granted pursuant to Article V.~~

~~(b) Attend, in a non-voting capacity, meetings of the Medical Staff and the department/division of which he or she is a member, including open committee meetings and education programs.~~

~~(c) Serve on the Emergency Call panel at the discretion of the Department Chair or Division Chief.~~

~~Courtesy staff members shall not be eligible to hold office in the Medical Staff.~~

~~LIMITATION~~

~~Courtesy staff members who admit or regularly care for more than twelve patients in a Medical Staff year shall, upon review of the Medical Executive Committee, be obligated to seek appointment to the appropriate staff category~~.

9. **ADDITION: ARTICLE III: CATEGORIES OF MEMBERSHIP, SECTION 3.6 PROVISIONAL STAFF, 3.6-4 TERM OF PROVISIONAL STAFF STATUS & 3.6-2 PREROGATIVES:**

TERM OF PROVISIONAL STAFF STATUS

A member shall be eligible to request advancement from provisional staff after a minimum period of six (6) months if the member's proctoring is fully completed. Otherwise, a member shall remain in the provisional staff for a period of 24 months unless that status is extended by the Medical Executive Committee upon determination of good cause, which determination shall not be subject to review pursuant to Articles VI or VII.

10. **DELETION: ARTICLE III: CATEGORIES OF MEMBERSHIP, SECTION 3.8 ADMINISTRATIVE STAFF**

~~QUALIFICATIONS~~

~~Administrative staff category membership shall be held by any physician who is not otherwise eligible for another category of membership and who is retained by the Medical Staff or hospital solely to perform ongoing medical administrative activities.~~

~~The administrative staff shall consist of members who:~~

~~(a) Are charged with assisting the Medical Staff in carrying out medical-administrative functions, including but not limited to quality assessment, quality improvement, and utilization review;~~

(b) ~~Document their (1) current licensure, (2) adequate experience, education and training, (3) current professional competence, (4) good judgment, and (5) current physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent to exercise their duties;~~

(c) ~~Are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect their judgment in carrying out the medical-administrative functions, and (3) to be willing to participate in and properly discharge those responsibilities determined by the Medical Staff.~~

~~**PREROGATIVES**~~

~~The administrative staff shall be entitled to attend meetings of the Medical Staff and various departments/divisions, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except to the extent the right to vote is specified at the time of appointment.~~

~~Administrative staff members shall not be eligible to (1) hold office in the Medical Staff organization, (2) admit patients, (3) exercise clinical privileges, (4) appeal rights, hearings, and appellate reviews. They shall not be required to carry professional liability insurance in connection with their activities for the Medical Staff or hospital. Medical staff dues shall be reduced by one-half for this category of membership~~.

11. **DELETION: ARTICLE III: CATEGORIES OF MEMBERSHIP, SECTION 3.9 TEMPORARY STAFF**

~~**QUALIFICATIONS**~~

~~The temporary staff shall consist of physicians, dentists and podiatrists who do not actively practice at the Hospital but are important resource individuals for Medical Staff quality assurance or patient care activities. Such persons shall be qualified to perform the functions for which they are made temporary members of the staff.~~

~~**PREROGATIVES**~~

~~Temporary Medical Staff members who are appointed to engage in quality assurance activities, Focused Practitioner Performance Review and or related functions without clinical privileges shall be entitled to attend all meetings of committees to which they have been appointed for the limited purpose of carrying out quality assurance functions. They shall have no privileges to perform clinical services in the Hospital. They may not admit patients to the hospital, or hold office in the Medical Staff organization. They may, however, serve on designated committees with or without vote at the discretion of the Medical Executive Committee. They may attend other Medical Staff meetings upon invitation.~~

12. **DELETION: ARTICLE III: CATEGORIES OF MEMBERSHIP, SECTION 3.10 AFFILIATE STAFF**

~~**QUALIFICATIONS**~~

~~**The Affiliate Staff shall consist of members who:**~~

~~(a) The affiliate staff shall consist of physicians, dentists, or podiatrists who do not actively practice at the hospital but are an important resource for the Medical Staff.~~

~~**PREROGATIVES**~~

~~**The Affiliate Staff member shall:**~~

~~**(a) Are not eligible to admit patients to the hospital or to exercise clinical privileges in the hospital, or to vote or hold office in the Medical Staff organization, but they may serve upon committees with or without vote at the discretion of the Medical Executive Committee. They may attend staff and department/division meetings, including open committee meetings and educational programs.**~~

~~(b) Shall pay dues.~~

~~(c) Will not have any hearing or appeal rights.~~

~~(d) Not be subject to the requirement for Provisional Staff term described in Section 3.6 of these Bylaws.~~

13. **ADDITION: ARTICLE IV, MEMBERSHIP & MEMBERSHIP RENEWAL, SECTION 4.1, GENERAL**

Except as otherwise specified herein, no person (including persons engaged by the Hospital in administratively responsible positions) shall exercise clinical privileges in the ~~Hospital~~ ***Medical Center or via telemedicine*** unless and until he or she applies for and obtains membership on the Medical Staff or is granted temporary privileges as set forth in these Bylaws.

14. **ADDITION: ARTICLE IV, MEMBERSHIP & MEMBERSHIP RENEWAL, SECTION 4.5-2 (j), EFFECT ON APPLICATION**

(j) Recognizes that applicant has no procedural rights in connection with an application ~~rejected~~ ***deemed voluntarily withdrawn*** for incompleteness.

15. **ADDITION/DELETION: ARTICLE IV, MEMBERSHIP & MEMBERSHIP RENEWAL, SECTION 4.5-3, VERIFICATION OF INFORMATION**

The applicant shall deliver a completed application to the ~~Chief Executive Officer or~~ Medical Staff office with payment of application fee, if any is required. The ***medical staff office*** Credentials ***Coordinator*** ~~Committee~~ shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. If all references and other information required to process the application are not received within ninety (90) days from the date application was first submitted, the application is automatically deemed to be incomplete and ~~**rejected**~~ ***deemed voluntarily withdrawn*** for that reason.

16. **ADDITION/DELETION: ARTICLE IV, MEMBERSHIP & MEMBERSHIP REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES, SECTION 4.6-3, STANDARDS AND PROCEDURE FOR REVIEW**

When a staff member submits ~~the first application for membersip renewal, and every two years thereafter~~ ***an application for reappointment***, or when the member submits an application for modification of staff status or clinical privileges, the member shall be subject to an in depth review, generally following the procedures set forth in Section 4.5-3 through Section 4.5-11. ~~If an Active Staff or a Courtesy Staff member had no Hospital activity during the two-years preceding membership renewal and, therefore, has no basis on which professional performance can be reviewed, he or she shall be recommended for renewal of membership to the Affiliate Staff~~.

17. **DELETION: ARTICLE VI, SECTION 4.6.4, EXTENSION OF MEMBERSHIP**

~~**If it appears that an application for membership renewal will not be fully processed by the expiration date of the member's membership, for reasons other than due to the re-applicant's failure to return documents or otherwise timely cooperate in the membership renewal process, the Medical Executive Committee and the Board of Directors (or its duly appointed committee in expedited cases) shall approve a time and member specific extension of the member's status and clinical privileges. With respect to such delays not caused by the staff member, if for any reasons the Medical Executive Committee and/or Board of Directors (or its duly appointed committee in cases eligible for expedited processing) fails to approve an extension or the extension time runs out prior to completion of membership renewal procedures, the member's membership and privileges shall be temporarily re granted without interruption until processing of the reapplication is completed. Any extension of membership pursuant to this Section does not create a vested right in the member for continued membership throughout the entire next term but only until such time as processing of the application is concluded. The member shall continue to be subject to the reapplication review process as outlined in Sections 4.5-3 through 4.5-11. Failure by the member to timely complete and return the membership renewal application form or provide other documentation or cooperation will result in termination of the members membership**~~.

18. **ADDITION/DELETION: ARTICLE IV, MEMBERSHIP & MEMBERSHIP REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES, SECTION 4.6-5, FAILURE TO FILE MEMBERSHIP RENEWAL APPLICATION**

Failure without good cause to timely file a completed application for renewal of membership shall result in the ~~**automatic suspension of the member's admitting privileges and expiration of other practice privileges and prerogatives at the end of the current staff membership, unless otherwise extended by the Medical Executive Committee with the approval of the Board of Directors. If the member fails to submit a completed application for membership renewal within 30 days past the date it was due, the**~~ member ~~**shall be**~~ ***being*** deemed to have resigned membership ***and privileges*** ~~***in the Medical Staff***~~ ***as of the end of the current staff membership***. In the event membership ***and privileges*** terminate for the reasons set forth herein, the procedures set forth in Article VII shall not apply.

19. **ADDITION/DELETION, ARTICLE V: CLINICAL PRIVILEGES, SECTION 5.1, EXERCISE OF PRIVILEGES**

Except as otherwise provided in these Bylaws, a member providing clinical services at this ~~Hospital~~ ***Medical Center or via telemedicine*** shall be entitled to exercise only those clinical privileges specifically granted.

20. **DELETION, ARTICLE V: CLINICAL PRIVILEGES, SECTION 5.3-3, MEDICAL STAFF ADVANCEMENT**

~~**The failure to obtain certification for any specific clinical privilege shall not, of itself, preclude advancement in Medical Staff category of any member. If such advancement is granted absent such certification, continued proctorship on the uncertified procedure shall continue for the specified period of time. Refer to Medical Staff Policy, *Focused Professional Practice Evaluation/Proctoring, 8710-542.***~~

21. **ADDITION/DELETION, ARTICLE V: CLINICAL PRIVILEGES, SECTION 5.5(b), TEMPORARY CLINICAL PRIVILEGES, LOCUM TENENS**

(b) Locum Tenens

Following the procedures in Section 5.5 temporary privileges may be granted to a person serving as a locum tenens for a current member of the Medical Staff. Such person may attend only patients of the member(s) for whom he or she is providing coverage. Such privileges shall be granted for a period not to exceed sixty (60) days, unless the Medical Executive Committee recommends a longer period for good cause ***not to exceed beyond 120 days***. ~~The locum tenens physician must apply for the appropriate category of staff membership if a longer period of coverage is requested.~~

22. **ADDITION/DELETION, ARTICLE V: CLINICAL PRIVILEGES, SECTION 5.5-4 (a)-(1) & (2), TEMPORARY CLINICAL PRIVILEGES, APPLICATION AND REVIEW**

(a)-(1) ~~**With respect to applications by locum tenens, or to fulfill an important patient care need**~~, after verification of current licensure and current competence;

(a)-(2) ~~**With respect to a new applicant awaiting review and approval of the Medical Executive Committee and the governing board in compliance with requirements in section 5.5-2, after the following has been completed**~~:

23. **DELETION, ARTICLE VI: EVALUATION AND CORRECTIVE ACTION, SECTION 6.1-3, REVIEW OF MEMBERS**

All members and privilege holders ~~**not otherwise subject to initial review**~~ are reviewed for compliance with the relevant department peer review criteria on an ongoing basis.

24. **DELETION, ARTICLE VI: EVALUATION AND CORRECTIVE ACTION, SECTION 6.1-5 (a), EXTERNAL REVIEW**

(a) Committee or department review(s) that could affect an individual's membership or privileges do not provide a sufficiently clear basis for action ***or are not reasonably supported by the facts or evidence of the matters or cases being reviewed***;

25. **DELETION/ADDITION, ARTICLE VI: SUMMARY RESTRICTION OR SUSPENSION 6.3-1 CRITERIA FOR INITIATION**

Whenever a member's conduct ~~**or physical condition, including but not limited to temporary impairment due to the consumption of alcohol or chemicals, appears to require that immediate action be taken to protect the life or well being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, or safety of any patient, prospective patient, or other person**~~ ***is such that failure to take action may result in an imminent danger to the health of any individual***, the Chief of ~~**the medical**~~ Staff, the Chief of Staff-elect ~~**of the medical staff**~~, ~~**or**~~ the Immediate Past Chief of Staff ~~**of the medical staff**~~, ***or the*** Chair of ***the applicable*** Department together with either a member of the Board of Directors or the Chief Executive Officer acting in his capacity as an agent of the Board of Directors or the Chief Executive Office acting in his capacity as an agent of the Board of Directors, shall conjointly have the authority to summarily restrict or suspend the Medical Staff privileges of a member and such summary suspension shall become effective immediately upon imposition.

26. **ADDITION: ARTICLE VI, SECTION 6.4-1 (d) LICENSURE AUTOMATIC SUSPENSION OR LIMITATION**

(d) Expiration: Whenever a member's license is expired or evidence of renewal has not been received, the member shall be automatically suspended until such time as evidence of current licensure is received.

27. **ADDITION: ARTICLE VI, SECTION 6.4-2 (c) LICENSURE AUTOMATIC SUSPENSION OR LIMITATION**

(c) ***Expiration: Whenever a member's DEA certificate is expired or evidence of renewal has not been received, the member's right to prescribe such medication shall automatically be suspended until such time as evidence of current DEA certificate is received.***

28. **ADDITION/DELETION: ARTICLE VI, SECTION 6.4-7 EXCLUSION FROM GOVERNMENTAL HEALTHCARE PROGRAM**

In the event a member is excluded from participation in a government healthcare program, the member shall be automatically suspended. Such suspension shall remain in place until the member submits a plan, acceptable to the Medical Executive Committee and the Board of Directors, which permits the member to exercise privileges without subjecting the hospital to sanctions or denial of payment. Failure to submit an acceptable plan within ninety (90) days after written notice of suspension shall result in automatic termination.

29. **DELETION: ARTICLE VII: HEARINGS AND APPELLATE REVIEWS, SECTION 7.2 (d), GROUNDS FOR A HEARING**

(d) ~~**Demotion to lower Medical Staff category**~~.

30. **DELETION: ARTICLE VIII: OFFICERS, SECTION 8.6-1 (i), DUTIES OF OFFICERS, CHIEF OF STAFF**

(i) Relieving any staff member, which he has appointed to a committee position for any reason; ~~**and shall supervise the professional work in the Hospital**~~

31. **ADDITION/DELETION: ARTICLE XI, SECTION 9.2 CURRENT DEPARTMENT AND DIVISIONS**

(c) Department of Emergency Medicine
~~(2) Occupational Medicine Division~~

(d) Department of Medicine
~~**(2) Dermatology & Allergy Division**~~

(e) ~~**Department of Obstetrics Gynecology**~~ ***Women & Children***
(1) OBGYN
(2) Pediatrics & Neonatology

(g) ~~**Department of Pediatrics**~~
~~**(1) Neonatology**~~

32. ADDITION/DELETION: ARTICLE XI, SECTION 9.4 (a), (g) & (h) FUNCTIONS OF DEPARTMENTS

(a) Conducting ***timely*** patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. The department shall routinely collect information about important aspects of patient care provided in the department, periodically ***and timely*** access this information, and develop objective criteria for use in evaluating patient care.

(g) Submitting ***timely*** minutes to the Quality Assurance/Performance Improvement and Medical Executive Committees concerning:

(h) For departments with more than one division, the division chiefs shall meet as often as necessary, ~~**but at least quarterly**~~, with the department chairman.

33. ADDITION: ARTICLE XI, SECTION 9.5 FUNCTIONS OF DIVISIONS

No such rule or regulation shall become effective until approved by the appropriate department ***chief (or, by majority vote, the department chiefs may elect to require voting on proposed division rules and regulations by all eligible members of the applicable department)***, the Medical Executive Committee and the Board of Directors.

34. **REVISION: ARTICLE XI, SECTION 9.6-3 TERM OF OFFICE**

Each department chairman and vice chairman shall serve a ~~**one (1)**~~ ***two (2)*** year term which coincides with the Medical Staff year unless they shall sooner resign....

35. **ADDITION: ARTICLE XI, SECTION 9.6-5 (d) DUTIES**

Develop and implement departmental programs for ***timely & effective*** retrospective patient care review, on-going monitoring practice, credentials review and privilege delineation.....

36. **REVISION: ARTICLE XI, SECTION 9.7-3 TERM OF OFFICE**
Each division chief shall serve a ~~one~~ *two (2)* year term that coincides with the Medical Staff year or until his or her successor is chosen, unless he or she shall sooner resign or be removed from office…..

37. **ADDITION: ARTICLE XI, SECTION 9.8 MEMBER-AT-LARGE, JOB DESCRIPTION**
QUALIFICATIONS
Member-at-Large will be a member of the Active Medical Staff, meet all requirements for medical staff membership and be a member in good standing.

SELECTIONS
Each Member-At-Large will be elected by a majority vote of the medical staff members. If there is a vacancy due to any reason, the MEC shall designate a new member-at-large to serve the remaining term, or call a special election.

TERM OF OFFICE
Each Member- At-Large shall serve a one-year term that coincides with the Medical Staff year or until his or her successor is chosen, unless he or she shall sooner resign or be removed from office or lose Medical Staff membership or clinical privileges.

REMOVAL
After election, a Member-At-Large may be removed by the Chief of Staff, for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude with ratification by the Medical Executive Committee.

DUTIES
Each Member-At Large shall:
(a) ***Attend the Medical Executive Committee Meetings***
(b) ***Perform such other duties as may be delegated by the Chief of Staff/MEC***

38 **ADDITION: ARTICLE X, SECTION 10.2-1 TERM OF COMMITTEE**
Committee members may serve consecutive terms.

39. **ADDITION/DELETION: ARTICLE X, SECTION 10.2-3 VACANCIES**
Unless otherwise specifically provided, vacancies on any committee ~~**shall**~~ may be filled ~~**in the same manner in which an original appointment to such committee is made; provided, however, that if an individual who obtains membership by virtue of these Bylaws is removed for cause, a successor may be selected**~~ by the Chief of Staff ***or designee***.

40. **ADDITION/DELETION: ARTICLE X, SECTION 10.3 -1 (MEC) COMPOSITION**
~~**Members of the Medical Executive Committee cannot serve in more than one capacity**~~.
~~**Regular**~~ ***Ex-Officio*** attendees of the Medical Executive Committee, without vote, shall be as follows:

41. **ADDITION/DELETION: ARTICLE X, SECTION 10.5 -1 (BIOETHICS) COMPOSITION**

The Bioethics Committee ***shall be chaired by a member of the medical staff, and*** shall consist of physicians and such other staff members as the Medical Executive Committee may deemed appropriate.

42. **ADDITION/DELETION: ARTICLE X, SECTION 10.8-1 & 10.8-3 (CANCER COMMITTEE) COMPOSITION & MEETINGS**

10.8-1 COMPOSITION

Others may be appointed as the Medical Executive Committee or its designee may deem appropriate, ~~**which may include a dietary/nutrition specialist, pharmacist pastoral care representative, and American Cancer Society representative**~~ ***and in conformance with the membership requirements of the American College of Surgeons' Commission on Cancer.*** To assure continuity and to facilitate planning, the members shall be appointed to serve for a period of three (3) years ***and may serve consecutive terms.***

10.8-3 MEETINGS

The committee shall meet at least quarterly ~~**for the purpose of policy decisions and for patient care evaluation.**~~

43. **ADDITION/DELETION: ARTICLE X, SECTION 10.9-1 (CONTINUING MEDICAL EDUCATION COMMITTEE) COMPOSITION**

The committee shall consist of at least five (5) members of the Medical Staff. The members and chairman ~~**shall**~~ ***may*** be appointed by the Chief of Staff for a term of three (3) years. Two (2) members ~~**shall**~~ ***may*** be replaced annually. ~~**The Mission of Tri-City Medical Center's Continuing Medical Education Program is to provide quality educational opportunities that enhance the knowledge base and clinical competency of practicing teaching, and research physician affiliated with Tri-City Medical Center, thus enabling physicians to practice more effectively and efficiently in today's healthcare environment.**~~

44. **ADDITION/DELETION: ARTICLE X, SECTION 10.18-1 (PHARMACY & THERAPEUTICS COMMITTEE) COMPOSITION**

The committee shall consist of at least ~~**one**~~ ***five (5)*** members ~~**from each department**~~ of the Medical Staff, one or more members from ……..

45. **ADDITION/DELETION: ARTICLE X, SECTION 10.19 (~~PHYSICIANS'~~ PRACTITIONERS' WELLBEING COMMITTEE) COMPOSITION, OBJECTIVES, COMPOSITION & FUNCTIONS**

~~**The committee's purpose is to assure that patients being treated at Tri-City Medical Center will, as much as humanly possible, not be under the jeopardy of an impaired members; and further, to assure that an impaired member will be no danger to himself and to make every attempt to encourage and support his or her recovery.**~~

~~**The purpose of this committee is to establish guidelines and strategies for providing assistance for those members who are experiencing problems, which might impair their function and the function of their families. Experience of medical staffs and societies indicates that these dysfunctions may involve the abuse of mood altering chemicals, including alcohol, and psychiatric or physical disorders of members.**~~

~~**The committee will provide strategies, which are most efficacious in working with these members and their families. Medical doctors must identify, in a timely**~~

~~manner, cases of member dysfunction in order for the committee to intervene early and assist the member's return to an appropriate level of practice.~~ *The Medical Staff recognizes its obligation to protect patients, its members, and other persons in the hospital from harm. This Committee is designed to provide education about member health; address prevention of physical, psychiatric, or emotional illness; and facilitate confidential diagnosis, treatment, and rehabilitation of members who suffer from a potentially impairing condition. The purpose of the process is to facilitate the rehabilitation by assisting a member to retain and to regain optimal professional functioning consistent with the protection of patients. If at any time during the diagnosis, treatment, or rehabilitation phase of the process it is determined that a member is unable to safely perform the privileges granted, the matter is forwarded for appropriate corrective action.*

~~**OBJECTIVES**~~

~~**The objectives of the committee are to:**~~

~~(a) **Identify and verify the dysfunctional member while assuring maximum confidentiality. Confidentiality of any informant will be maintained, and any retaliation will not be tolerated (refer to Policy 511.1)**~~

~~(b) **Motivate him or her to voluntarily enter treatment.**~~

~~(c) **Refer him or her to bthe best equipped facilities, organizations, and services to give them the best chance for recovery and maintenance of recovery.**~~

~~(d) **Assume an advocacy role on his or her behalf**~~

~~(e) **Aid his or her re-entry into professional activities after the recover from various sources.**~~

~~(f) **Provide the means of protecting (1) the member's patients, (2) his or her medical colleagues, (3) the member's family, and (4) the member himself from the consequences of non-treatment, incomplete treatment, or the failure of perfectly adequate treatment but inadequate recovery. The member's genuine desire to maintain recover for the rest ofhis or her professional life is vitally necessary.**~~

COMPOSITION

The committee will consist of ***at*** *least* four **(4)** ~~**to six (6)**~~ members of the Medical Staff who are ~~**not only**~~ well read and well versed in the problems of the well-being of members, ~~**but who are also willing to execute discipline at the request of the Medical Executive Committee. They must assure ongoing help to the impaired colleague after the execution of this discipline**~~.

FUNCTIONS

The committee's functions are to:

~~**(a) Inform the impaired member, as well as the Medical Staff, of the availability of various facilities, organizations, and services that have the best personal and equipment to help recover and maintain recovery of the impared colleagues.**~~ ***Educate members and hospital staff about illness and impairment recognition issues specific to members.***

~~***(b) Establish an effective outreach program, which will include a plan of education regarding problems of member dysfunction.***~~ ***Receive self-referrals by members.***

(c) Verify reported problems suggesting member dysfunction, make assessments of the validity of evidence, and as directed by the Well-Being Committee Chairman, report

those findings to the Medical Executive Committee at least on a quarterly basis. *Receive referrals by others and maintain informant confidentiality.*

(d) ~~Assure the protection of the public at large, as well as the impaired members. This will be done by making appropriate recommendations to the Medical Executive Committee.~~ *Refer members to appropriate professional internal or external resources for evaluation, diagnosis, and treatment of the condition or concern.*

(e) *Evaluate the credibility of a complaint, allegation, or concern.*

(f) Monitor the member and the safety of patients until the rehabilitation is complete and periodically thereafter, if required.

(g) Report to the Medical Executive Committee instances in which a member is providing unsafe treatment.

(h) Initiate appropriate actions when a member fails to complete the required program.

46. **REVISION: ARTICLE X, SECTION 10.20-1 MEDICAL QUALITY ~~ASSURANCE/ PERFORMANCE IMPROVEMENT~~ PEER REVIEW COMMITTEE) COMPOSITION**

COMPOSITION

The committee shall consist of a physician chairman, selected by the Chief of Staff; and a member and an alternate member elected by each department. The alternate member shall attend ~~Quality Assurance/Performance Improvement/Patient Safety~~ Medical Quality Peer Review Committee meetings in the member's absence. All department chairmen, Medical Staff committee chairmen, and the Director of Patient Care Review will be asked to attend and participate in committee functions when appropriate and will serve in an ad hoc capacity.

With the approval of the Chief of Staff, up to two additional physicians may be appointed by the committee chair to promote committee priorities. The Chief of Staff shall have the authority to remove the chairman and appoint a new chairman prior to expiration of the one (1) year term, subject to approval of the Medical Executive Committee.

DUTIES

The ~~Quality Assurance/Performance Improvement/Patient Safety~~ Medical Quality Peer Review Committee shall perform the following duties:

(a) Accept responsibility and accountability for that portion of the overall quality assurance/performance improvement program developed by the Board of Directors and Administration, which is related to the Medical Staff including but not limited to, evaluation of the accuracy, timeliness and completion of medical records.

(b) Recommend plans for improving and sustaining quality patient care on an ongoing basis within the Hospital to the Medical Executive Committee for approval. These may include mechanisms to:

(1) ~~Establish systems to identify~~ Evaluate opportunities for improvement in patient care and patient safety (medical errors).

(2) ~~Set~~ Evaluate priorities for action on opportunities for improvement.

(3) Refer opportunities for improvement for assessment and for corrective action to appropriate departments, divisions, or committees.

(4) ~~Track and analyze~~ Evaluate the results of quality assurance, performance improvement, safety activities, and patient satisfaction throughout the Hospital to show measurable improvement in health outcomes, decreases in medical errors and to ensure sustained improvements.

(5) Review and track medical errors and adverse patient events. Causal factors related to the Medical Staff are referred per # 3.

(6) Review and evaluate the activities of subcommittees for department and division quality review and hospital-wide quality assessment and performance improvement activities, directly or through its subcommittee(s).

(7) ~~Coordinate~~ Evaluate the quality assurance/performance improvement/patient safety activities on an annual basis to assure they are in proportion with the scope and complexity of the Hospital's Services.

(c) Submit regular confidential reports to the Medical Executive Committee on the quality of medical care provided and on quality review activities conducted.

(d) Delegate specific responsibilities to and Rreceive reports ~~of~~ from the Quality Assessment/Performance Improvement ~~Outcomes~~ Committee~~,~~. ~~a subcommittee of the QA/PI Committee with representation from medical staff, nursing, ancillary, and administration as determined by the QA/PI Chair in consultation with the Chief of Staff, and with specific responsibilities as delegated by the QA/PI Committee.~~

MEETINGS

The committee shall meet as often as necessary at the call of its chairman, but at least ten times annually. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Executive Committee and Board of Directors, except that routine reports to the Board shall not include Focused Practitioner Performance Review evaluations related to individual Medical Staff members.

47. ADDITION: ARTICLE X, SECTION 10.20-2 QUALITY ASSURANCE/ PERFORMANCE IMPROVEMENT COMMITTEE)

COMPOSITION

The committee shall consist of the Medical Peer Review Committee physician chairman with representation from medical staff, nursing, ancillary, and administration as determined by the Medical Quality Peer Review Committee Chair in consultation with the Chief of Staff.

DUTIES

The Quality Assurance/Performance Improvement (QA/PI) Committee shall perform the following duties:

(a) **Recommend plans for improving and sustaining quality patient care on an ongoing basis within the Hospital to the Medical Quality Peer Review Committee for approval. These may include mechanisms to:**

1) **Establish systems to identify opportunities for improvement in patient care and patient safety (medical errors).**

2) **Set priorities for action on opportunities for improvement.**

3) **Refer opportunities for improvement.**

4) **Track, analyze and submit the results of quality assurance, performance improvement, safety activities, and patient satisfaction throughout the Hospital to show measurable improvement in health outcomes, decreases in medical errors and to ensure sustained improvements.**

5) **Review adverse patient events.**

6) **Coordinate quality assurance/performance improvement/patient safety activities on an annual basis to assure they are in proportion with the scope and complexity of the Hospital's Services.**

7) **Accept specific responsibilities as delegated by the Medical Quality Peer Review Committee.**

(b) **Submit regular confidential reports to the Medical Quality Peer Review Committee on quality review activities conducted.**

MEETINGS
The committee shall meet as often as necessary at the call of its chairman, but at least ten times annually. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Quality Peer Review Committee.

48. **ADDITION/DELETION: ARTICLE X, SECTION 10.23-1 INTERDISCIPLINARY PRACTICE COMMITTEE) COMPOSITION**
The committee shall ~~**consist of**~~ ***include as a minimum*** the chairman, the Chief Nursing Officer ~~Executive~~ , ***the administrator or*** designee, and an equal number of physicians appointed by the Chief of Staff and ***registered*** nurses appointed by the Chief Nursing Officer ~~**Executive**~~. Additionally, licensed or certified health professionals other than registered nurses who are performing functions requiring standardized procedures may be appointed by the Chief of Staff or his designee.

49. **ADDITION/DELETION: ARTICLE XI, SECTION 11.2-2 (a), (QUORUM)**
Definition of a Quorum
~~**Twenty-five percent (25%) of the active Medical Staff members of the committee or department, but not less than two members, shall constitute a quorum at any meeting.**~~

At special meetings of the Medical Staff and at the General Medical Staff meetings, fifty-one percent (51%) of those Active members present shall constitute a quorum to vote on an action item. Quorum requirements for the MEC and QAPI Committee shall require at least 51% of voting members to vote on an action. Quorum requirement for all other medical staff meeting shall be recognized when at least 3 voting members are present tovote on an action item.

50. ***ADDITION: ARTICLE XI, SECTION 11.2-6 RIGHTS OF EX-OFFICIO MEMBERS***
Except as otherwise provided in these Bylaws, persons serving as ex-officio members of a Committee shall have all right and privileges of regular members therefore, except they shall not vote or be counted in determining a quorum.

51. ***ADDITION/DELETION: ARTICLE XIV: ADOPTION AND AMENDMENT OF BYLAWS***
SECTION 14.1, PROCEDURE AND SECTION 14.2, ACTION OF BYLAW CHANGE
PROCEDURE
Upon the request of the ***Bylaws Committee***, the Chief of Staff, ***and*** the Medical Executive Committee, ~~**the Bylaws Committee**~~, or upon timely written petition signed by at least 10% of the members of the Medical Staff in good standing who are entitled to vote at Medical Staff meetings, consideration will be given to the ***recommendation to the Board regarding the*** adoption, amendment, or repeal of these Bylaws. Such adoption, amendment, or repeal of the Bylaws may be acted upon following introduction of the proposed action at a Medical Staff meeting, or by mail~~**ing**~~ ***ballot or by electronic method*** the proposed action to each staff member entitled to vote ~~**thirty (30)**~~ ***at least 10*** days prior to finalizing of the document voting. Such introduction shall include the exact wording of existing Bylaws language, if any, and the proposed change(s).

ACTION OF BYLAW CHANGE
Discussion and vote on adoption, amendment, or repeal of Bylaws shall take place at the next Medical Staff meeting following introduction as outline in 14.1. ***In this instance***, a quorum of voting members must be present for the purpose of enacting a Bylaws change. ***In addition, and as an alternative method, balloting may occur electronically by the use of a verifiable e-mail sent to the Director of the Medical Staff Office***. The change shall require an affirmative ***majority*** vote ~~**of two-thirds (66 2/3%)**~~ of the members voting **at a meeting** in person or by ~~**written absentee or**~~ ***electronic*** ballot. ~~**that must be received prior to the meeting**~~. ~~**In addition, as an alternative method, balloting may occur electronically by the use of a verifiable e-mail sent to the Director of the Medical Staff Office by the voting member personally, or by the facsimile transmission of a written signed ballot from the voting member to the same Office. An affirmative vote of two-thirds (66 2/3%) of the members voting via this alternative method is required**~~.

AUDIT, ETHICS AND COMPLIANCE COMMITTEE
September 22nd, 2015

Administrative Policies & Procedures			
1. Sanctions for Non Compliance with Privacy and Security Policies and Procedures	8610-531	3 year review, revised	
2. Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment and Health Care Operations (TPO)	8610-592	NEW	
3. Use and Disclosure of Protected Health (PHI) Information for Fundraising	8610-525	3 year review, revised	

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: 6/08

SUBJECT: Sanctions, to Comply with Privacy and Security Policies & Procedures

REVISION DATE: 8/10

POLICY NUMBER: 8610-531

Administrative Policies & Procedures Committee Approval:	~~08/10~~06/15
~~Operations Team Committee Approval:~~	~~08/10~~
Medical Executive Committee Approval:	07/15
Audit and Compliance~~Professional Affairs~~ Committee Approval:	08/10
Board of Directors Approval:	08/10

A. PURPOSE:

1. The purpose of this Policy is to describe the process to impose sanctions and/or take other corrective actions against Workforce members, Medical Staff members and Business Associates who fail to comply with the privacy and security policies and procedures of Tri-City Healthcare District (TCHD).

B. DEFINITION(S):

1. Business Associate: a person or organization who, on behalf of TCHD, performs certain functions or activities involving the Use or Disclosure of PHI or services that require the Business Associate to create, receive, maintain or transmit PHI on behalf of the TCHD or where TCHD needs to Disclose PHI to Business Associates for the services.
2. Business Associate Addendum or BAA: is an Addendum to an applicable Services Agreement between the District and a Business Associate that outlines the specific obligations of the Business Associate related to the Use or Disclosure of District PHI.
3. Disclosure: the release, transfer, provision of, access to or divulging of PHI outside TCHD.
4. Protected Health Information (PHI): individually identifiable health transmitted or maintained in paper or electronic form that is created or received by TCHD AND
   a. Relates to the past, present or future physical or mental health or condition of an individual; OR
   b. Relates to the provision of health care to an individual; OR
   c. Relates to the past, present, or future payment, AND
   d. Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
5. Services Agreement: an agreement between the District and a third part whereby the third party performs a function, activity or service on behalf of the District. Services Agreements that require the District to Disclose PHI for such functions, activities or services require Business Associate Addendums.
6. Use: the sharing, application, utilization, examination or analysis of PHI within TCHD.
7. Workforce: employees, 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.

C. POLICIES:

1. TCHD Workforce members are required to comply with TCHD policies and procedures, including those related to patient privacy and confidentiality, as a condition of their employment. TCHD Workforce members acknowledge compliance with these obligations as part of the TCHD Code of Conduct.

2. TCHD shall take appropriate actions to enforce TCHD's Privacy and Security policies and procedures as well as the underlying state and federal privacy laws and impose appropriate discipline against Workforce members who are non-compliant with such policies and laws.
3. TCHD shall impose appropriate sanctions or take other appropriate actions in the event that a Medical Staff member or Business Associate fails to comply with TCHD's privacy and security policies and procedures and related privacy laws when accessing, Using or Disclosing TCHD patient PHI in connection with TCHD business.
4. TCHD shall document the sanctions that are applied for failure to comply with TCHD privacy and security policies and procedures and related documentation shall be retained in accordance with TCHD's Records Retention and Destruction Board Policy.

D. PROCEDURES:

1. Workforce members
   a. In the event that TCHD identifies non-compliance of TCHD policies and procedures by any Workforce member, the Privacy Officer and/or Security Officer, as appropriate shall confer with the Human Resources Department and Workforce member Supervisors to determine recommendations for appropriate discipline.
   b. TCHD may take into account the following matters when evaluating the appropriate discipline to impose in a given situation:
      i. The severity, frequency and nature of the non-compliance;
      ii. Whether the actions were intentional or unintentional and/or have been or will be reported to law enforcement for investigation of potential criminal violations;
      iii. Any prior non-compliance with privacy and/or security policies and procedures and applicable laws by the same Workforce member;
      iv. Whether the non-compliance indicates a pattern of improper access, Use or Disclosure; and/or
      v. Application of discipline to Workforce members in a consistent manner.
   c. TCHD may impose any of the following disciplinary actions or a combination of them against Workforce members for non-compliance with TCHD privacy and security policies and procedures:
      i. Focused education and training;
      ii. Monitoring;
      iii. Counseling;
      iv. Administrative leave;
      v. Termination; and/or
      vi. Other appropriate disciplinary actions
   d. The process for imposing sanctions against Workforce members should also take into account applicable Human Resource Department policies, collective bargaining agreements and public agency-related requirements.
   e. Recommendations for Workforce member sanctions shall be presented to Vice President of Human Resources.
2. Medical Staff
   a. Medical Staff members have access to TCHD patient PHI and may be Authorized Users under TCHD Security policies for purposes of patient care and administrative responsibilities (see also Section 3 on Business Associates).
   b. Medical Staff must comply with TCHD's privacy and security policies and procedures and applicable laws when accessing, Using and Disclosing TCHD PHI for patient care and TCHD business.
   c. In the event that TCHD identifies non-compliance of TCHD policies and procedures by any Medical Staff member, the Privacy Officer and/or Security Officer, as appropriate, shall confer with the Chief of Staff and/or legal counsel to determine recommendations for appropriate sanctions and/or other actions.

d. **The process for imposing sanctions or taking other actions against any member of the Medical Staff for non-compliance with TCHD privacy and security policies and procedures should take into account relevant requirements and conditions if any, set forth in Medical Staff Bylaws, rules and regulations, and contractual arrangements.**

3. **Business Associates**
   a. **TCHD Business Associates may have access to TCHD PHI and/or may be Authorized Users under TCHD Security policies as necessary and appropriate to their contractual obligations.**
   b. **TCHD Business Associates must comply with TCHD's privacy and security policies and procedures and applicable laws when accessing, Using and Disclosing TCHD PHI for TCHD business purposes if such access, Use and Disclosure is otherwise permitted under the Business Associate Addendum.**
   c. **In the event that TCHD identifies non-compliance of TCHD policies and procedures by any Business Associate, the Privacy Officer and/or Security Officer, as appropriate, shall confer with the Department Director and/or legal counsel to determine recommendations for appropriate sanctions or other actions which may include, but is not limited to, removal of the Business Associate vendor, termination of the services contract and/or demands for indemnification.**
   d. **The process for imposing sanctions and/or taking other actions against Business Associates for non-compliance with TCHD privacy and security policies and procedures should take into account the requirements and/or conditions of the Services Agreement and Business Associate Addendum.**

E. **REFERENCE LIST:**
1. **45 Code of Federal Register (CFR) Section 160.103**
2. **45 CFR Section 164.308(ii)(C)**
3. **45 CFR Section 164.530(e)**
4. **TCHD Records Retention and Destruction Board Policy #14-0008**
5. **TCHD Disciplinary Action for Breaches of Confidentiality of Restricted Electronic Information Policy #8610-609**
6. **TCHD Code of Conduct**

~~A. **PURPOSE**~~
~~1. To ensure consistent enforcement of policies and procedures to prevent and detect violation of law. Enforcement is supported by the imposition of fair and consistent disciplinary mechanisms.~~

~~B. **DEFINITIONS**~~
~~1. Sanction: a covered entity must have and apply appropriate sanctions against members of its workforce who fail to comply with the privacy and security policies and procedures of the covered entity.~~
~~2. Documentation: a covered entity must document the sanctions applied, if any.~~

~~C. **POLICY**~~
~~1. Tri-City Healthcare District (TCHD) shall undertake appropriate actions to enforce TCHD's Compliance, Privacy and Security policies and procedures and shall have and apply appropriate disciplinary sanctions against members of its workforce who fail to comply with TCHD policies and procedures or the Privacy and Security regulations (i.e. HIPAA and equivalent state laws.)~~
~~a. TCHD will apply appropriate sanctions against members of its workforce who fail to comply with TCHD policies and procedures~~
~~i. Actions taken may be up to and including termination~~
~~b. The type of sanction applied shall vary depending on the severity of the violation, whether the violation was intentional or unintentional, whether the violation indicates a pattern or practice of improper access, use or disclosure of health information, and similar factors.~~

~~c.~~**a.** ~~Employees, agents, and other contractors should be aware that violations of a severe nature may result in notification to law enforcement officials as well as regulatory, accreditation, and/or licensure organization.~~

~~d.~~**b.**

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: New

SUBJECT: Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment and Health Care Operations (TPO)

REVISION DATE(S):

POLICY NUMBER: 8610-592

Administrative Policies and Procedures Approval Date(s): 06/15
Medical Executive Committee Approval Date(s): 07/15
Audit and Compliance Committee Approval Date(s):
Board of Directors Approval Date(s):

A. **PURPOSE:**

1. The purpose of this Policy is to provide guidelines for Uses and Disclosures of PHI for Treatment, Payment and Health Care Operations (TPO)

B. **DEFINITIONS:**

1. Authorization: the written form that complies with HIPAA and state law that is obtained from the Individual or his or her Personal Representative in order for TCHD to Use and Disclose PHI.
2. Covered Entity: Includes health care providers like the District that transmit health information in electronic form in connection with certain standard transactions (e.g. claims processing).
3. Disclosure: the release, transfer, provision of, access to or divulging of PHI outside TCHD.
4. Health Care Operations: are certain activities of a Covered Entity to the extent that they are related to covered functions and include, but are not limited to, quality improvement, case management and care coordination, accreditation, certification, licensing, credentialing, conducting or arranging for legal, auditing, compliance functions, business and planning development and business management and general administrative activities.
5. Health Care Provider: for purposes of HIPAA, is a person or entity that furnishes, bills or is paid for health care (care, services or supplies related to the health of an individual) in the normal course of business.
6. Payment: includes activities undertaken by a health care provider to obtain or provide reimbursement for the provision of care including, but not limited to, determinations of eligibility, billing, claims management, collection activities, obtain payment under a contract of reinsurance or stop loss, related health care date processing, review of coverage under health plans, medical necessity reviews, and utilization management.
7. Protected Health Information (PHI): individually identifiable health transmitted or maintained in paper or electronic form that is created or received by TCHD AND
   a. Relates to the past, present, or future physical or mental health or condition of an individual; OR
   b. Relates to the provision of health care to an individual; OR
   c. Relates to the past, present, or future payment, AND
   d. Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
8. Treatment: the provision, coordination, or management of health care and related services by one or more providers, including coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient from health care from one health care provider to another.

9. Use: the sharing, application, utilization, examination or analysis of PHI within TCHD

C. **POLICIES:**

1. In general, TCHD may not Use or Disclose a patient's PHI without the patient's Authorization, unless otherwise permitted to do so by both state and federal laws.
2. Except as provided under state and/or federal laws, TCHD may Use or Disclose a Patient's PHI for Treatment, Payment and Healthcare Operations (TPO) without a patient Authorization.
3. If state and/or federal laws require a patient Authorization in circumstances involving TPO, then TCHD must comply with such Authorization requirements.
4. TCHD shall make reasonable efforts to limit PHI to the Minimum Necessary to accomplish the intended purpose when using PHI for TPO except as otherwise permitted under applicable state and/or federal laws.

D. **PROCEDURES:**

1. Treatment
   a. TCHD may Use or Disclose PHI for its own Treatment purposes.
   b. TCHD may Disclose PHI for Treatment activities of another health care provider.
   c. Examples of Treatment include:
      i. Direct and indirect provision of health care services.
      ii. Coordination and management of health care and related services.
      iii. Consultation with another health care provider.
      iv. Referrals to other health care providers such a home health care, physical therapy, and durable medical equipment, etc.
2. Payment
   a. TCHD may Use or Disclose PHI for its own Payment purposes. TCHD may Use a patient's PHI to:
      i. Determine his or her eligibility for coverage and health care benefits under a health care plan.
      ii. Submit claims to health plans and other payers for health care services it provides to patients.
      iii. Review health care services for medical necessity.
      iv. Conduct utilization review activities.
   b. TCHD may Disclose PHI to another Covered Entity or health care provider for Payment activities of the entity that receives the information. For example, TCHD may Disclose PHI to an ambulance supplier or health care provider as necessary for that Covered Entity or health care provider to bill and obtain reimbursement for its services.
3. Healthcare Operations
   a. TCHD may Use or Disclose PHI for its own Health Care Operations.
   b. Examples of Health Care Operations include:
      i. Conduct quality improvement activities, patient safety activities, protocol development, case management and care coordination and contact providers and patients with information on treatment alternatives and related functions that do not include treatment.
      ii. Review the competence or qualifications of health care professionals and provider performance, conduct training programs for health care and non-health care professionals and accreditation, certification, licensing or credentialing activities.
      iii. Conduct or arrange for medical review, legal services, auditing functions, fraud and abuse detection and compliance.
      iv. Undertake business planning and development activities.
      v. Engage in business management and general administrative activities.
   c. TCHD may Disclose PHI to another Covered Entity for the Health Care Operations of that Covered Entity if: (1) both TCHD and the other Covered Entity has or had a relationship with the patient who is the subject of the PHI being requested; (2) the PHI pertains to such Disclosure; and (3) the Disclosure is for a purpose listed in 3.b.(i) or (ii) above or for the purpose of fraud and abuse detection or compliance.

4. Patient Authorizations Required for Certain Purposes
In certain circumstances, the Use and Disclosure of PHI for Treatment, Payment and Health Care Operations is not permitted without a patient's Authorization. State and/or federal laws may impose stricter standards that require TCHD to obtain Authorizations and/or impose other limitations on the Use and Disclosure of PHI in these circumstances:
   a. Psychotherapy notes: HIPAA has special provisions regarding the Use and Disclosure of psychotherapy notes which must be complied with for all patients in California. Psychotherapy notes require separate Authorizations under HIPAA – a general request for release of medical records will not suffice (45 Code of Federal Register (CFR) Section 164.508 (a)(2).)
   b. HIV test results: California strictly limits the Disclosure of HIV test results. Generally, with some exceptions, California law requires a specific authorization – a general authorization to release medical records is not sufficient. (California Health & Safety Code Section 120980).
   c. Marketing: Generally, a patient authorization will be required. (45 CFR Section 164.508(a)(3) and Civil Code Section 56.10(d).)
   d. Sale of PHI: Generally, a patient authorization will be required. (45 CFR Section 164.508(a)(4) and California Civil Code Section 56.10(d).)
   e. Mental health and substance abuse: State and/or federal laws may impose more protections on the Use and Disclosure of TPO for mental health and substance (alcohol and drug) abuse patients. TCHD employees shall review and follow requirements in applicable TCHD policies and procedures and applicable laws and regulations related to the Use and Disclosure of PHI for Treatment, Payment and Health Care Operations when such services are involved. (45 CFR Section 164.508(a)(2); 42 CFR Part 2; Cal. Welf. & Inst. Code 5328 et seq.)

E. **REFERENCE LIST:**

1. 45 CFR Section 160.103
2. 45 CFR Section 164.501
3. 45 CFR Section 164.502(b)
4. 45 CFR Section 164.506
5. 45 CFR Section 164.508(a)(2)(3) and (4)
6. California Civil Code Section 56.10(d)
7. California Health & Safety Code Section 120980

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: 03/03

SUBJECT: Use and Disclosure of Protected Health Information (PHI) for Fundraising

REVISION DATE: 02/06; 01/09;

POLICY NUMBER: 8610-525

Administrative Policies & Procedures Committee Approval: ~~03/09~~ 06/15
~~Operations Team Committee Approval:~~ ~~03/09~~
Audit, Ethics and Compliance~~Professional Affairs~~ Committee Approval: 04/09
Board of Directors Approval: 04/09

A. **PURPOSE:**

~~3.~~1. To establish policie~~s~~ and procedures for the ~~u~~Use and D~~d~~isclosure of **specified Tri-City Healthcare District (TCHD)** patient information **for fundraising including, Disclosures ~~by~~ to** the Tri-City Hospital Foundation **and/or Business Associates for the purpose of TCHD fundraising** in accordance with the Health Information Portability and Accountability Act of 1996 (HIPAA).

B. **DEFINITIONS:**

1. **Authorization: the written form that complies with HIPAA and state law that is obtained from the Individual or his or her Personal Representative in order for TCHD to Use and Disclose PHI.**
2. **Business Associate: a person or organization who, on behalf of the District, performs certain functions or activities involving the Use or Disclosure of PHI or services that require the Business Associate to create, receive, maintain or transmit PHI on behalf of the District or where the District needs to Disclose PHI to Business Associates for the services.**
3. **Direct solicitation fundraising literature: Any written communications which primary purpose is the direct solicitation of the financial resources necessary to support the mission and purposes of TCHD.**
4. **Disclosure: the release, transfer, provision of, access to or divulging of PHI outside TCHD.**
5. Fundraising: The process of securing the financial resources necessary to support the mission and purposes of the ~~Foundation~~**TC~~M~~HD**.

~~1.~~6. **Payment: includes activities undertaken by a health care provider to obtain or provide reimbursement for the provision of care including, but not limited to, determinations of eligibility, billing, claims management, collection activities, obtain payment under a contract of reinsurance or stop loss, related health care data processing, review of coverage under health plans, medical necessity reviews, and utilization management.**

7. Permissible P~~p~~atient l~~i~~nformation: **The limited categories of PHI that TCHD~~MC~~ may Use or D~~d~~isclose to a Business Associate or to the Tri-C~~c~~ity Hospital Foundation without a patient aAuthorization, for the purpose of raising funds for TCHD~~MC won~~'s own benefit and expressly limited to the following:**
   a. **Demographic information relating to the l~~i~~ndividual including name, address, other contact information, age, gender, and date of birth**
   b. **D~~d~~ates of health care provided to an l~~i~~ndividual**
   c. **D~~d~~epartment of service (general department of transferred) information**
   d. **T~~t~~reating physician**
   e. **O~~o~~utcome information**

~~4.~~**f. Hhealth insurance status** ~~(i) Name; (ii) Address; (iii) Other contact information (phone number, e-mail address, etc.); (iv) Age; (v) Gender; (vi) Insurance status; (vii) Date(s) of service (§164.514).~~

8. Protected Health Information (PHI): **individually identifiable health transmitted or maintained in paper or electronic other form that is created or received by TC~~M~~CHD AND**

a. Relates to the past, present, or future physical or mental health or condition of an individual; OR

b. Relates to the provision of health care to an individual; OR

c. Relates to the past, present, or future payment, AND

~~Identifies the individual OR~~

d. Identifies the individual OR ~~W~~with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

~~5. Information relating to: (i) Diagnosis; (ii) Nature of services; (iii) Treatment; and (iv) place within Medical Center where patient receives treatment that identifies the treatment (i.e. Medical Center Department) (§164.514).~~

9. ~~Direct solicitation fundraising literature: Any written communications which primary purpose is the direct solicitation of the financial resources necessary to support the mission and purposes of the Foundation.~~ **Treatment: the provision, coordination, or management of health care and related services by one or more providers, including coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient from health care from one health care provider to another.**

~~6.~~**a. Use: the sharing, application, utilization, examination or analysis of PHI within TCHD.**

~~7. Business Associate: Any person or entity that is not a member of the workforce of either the Tri-City Hospital Foundation or the Tri-City Medical Center (TCMC) that provides certain functions, activities or services for the Tri-City Hospital Foundation or TCMC.~~

C. **POLICY:**

1. In order to protect the privacy of a patient's information, ~~the~~ Tri-City Hospital Foundation shall act in accordance and compliance with HIPAA and the Privacy Practices of TC~~M~~CHD **when conducting fundraising activities for TCHD**.

2. TC~~M~~CHD may U~~u~~se or D~~d~~isclose Permissible Patient Information to its B~~b~~usiness A~~a~~ssociates or to the Tri-City Hospital Foundation for the benefit ~~for~~of TC~~M~~CHD fundraising. Such U~~u~~ses and D~~d~~isclosures are subject to the minimum necessary ~~standard~~requirements.

TCHD may not condition Treatment or Payment on a patient's choice with respect to fundraising communications.

~~8. Such notifications shall provide a clear and conspicuous opportunity to receive any further fundraising communications and shall not cause the individual to incur an undue burden or more than a nominal cost.~~ ~~After a patient has been made aware of the TCMC's Notice of Privacy Practices, the Tri-City Hospital Foundation may use or disclose permissible patient information for its fundraising purposes (§164.514). All other patient information is PHI and will not be used or disclosed by the Tri-City Hospital Foundation for its fundraising purposes without first obtaining the patient's written consent and authorization (§164.514).~~

~~TCMC will not make fundraising communications to an individual who has opted out of such communication.~~

~~9. Patients who desired to opt back in to receive fundraising communications can email _____ or call _____ The Tri-City Hospital Foundation shall include specific language in all of its direct solicitation fundraising literature that allows its recipient's to opt out from receiving future direct solicitation fundraising literature.~~

~~10. The Tri-City Hospital Foundation may share patient information with its business associates provided the Tri-City Hospital Foundation obtains satisfactory assurances that the business associate will appropriately safeguard the information (§164.502).~~

D. **PROCESS:**

1. Notice of Privacy Practices

a. TCMCHD's Notice of Privacy Practices shall indicate that TCMC "may Uuse or Ddisclose" a patient's PHI to its fFoundation or bBusiness Aassociates for fundraising purposes and that the patient has the right to opt out of receiving such communications.

b. TCHD may not Use or Disclose PHI for fundraising purposes unless the statement required by Section 1.a is included in the Notice of Privacy Practices.

~~1.~~2. Use of Permissible Patient Information

a. After a patient has been made aware of the TCMC's Notice of Privacy Practices, ~~the Tri-City Hospital~~**TCHD** ~~Foundation~~ may uUse or Ddisclose pPermissible pPatient information ~~for its~~ fundraising purposes ~~(§164.514)~~.

~~11.~~3. **Except as provided in this Policy, TCHD**~~Use of PHI~~

~~a. Before the Foundation can use PHI for its fundraising purposes, the patient must sign the Tri-City Hospital Foundation's *Consent For Use Of Protected Health Information* form.~~

~~i. The Tri-City Hospital Foundation's *Consent For Use Of Protected Health Information* form shall read as follows: "I understand that information relating to my medical diagnosis, my nature of services, my treatment and the place within the Tri-City Medical Center where I have or will receive treatment (if such place identifies the type of treatment I have or will receive) is considered Protected Health Information (PHI) and ordinarily cannot be used for fundraising purposes. I hereby voluntarily give my consent to the Tri-City Hospital Foundation to receive and use such information in order for the Tri-City Hospital Foundation to raise money for the Tri-City Medical Center. If I decide I no longer wish to authorize the Tri-City Hospital Foundation to receive and use my Protected Health Information for their fundraising purposes, I shall so notify the Tri-City Medical Center Foundation at 4002 Vista Way, Oceanside, CA 92056 in writing."~~

~~ii. All signed *Consent For Use Of Protected Health Information* forms shall be kept and maintained by the Tri-City Hospital Foundation.~~

a. ~~The Foundation may not share~~ ***Disclose PHI*****Permissible Patient Information to the Tri-City Hospital Foundation or Business Associates** ~~with any outside entity~~ for fundraising purposes **without first obtaining**~~unless~~ ~~the~~**a** patient's ~~has specifically~~ **Aauthorization for such purpose.**

4. Fundraising Notifications

a. Each fundraising notification shall provide the patient with a clear and conspicuous opportunity to elect not to receive any further fundraising communications.

b. The method provided to opt out of receiving further fundraising communications shall not result in a patient incurring an undue burden or more than a nominal cost. Tri-City Hospital Foundation permits patients to opt out of future fundraising communications by telephone at (760) 940-3370 or by e-mail at TCHFoundation@tcmc.com.

5. Patients Who Opt Out

a. Fundraising communications will not be made to patients who have opted out of such communications.

b. Tri-City Hospital Foundation will track opt out notifications to ensure that further fundraising communications are not made to patients who have elected to opt out.

6. Opting Back In.

~~b.~~**a. Patients who desire to opt back in to receive fundraising communications can do so by sending an e-mail with such request to TCHFoundation@tcmc.com or by opting in at an event or through the Foundation's website.**~~ed release to the entity.~~

~~2.~~7. Direct Solicitation Fundraising Literature

a. Direct solicitation fundraising literature does not include general marketing communications to donors or prospective donors such as newsletters or other similar general communication media **where TCHD does not Disclose patient PHI to Tri-City Hospital Foundation for such purposes**. ~~Educational and other events that the~~

~~Foundation or Medical Center sponsors, even if those events will contain active or passive fundraising, are not considered direct solicitations as long as the event is not primarily a fundraising event.~~

~~b. The following specific opt-out language is required to be placed in all of its direct solicitation fundraising literature:~~

~~i. "Please write to us at our address if you wish to have your name removed from the list to receive future fundraising requests supporting Tri-City Medical Center."~~

~~ii. If any person or entity opts out from receiving direct solicitation fundraising literature or indicates they no longer wish to receive any other literature sent by the Tri-City Hospital Foundation, the Tri-City Hospital Foundation shall make the appropriate arrangements within its mailing database to prevent that person or entity from receiving any future literature from the Tri-City Hospital Foundation.~~

~~iii. The Tri-City Hospital Foundation shall maintain a list of the names, addresses (including e-mail addresses) and phone numbers of all persons and entities that have opted out from receiving its direct solicitation fundraising literature or have indicated they no longer wish to receive any other literature sent by the Tri-City Hospital Foundation.~~

~~iv. Before any of its literature is sent, the Tri-City Hospital Foundation shall compare the proposed distribution list with the list of those persons or entities that have indicated they no longer wish to receive literature from the Tri-City Hospital Foundation, including direct solicitation fundraising literature and shall remove from said distribution list any such persons or entities and/or take any other reasonable steps to prevent their receipt of Tri-City Hospital Foundation literature.~~

~~3.~~**8.** Business Associates

a. Before the Tri-City Hospital Foundation shares any **Permissible P**patient information with a ~~b~~**B**usiness a**A**ssociate, the **T**ri-City Hospital Foundation shall have the ~~b~~**B**usiness a**A**ssociate sign the **TCHD**~~MC's~~ Business Associate A~~greement~~**ddendum.**

b. If the Tri-City Hospital Foundation becomes aware of a ~~material~~ breach of the Privacy Practices of ~~the~~ **TC**~~M~~**CHD** by **a** ~~one of its b~~**B**usiness **A**ssociate~~s~~, the Tri-City Hospital Foundation ~~must take the appropriate steps to either correct the breach or end the relationship with the business associate~~**shall immediately notify the Privacy Officer**.

~~B. **ADJUNCT POLICIES:**~~

~~3. Administrative Policy #511 - Business Associate Agreement~~

~~4. Administrative Policy #518 - Notice of Privacy Practices~~

E. **REFERENCES:**

1. **45 Code of Federal Regulations (CFR) Section 164.502**
2. ~~Federal Register~~ **45 CFR Section** §164.514**(f)**

~~1.~~**3.** ~~and §164.502~~**TCHD Notice of Privacy Practices Policy # 518.**

AUGUST 27, 2015 REGULAR BOARD OF DIRECTORS MEETING MINUTES TO BE DISTRIBUTED PRIOR TO THE MEETING AND WILL BE AVAILABLE FOR PUBLIC REVIEW IN THE ADMINISTRATION OFFICE THE AFTERNOON OF MONDAY, SEPTEMBER 21, 2015.

MINUTES ARE NOT INCLUDED IN PACKET DUE TO A GLITCH IN THE COMPUTER FILE

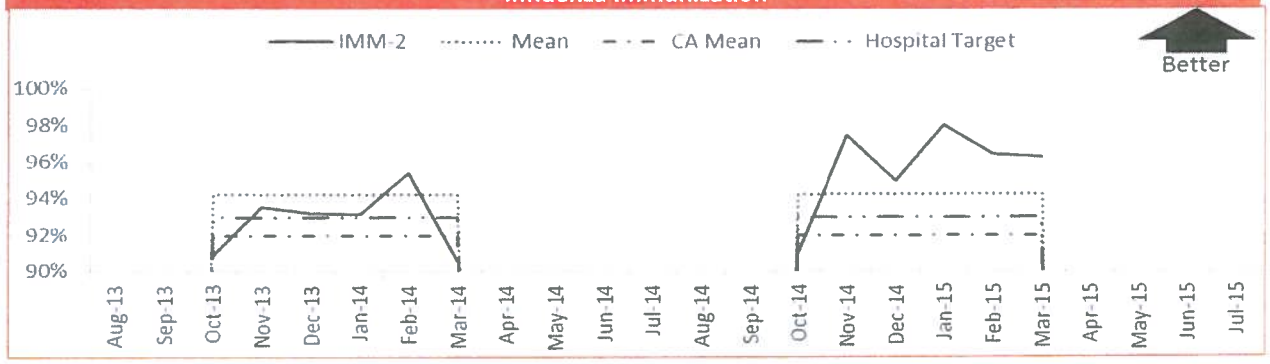
Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Process of Care Measures (Core Measures)

Centers for Medicare & Medicaid (CMS)

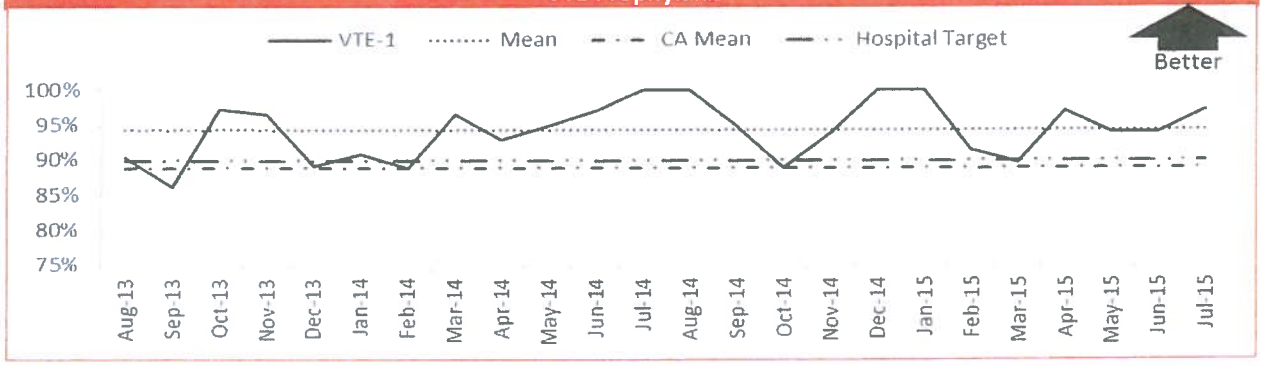
Influenza Immunization



Action Plan

Continue to monitor

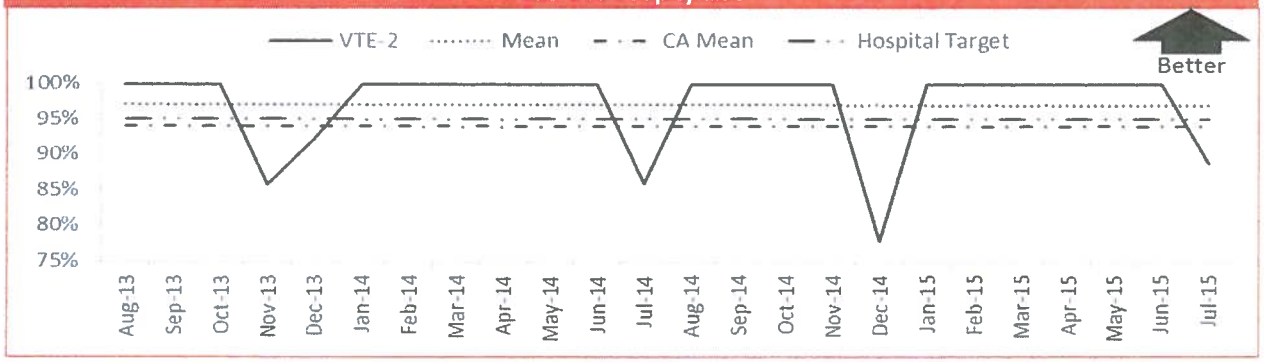
VTE Prophylaxis



Action Plan

Continue to monitor

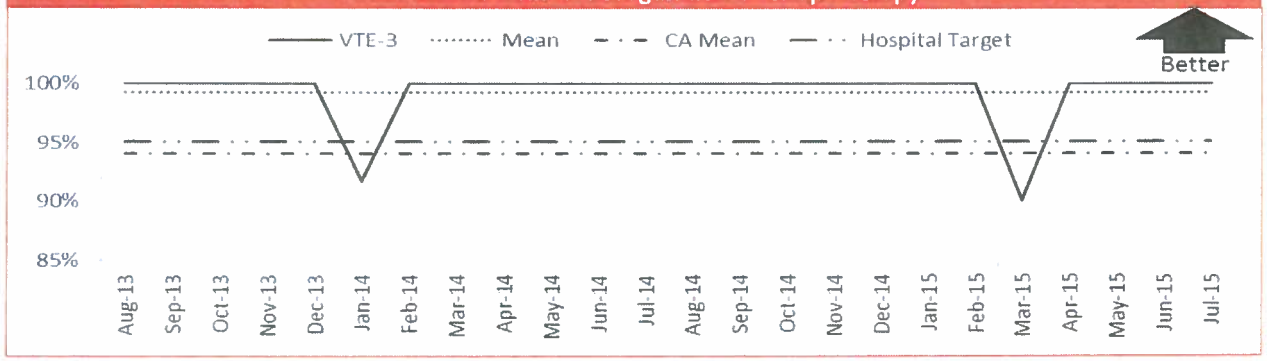
ICU VTE Prophylaxis



Action Plan

Continue to monitor

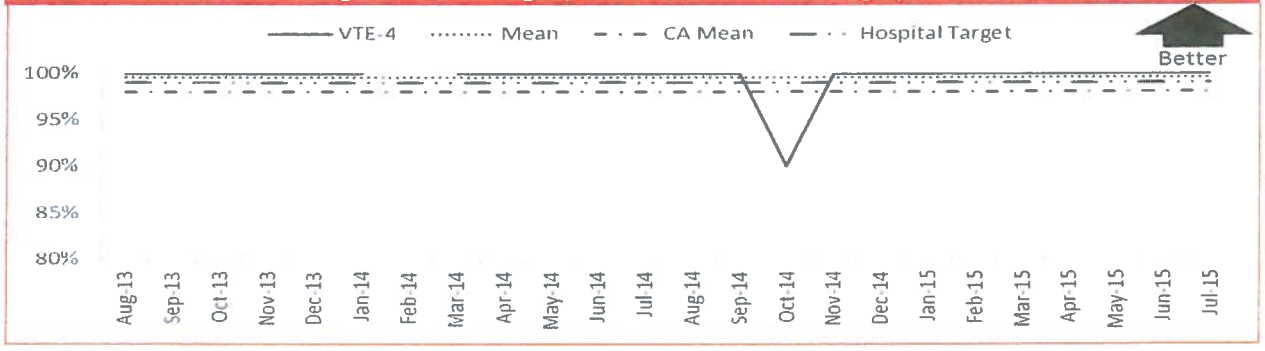
VTE Patients with Anticoagulation Overlap Therapy



Action Plan

Continue to monitor

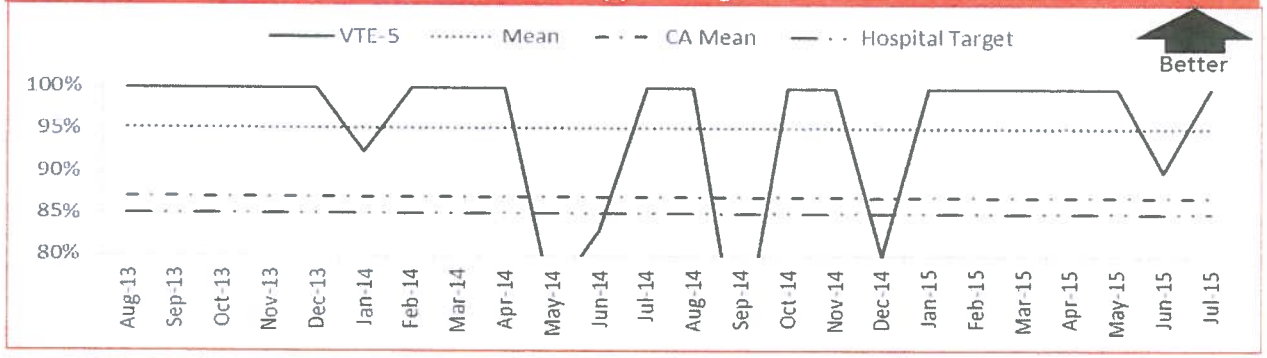
VTE Patients Receiving UFH with Dosages / Platelet Count Monitoring by Protocol or Nomogram



Action Plan

Continue to monitor

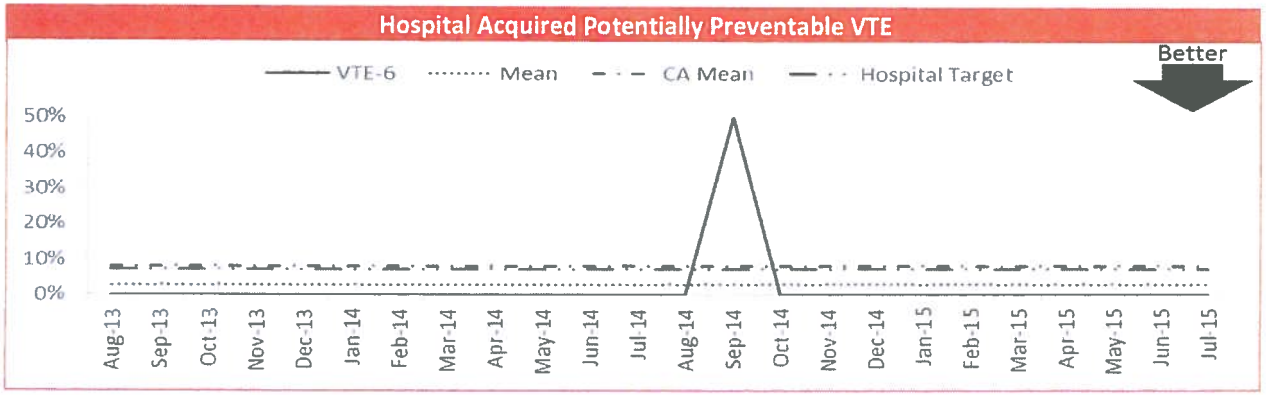
VTE Warfarin Therapy Discharge Instructions



Action Plan

Continue to monitor

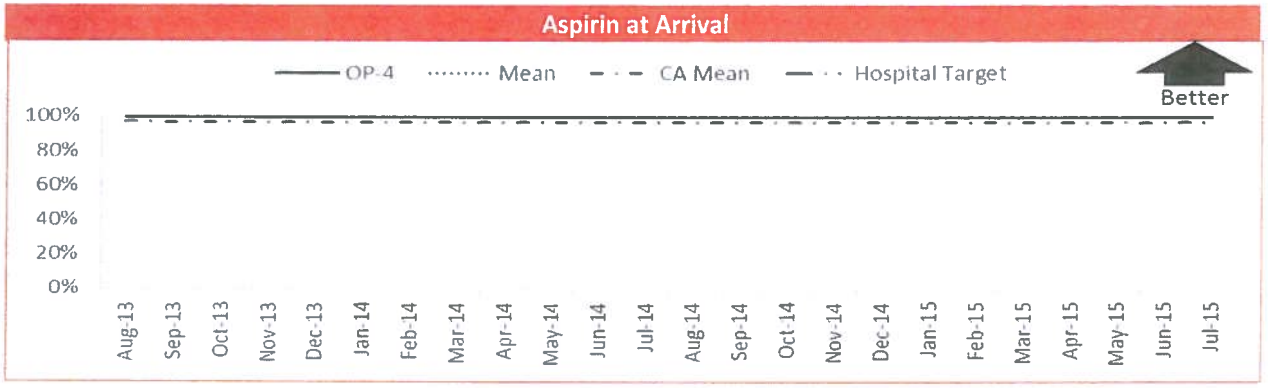
Hospital Acquired Potentially Preventable VTE



Action Plan

Continue to monitor

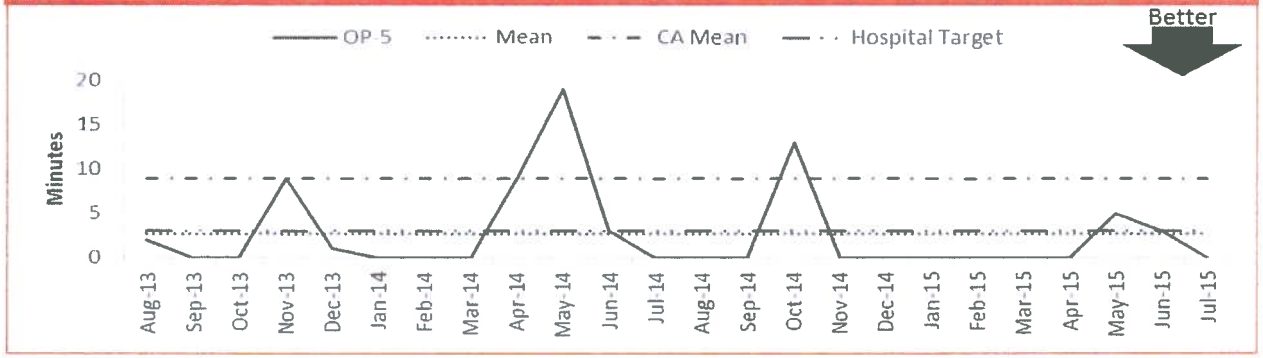
Aspirin at Arrival



Action Plan

Continue to monitor

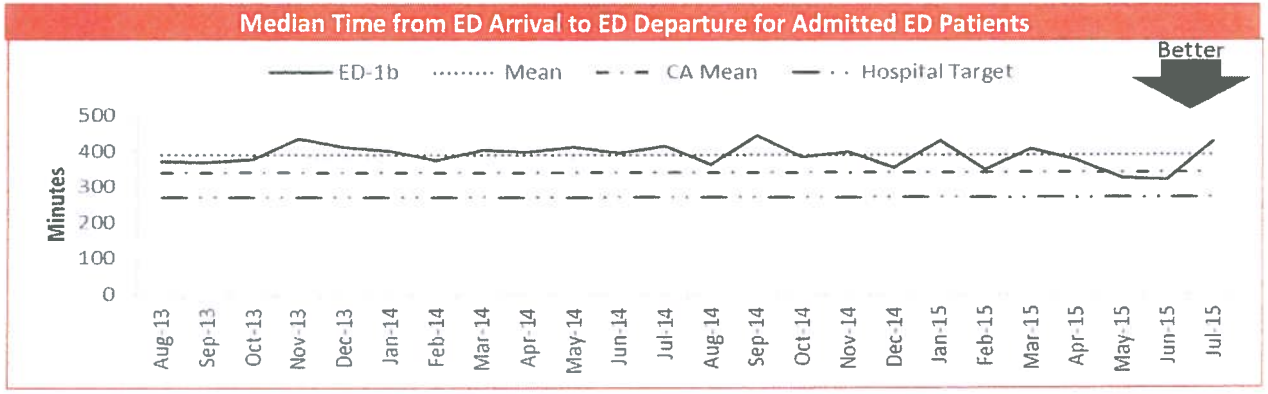
Median Time to ECG



Action Plan

Continue to monitor

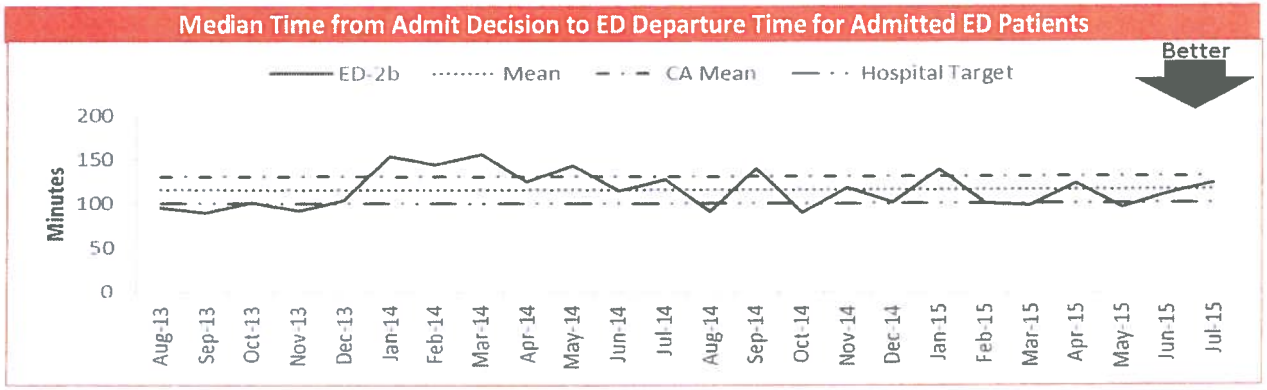
Median Time from ED Arrival to ED Departure for Admitted ED Patients



Action Plan

Continue to monitor

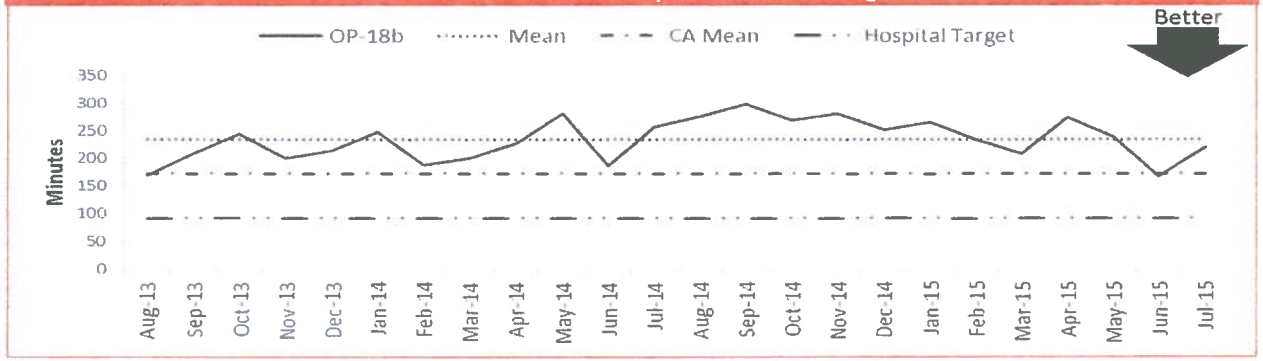
Median Time from Admit Decision to ED Departure Time for Admitted ED Patients



Action Plan

Continue to monitor

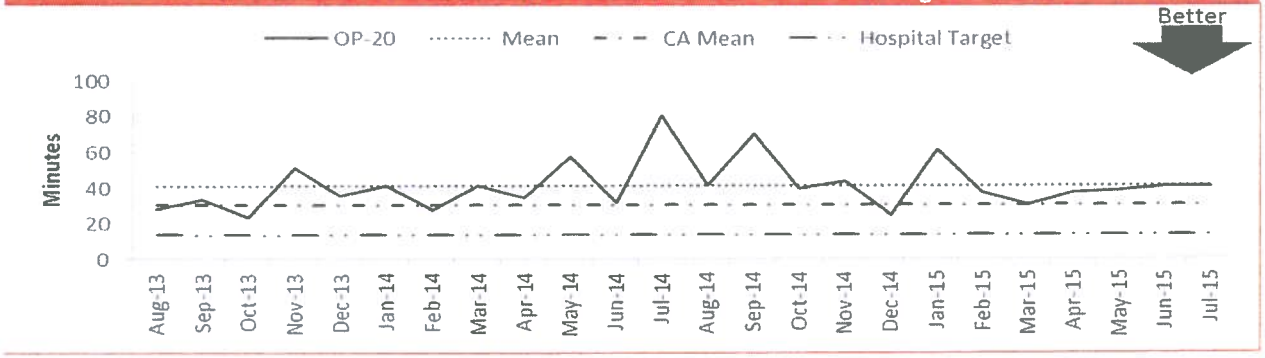
Median Time from ED Arrival to ED Departure for Discharged ED Patients



Action Plan

Continue to monitor

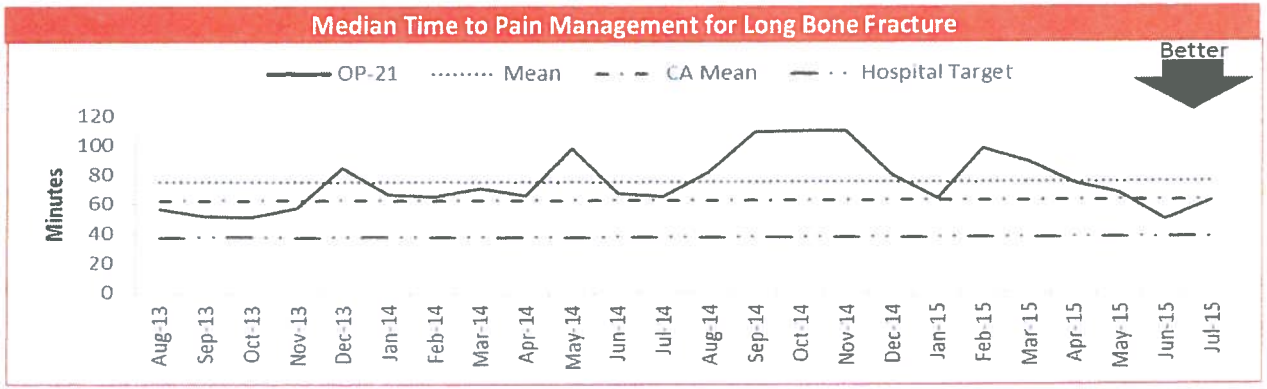
Median Time from ED Arrival to Provider Contact for ED Discharged Patients



Action Plan

Continue to monitor

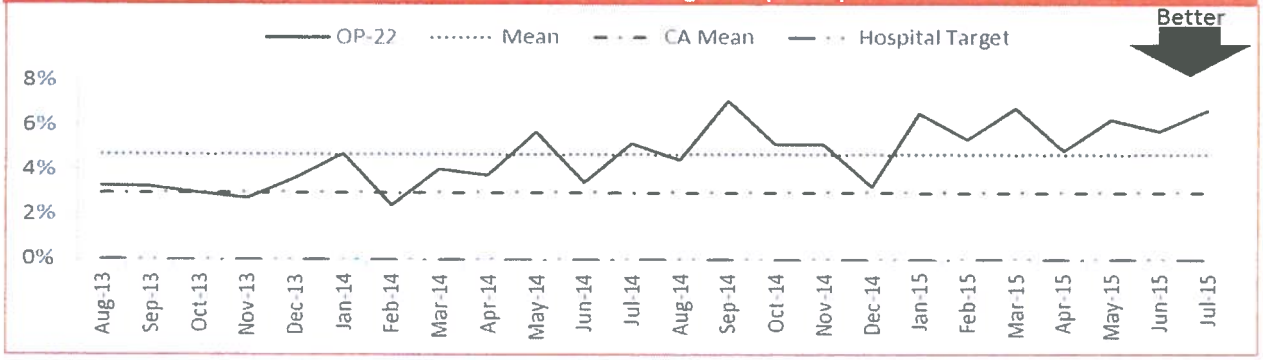
Median Time to Pain Management for Long Bone Fracture



Action Plan

Continue to monitor

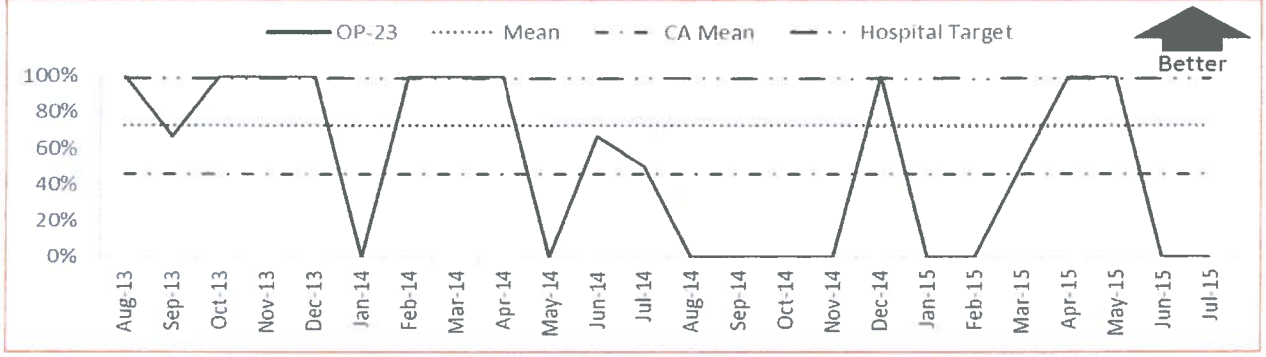
Patient Left Before Being Seen (LWOT)



Action Plan

Continue to monitor

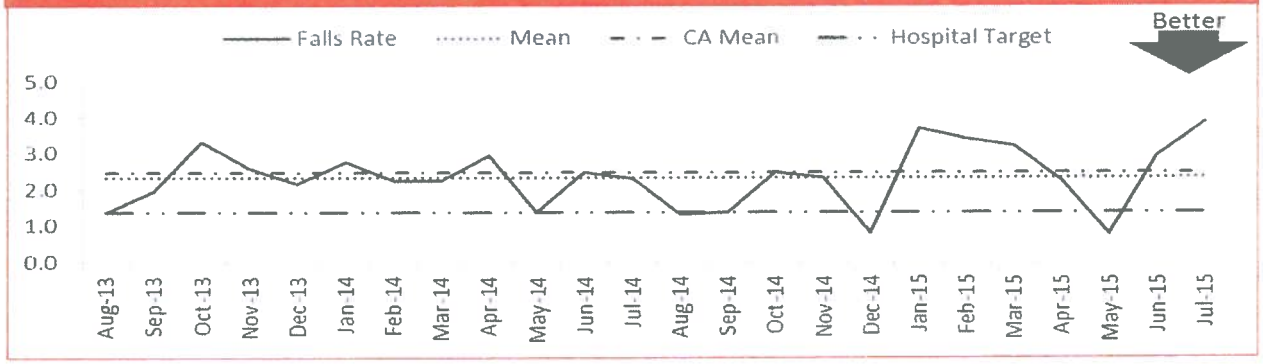
Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival



Action Plan

Continue to monitor

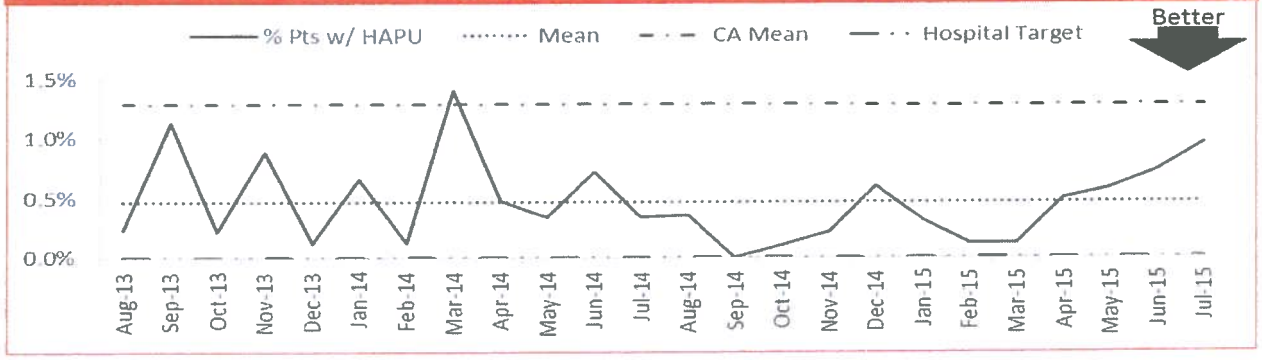
Hospital Wide Falls Rate Per 1000 Pt Days



Action Plan

Continue to monitor

Hospital Wide % Patients with HAPU



Action Plan

Increase Skin & Wound Champions on all units (model after Telemetry)
Created workgroup with tool to determine if HAPU is Avoidable vs. Unavoidable
Continue with HAPU Case Reviews
Continue with mandatory yearly RN Wound Class
Implementation of PowerPlans for standardized wound care per policy

Control Chart Interpretation

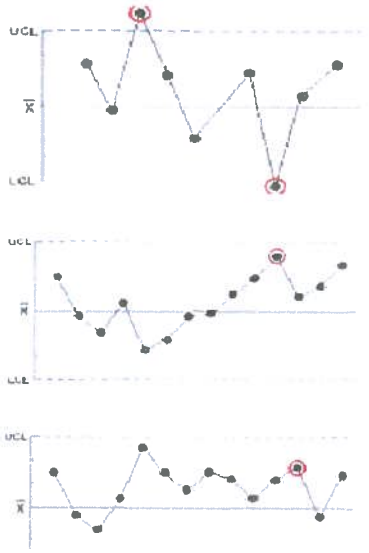
Legend

- Hospital Mean
- Hospital Rate
- Hospital UCL
- CA Mean

Hospital Mean is the average value we can expect based on the data collected.

Hospital Rate is the actual value.

Hospital UCL (Upper Control Limit) is the highest level of quality that is still considered "normal" given the data history. It is usually 3 standard deviations from the mean.



Description	Indication
One point is more than 3 standard deviations (UCL) from the mean.	One sample (two shown in this case) is grossly out of control.
Six (or more) points in a row are continually increasing (or decreasing).	A trend exists. Procedures in place have an effect on outcomes either positive or negative.
8 (or more) points in a row are on the same side of the mean	Some prolonged bias exists.

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCMC Days in Accounts Receivable (A/R)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	C/M YTD Avg	Goal Range
FY16	46.7	45.7										46.2	48-52
FY15	46.3	48.8	47.9	48.9	49.0	48.9	51.0	50.6	50.6	51.0	49.9	47.5	48-52

TCMC Days in Accounts Payable (A/P)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	C/M YTD Avg	Goal Range
FY16	83.6	85.8										84.7	75-100
FY15	78.1	77.1	81.2	77.9	79.5	77.6	79.5	77.0	84.3	82.6	82.8	77.6	75-100

TCHD EROE $ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	C/M YTD	C/M YTD Budget
FY16	$862	$612										$1,474	$60
FY15	$368	($348)	$112	$568	$556	$632	$198	$370	$292	$343	$1,814	$20	

TCHD EROE % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	C/M YTD	C/M YTD Budget
FY16	3.03%	2.20%										2.62%	0.11%
FY15	1.33%	-1.32%	0.41%	1.93%	1.99%	2.20%	0.70%	1.42%	1.02%	1.22%	6.04%	0.04%	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

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

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	C/M YTD	C/M YTD Budget
FY16	$2,046	$1,817										$3,863	$2,677
FY15	$1,761	$988	$1,456	$1,888	$1,896	$1,983	$1,498	$1,652	$1,591	$1,620	$3,136	$2,749	

TCHD EBITDA % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	C/M YTD	C/M YTD Budget
FY16	7.20%	6.53%										6.87%	4.77%
FY15	6.38%	3.75%	5.37%	6.42%	6.77%	6.91%	5.34%	6.34%	5.58%	5.76%	10.44%	5.09%	

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

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	C/M YTD	C/M YTD Budget
FY16	6.13	6.05										6.09	6.05
FY15	5.93	5.89	6.01	6.09	6.39	6.28	5.89	5.69	6.18	6.17	5.89	5.75	

TCHD Fixed Charge Coverage Covenant Calculation

	TTM Jul	TTM Aug	TTM Sep	TTM Oct	TTM Nov	TTM Dec	TTM Jan	TTM Feb	TTM Mar	TTM Apr	TTM May	Covenant	
FY16	1.88	1.96										1.10	
FY15	1.55	1.60	1.52	1.49	1.20	1.24	1.32	1.45	1.53	1.51	1.77	1.10	

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

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
FY16	$30.7	$33.4									
FY15	$27.7	$21.4	$19.9	$18.8	$18.9	$22.2	$19.9	$16.4	$13.4	$17.8	$26.4

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Volume

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	49	28										77
FY15	35	32	46	48	35	33	39	35	31	35	37	406

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	20	19										39
FY15	14	9	22	24	18	21	19	13	21	19	19	199

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	9	10										19
FY15	6	10	9	8	12	11	9	7	16	14	6	108

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	16	19										35
FY15	10	7	10	12	13	7	11	8	9	21	11	119

Performance compared to prior year: Better Worse

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	40	36										76
FY15	45	51	32	43	49	27	33	43	37	39	40	439

Inpatient Behavioral Health - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	19.9	19.6										19.7
FY15	23.3	26.5	27.1	21.2	22.8	19.1	18.3	17.5	19.6	16.9	17.5	20.7

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	7.1	4.9										6.0
FY15	5.2	3.5	4.3	5.0	4.3	7.2	7.0	6.0	6.5	5.1	5.9	5.4

Neonatal Intensive Care Unit (NICU) - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	13.3	11.1										12.2
FY15	13.2	18.2	19.7	18.1	15.6	16.4	18.3	21.5	14.3	13.9	11.7	16.2

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	183.9	183.4										183.6
FY15	190.8	195.0	195.1	195.6	189.2	187.9	203.3	199.8	188.0	186.3	181.5	191.0

Performance compared to prior year: Better Worse

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	215	214										429
FY15	246	263	244	233	194	233	199	159	208	186	218	2383

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	16	9										25
FY15	16	19	12	19	17	11	15	8	12	22	23	174

Outpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	7	3										10
FY15	4	6	2	1	4	8	1	15	4	3	5	53

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	7	14										21
FY15	10	9	10	10	12	12	12	5	12	10	6	108

TCMC Adjusted Factor (Total Revenue/IP Revenue)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY16	1.65	1.63										1.64
FY15	1.64	1.63	1.58	1.58	1.56	1.58	1.58	1.63	1.62	1.63	1.65	1.61

Performance compared to prior year: Better Worse

Building Operating Leases
Month Ending Aug 31, 2015

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	Lease Term Beginning	Lease Term Ending	Services & Location	Cost Center
Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V#81981	Approx 6,200	$2.50	(a)	$ 18,600.00	02/01/15	10/31/18	**PCP Clinic Vista** 1926 Via Centre Drive, Ste A Vista, CA	7090
Tri-City Wellness, LLC 6250 El Camino Real Carlsbad, CA 92009 V#80388	Approx 87,000	$4.08	(a)	$ 239,250.00	07/01/13	06/30/28	**Wellness Center** 6250 El Camino Real Carlsbad, CA 92009	7760 - 90.65% 7597 - 4.86% 7777 - 4.49% 9520 - 77.25% 7893 - 12.53%
GCO 3621 Vista Way Oceanside, CA 92056 #V81473	1,583	$1.50	(a)	$ 3,398.15	01/01/13	12/31/15	**Performance Improvement** 3927 Waring Road, Ste.D Oceanside, Ca 92056	8756
Golden Eagle Mgmt 2775 Via De La Valle, Ste 200 Del Mar, CA 92014 V#81553	4,307	$0.95	(a)	$ 5,982.69	05/01/13	04/30/16	**Nifty After Fifty** 3861 Mission Ave, Ste B25 Oceanside, CA 92054	9551
Investors Property Mgmt. Group c/o Levitt Family Trust 2181 El Camino Real, Ste. 206 Oceanside, Ca 92054 V#81028	5,214	$1.65	(a)	$ 9,126.93	09/01/12	08/31/17	**OP Physical Therapy, OP OT & OP Speech Therapy** 2124 E. El Camino Real, Ste.100 Oceanside, Ca 92054	7772 - 76% 7792 - 12% 7782 - 12%
Melrose Plaza Complex, LP c/o Five K Management, Inc. P O Box 2522 La Jolla, CA 92038 V#43849	7,247	$1.22	(a)	$ 10,101.01	07/01/11	07/01/16	**Outpatient Behavioral Health** 510 West Vista Way Vista, Ca 92083	7320
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 [illegible]1250	4,760	$3.55	(a)	$ 22,900.00	10/01/12	10/01/22	**Chemotherapy/Infusion Oncology Office** 3617 Vista Way, Bldg.5 Oceanside, Ca 92056	7086
[illegible]geway/Bradford CA LP DBA: Vista Town Center PO Box 19068 irvine, CA 92663 V#81503	3,307	$1.10	(a)	$ 4,936.59	10/28/13	03/03/18	**Nifty after Fifty** 510 Hacienda Drive Suite 108-A Vista, CA 92081	9550
Tri City Real Estate Holding & Management Company, LLC 4002 Vista Way Oceanside, Ca 92056	6,123	$1.37		$ 8,065.25	12/19/11	12/18/16	**Vacant Medical Office Building** 4120 Waring Rd Oceanside, Ca 92056	8462 Until operational
Tri City Real Estate Holding & Management Company, LLC 4002 Vista Way Oceanside, Ca 92056	4,295	$3.13		$ 12,834.05	01/01/12	12/31/16	**Vacant Bank Building Property** 4000 Vista Way Oceanside, Ca 92056	8462 Until operational
Total				**$ 335,194.67**				

(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 8/31/2015

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6150	PCCN EXAM	70915	175.00	81825	MARIA CARLOS
7633	NUANCE TRAINING	60315	308.61	77046	JOHN WESTEY BURKE
8390	340B WORKSHOP	72415	573.66	79349	TORI HONG
8740	ASRT SCANNER	80615	125.00	82014	MAUREEN O'GRADY
8740	CHEMO AND BIO THERAPY	80615	139.00	82490	NOEMI RODRIGUEZ
8740	PALS RECERTIFICATION	71715	145.00	77983	JULIE MATTISON
8740	ACLS RENEWAL	71015	150.00	9715	SHIRLEY ARMSTRONG
8740	ACLS RENEWAL	81315	150.00	12376	IMELDA A. BROWNING
8740	ACLS RENEWAL	81315	150.00	52607	MELISSA PICOTTE
8740	AHA ACLS RECERTIFICATION	80615	150.00	77475	FLORENCIA BEATRICE JONES
8740	ACLS RENEWAL	71015	175.00	78113	GLORIA DHARMAPAL
8740	ACLS RENEWAL	71015	175.00	80547	ALYCE BUDDE
8740	ACLS RENEWAL	81315	175.00	81704	SONJA DAVILA
8740	PALS CERTIFICATIONS	71015	185.00	82477	LISA SHUE
8740	CARNIO SACRAL THERAPY	73015	200.00	39600	DEBRA KOECHERT
8740	SOCIETY OF NUCLEAR MED	80615	200.00	77784	HAMID WALEH
8740	PREPPING FOR PCCN	73015	200.00	80615	MARY JANE P. VELASCO
8740	AACN NTI	80615	200.00	81401	VALERIE FRANE
8740	ADVANCED PHARMACOLOGY	71715	200.00	82165	ROSEMARIE FINONES
8740	AA NURSING	71715	927.40	82127	LAUREN CASTONQUAY
8740	NURSING BSN	73015	2,500.00	79079	SHELLEY GUTIERREZ
8740	BSN COURSES	80615	2,500.00	81295	LORRAINE BULLA
8756	AADE CONFERENCE	80715	225.00	80490	APRIL LOMBARDO
8756	CALNOC CONFERENCE	63015	675.00	5704	JENESSA FRENCH
8765	AM ACADEMY OF ORTHO SURGERY	73015	2,310.38	78990	MARY MILLS

**This report shows payments and/or 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.