TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
December 10, 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. Conference with Labor Negotiators (Authority: Government Code Section 54957.6) Agency Negotiator: Tim Moran Employee organization: SEIU Employee organization: UFCW		
	b. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	c. Conference with Legal Counsel – Potential Litigation (Authority Government Code Section 54956.9(d) (4 Matters)		
	d. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: March 31, 2016		
	e. 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) Kimberly Ahinger v. Tri-City Healthcare District Case No. 37-2014-00026876-CU-WT-NC.		

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 disability, 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
	(3) Francisco Valle v. Tri-City Healthcare District Case No. 37-2015-00015754-CU-OE-NC (4) Medical Acquisitions Company vs. TCHD Case No: 2014-00009108 Case No. 2014-00022523 (5) Larry Anderson Employee Claims		
	i. 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	Community Update - None		
13	Report from TCHD Auxiliary	5 min.	Standard
14	Report from Chief Executive Officer	10 min.	Standard
15	Report from Chief Financial Officer	10 min.	Standard
16	New Business		
	a. Consideration and possible action to elect Board of Directors Officers for calendar year 2016	10 min.	Chair
	b. Consideration to appoint Ms. Kathy Mendez to an additional two-year term on the Finance, Operations & Planning Committee	2 min.	FOP Comm.
	c. Campus Development Plan - Information Only Presentation by Phillip Soule, Cunningham Group Architecture, Inc.	10 min.	CEO
17	Old Business - None		
18	Chief of Staff a. Consideration of November 2015 Credentialing Actions Involving the Medical Staff – New Appointments Only b. Medical Staff Credentials for November 2015 – Reappointments	5 min.	Standard

	Agenda Item	Time Allotted	Requestor
19	Consideration of Consent Calendar	5 min.	Standard
	(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 <u>require a second</u>.***		
	A. Human Resources Committee Director Kellett, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes) 1) Approval of Policy #8610-426 – Performance Evaluations 2) Approval of Policy #8610-463 – Workplace Violence 3) Approval of Policy #8610-427 – Fair Treatment for Supervisory & Management Employees		HR Comm.
	B. Employee Fiduciary Retirement Subcommittee Director Kellett, Subcommittee Chair Open Community Seats – 0 *No meeting held in November,2015*		Emp. Fid. Subcomm.
	C. Community Healthcare Alliance Committee Director Nygaard, Committee Chair Open Community Seats – 2 *No meeting held in November,2015*		CHAC Comm.
	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 Baxter Healthcare for IV Solutions and Tubing for a term of 36 months with two additional option years, beginning January 1, 2016 through December 31, 2018 for an estimated annual cost of $666,660 and a total cost not to exceed $1,999,980 for the 36 month term.		FO&P Comm.
	E. Professional Affairs Committee Director Dagostino, Committee Chair (Committee minutes included in Board Agenda packets for informational purposes.) **1) <u>Patient Care Services</u>** a. Chemotherapy Exposure, Spills and Handling of Linens Contaminated with Chemotherapeutic Agents and Body Fluids, Accidental Exposure To b. Clinical Alarm Management c. Disposal of Chemotherapy Waste Procedure		PAC

	Agenda Item	Time Allotted	Requestor
	d. Medication Administration Policy e. Potential Food and Drug Interactions, Patient Education Policy f. Risk Evaluation Mitigation Strategies (REMS) Policy (DELETE) g. Volunteers, Patient Care Services Departments Policy **2) <u>Administrative Policies & Procedures</u>** a. Alerts/Recalls/Notifications 229 b. Computer Hardware, Software and Services, Purchase of 615 c. Information Technology Standard 611 (DELETE) d. Software License Agreement 605 **3) <u>Unit Specific</u>** **<u>Engineering</u>** a. Designing and Installing Utility Systems b. Emergency Power Systems c. Humidity Level Control 2017 d. Initial Testing of New Utility Components e. Mapping the Distribution of Utility Systems Controls f. Operation of Fire and Smoke Dampers **<u>Environment of Care</u>** a. Acquisition of Furniture and Furnishings b. Providing a Safe Environment c. Waste Management **<u>Neonatal Intensive Care (NICU)</u>** a. Admission and Discharge Criteria for the NICU b. Exchange Transfusions Double and Partial Volume (DELETE) **<u>Pharmacy</u>** a. Medication Precautions (DELETE) b. Monitoring Effects of Medications on Patients (DELETE) **<u>Rehabilitation</u>** a. Goals & Objectives – 103 (DELETE) **<u>Security</u>** a. Closed Circuit Television System 512 b. Code Adam - Infant Abduction 503 c. Code Red - Security Department Response 504 d. Exterior Campus Rounding 227 **<u>Staffing</u>** a. Disaster Call Back List Policy (DELETE) **F. Governance & Legislative Committee** Director Schallock, Committee Chair Open Community Seats - 0 (Committee minutes included in Board Agenda packets for informational purposes.)		Gov. & Leg. Comm.

	Agenda Item	Time Allotted	Requestor
	1) **Rules & Regulations** a. Department of Pediatrics b. Division of Cardiology 2) Approval of Medical Staff Policy #8710-518 – Medical Record Documentation 3) Approval of Board Policy 15-027 Prohibition of Literature on District Properties 4) Approval of Board Policy 15-045 – Philanthropic Naming Policy **G. Audit, Compliance & Ethics Committee** Director Finnila, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes.) 1) **Approval of Administrative Policies & Procedures**: a. 8610-527 – Facility Directory & Visiting Guidelines for Clergy b. 8610-532 – Compliance Program Generally c. 8610-538 – Hiring and Employment; Screening Prospective Employees/Covered Contractors d. 8610-544 – Hiring and Employment; Duty to Report Suspected Misconduct/Potential Compliance Irregularity e.8750—547 - Education & Training – General Annual Compliance Training Program 2) Approval of Organizational Compliance Committee Charter		Audit, Comp. & Ethics Comm.
	(2) Minutes – Approval of a) October 29, 2015 – Regular Board of Directors Meeting b) November 5, 2015 – Special Board of Directors Meeting c) November 12, 2015 – Special Board of Directors Meeting d) November 17, 2015 – Special Board of Directors Meeting		Standard
	(3) Meetings and Conferences a) ACHD Trustee Leadership Development, Sacramento, CA January 21-22, 2016 b) CHA Legislative Day – Sacramento, CA March 16, 2016 c) ACHD Legislative Days – Sacramento, CA April 4-5, 2016 d) AHA Annual Meeting – Washington, D.C. May 1-4,2016 e) ACHD Annual Meeting – Monterey, CA May 3-5, 2016 f) 24th Annual Leadership Summit – San Diego, CA July 17-19, 2016		Standard

	Agenda Item	Time Allotted	Requestor
	g) Hospital Quality Institute Conference – San Diego, CA November 2-4, 2016 (4) Dues and Memberships a) Modern Healthcare Subscription Renewal – $119.00/Subscription (5) Proposed Board of Directors 2016 Meeting Calendar (6) Proposed Board of Directors 2016 Committee Meeting Calendar (7) Proposed Board of Directors 2016 Rotation Schedule		Standard Standard Standard Standard
20	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
21	Reports (Discussion by exception only) (a) Dashboard - Included (b) Construction Report – None (c) Lease Report – (September, 2015) (d) Reimbursement Disclosure Report – (September, 2015) (e) Seminar/Conference Reports - 1) Basic Compliance Academy – Director Mitchell 2) CHA Governance Info – Chairman Schallock	0-5 min.	Standard
22	Legislative Update	5 min.	Standard
23	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
24	Additional Comments by Chief Executive Officer	5 min.	Standard
25	Board Communications (three minutes per Board member)	18 min.	Standard
26	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session **(Includes 10 minutes for recess to accommodate KOCT tape change)**	**2 hrs/ 10 min.**	
27	Oral Announcement of Items to be Discussed During Closed Session (If Needed)		
28	Motion to Return to Closed Session (If Needed)		
29	Open Session		
30	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
31	Adjournment		

Finance, Operations and Planning Committee

Date of Meeting: November 17, 2015

Discussion:

Kathleen Mendez

Second Term Request - Community Member,
Finance, Operations & Planning Meeting

Projected Second Term Dates: December 2015 – December 2017

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
November 11, 2015

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 12/11/2015– 10/31/2017)

Any items of concern will be "red" flagged in this report. 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 12/11/2015 through 10/31/2017:

- **BUI, Hanh M., MD/Cardiology**
- **LLOYD, Amanda A., MD/Dermatology**
- **PLAXE, Steven C., MD/Gynecologic Oncology**
- **SAINI, Arvind, MD/Ophthalmology**

INITIAL APPLICATION WITHDRAWAL: (Voluntary unless otherwise specified)

Medical Staff:

TEMPORARY PRIVILEGES: Medical Staff/Allied Health Professionals:

None

TEMPORARY MEDICAL STAFF MEMBERSHIP: Medical Staff:

None

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
November 11, 2015

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 1/01/2016 – 12/31/2017)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 1/01/2016 through 12/31/17, 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:

- **BROWN, Dorothy W., M.D./Emergency Medicine/Active**
- **BYUN, Charlton K., M.D./Diagnostic Radiology/Provisional**
- **CIZMAR, Branislav, M.D./OB-GYN/Courtesy**
- **DANESHMAND, Shahram S., M.D./Maternal & Fetal Medicine/Provisional**
- **DANG, Paul T., M.D./Internal Medicine/Active**
- **GILL, John C., M.D./Family Medicine/Consulting**
- **KARAS JR., Stephen, M.D./Emergency Medicine/Active**
- **LEVINE, Neil D., M.D./Internal Medicine/Affiliate**
- **MALHIS, Safouh, M.D./Pulmonary Medicine/Active**
- **MATAYOSHI, Amy H., M.D./Nephrology/Active**
- **PATEL, Sanketkumar S., M.D./Internal Medicine/Provisional**
- **SORKHI, Ramin, M.D./General Surgery/Provisional**
- **ZAVERI, Maulik S., M.D./Ophthalmology/Provisional**
- **ZORRILLA, Juan C., M.D./Emergency Medicine/Active**

REINSTATEMENT: (Effective date 12/11/2015 to 7/31/2017)

- **MAZUR, Paul M.D./Cardiothoracic Surgery**

RESIGNATIONS: (Effective date 12/11/2015 unless otherwise noted)

Voluntary:

Attachment B

- **SPEELMAN, Patricia N., M.D./Dermatology**
- **SURI, Mandhir S., M.D./Neonatology**
- **WOSK, Bernard, M.D. /Pediatrics**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
November 11, 2015

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS (Effective Date: 12/11/2015, unless specified otherwise)

PRIVILEGE RELATED CHANGES

- None at this time

STAFF STATUS CHANGES

- **ESCH, James M.D./Orthopedic Surgery/Active**
- **HAAS, Terry A., M.D. / Internal Medicine/Affiliate**
- **LELEVIER, Jon A., M.D. / Internal Medicine/Affiliate**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 3 of 3
November 11, 2015

Attachment C

PROCTORING RECOMMENDATIONS (Effective 12/11/2015, unless otherwise specified)

- GE, Xupeng M.D. — Anesthesiology
- IPSON, Jason M.D. — Anesthesiology
- KRUETH, Stacy M.D. — Anesthesiology
- PHILLIPS, Jason M.D. — Urology

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE INITIAL CREDENTIALS REPORT
November 16, 2015

Attachment A

INITIAL APPOINTMENT TO THE ALLIED HEALTH PROFESSIONAL STAFF

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 AHPs have met the basic requirements of staff and are therefore recommended for appointment effective 12/11/2015 through 10/31/2017:

INITIAL APPLICATION WITHDRAWAL: (Voluntary unless otherwise specified)

Allied Health Professionals:

None

TEMPORARY PRIVILEGES: Allied Health Professionals:

None

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE REAPPOINTMENT CREDENTIALS REPORT – 1 of 3
November 16, 2015

Attachment B

BIENNIAL REAPPRAISALS: (Effective Dates 1/1/2016 – 12/31/2017)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 1/1/2016 through 12/31/17, 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:

- **KAUR, Manpreet, PAC/Allied Health Professional Supervising Physician Warren S. Paroly, MD**
- **ZACARIAS, Elizabeth PAC/Allied Health Professional Supervising Physician Neil Tomaneng, MD**

RESIGNATIONS: (Effective date 12/11/2015 unless otherwise noted)

- ***None***

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE CREDENTIALS REPORT – Part 3 of 3
November 16, 2015

Attachment C

PROCTORING RECOMMENDATIONS (Effective 12/11/2015, unless otherwise specified)

- **HERMANN, Linda PA-C** — **Allied Health Professional**
- **LISTER, Crystal CNM** — **Allied Health Professional**

TRI-CITY MEDICAL CENTER
HUMAN RESOURCES COMMITTEE
OF THE BOARD OF DIRECTORS
November 10, 2015

Voting Members Present:	Chair Cyril Kellett, Director Rosemarie Reno, Director Laura Mitchell, Dr. Gene Ma, Dr. Hamid Movahedian, Virginia Carson, Joe Quince
Non-Voting Members Present:	Kapua Conley, COO; Sharon Schultz, CNE; Esther Beverly, VP of HR; Cheryle Bernard-Shaw, CCO
Others Present:	Frances Carbajal
Members Absent:	Tim Moran, CEO; Gwen Sanders, Salvador Pilar, Dr. Martin Nielsen

Topic	Discussion	Action Follow-up	Person(s) Responsible
1. Call To Order	Chair Kellett called the meeting to order at 12:35 p.m.		Chair Kellett
2. Approval of the agenda	Chair Kellett called for a motion to approve the agenda of November 10, 2015 meeting with the removal of item 6.A. Director Reno moved and Director Mitchell seconded the motion. The motion was carried unanimously.		Chair Kellett
3. Comments from members of the public	Chair Kellett read the paragraph regarding comments from members of the public.		Chair Kellett
4. Ratification of Minutes	Chair Kellett called for a motion to approve the minutes of the October 13, 2015 meeting. Director Reno moved and Director Mitchell seconded the motion. The motion was carried unanimously.		Chair Kellett

Topic	Discussion	Action Follow-up	Person(s) Responsible
5. Old Business			
None			
6. New Business			
a. Policy Discussion/Action Policy 8610-415 Dress and Appearance Philosophy	The Committee reviewed Policy 8610-415 and agreed to the proposed revisions. Chair Kellett called for a motion to send Policy 8610-415 with revisions to the Board of Directors for approval. Director Mitchell moved and Director Reno seconded the motion. The motion was carried unanimously.	Policy 8610-415 to be sent to Board of Directors for approval after HR meets & confers with the unions	Esther Beverly
Policy 8610-455 Confidentiality	The Committee reviewed Policy 8610-455 and agreed to the proposed revisions. Chair Kellett called for a motion to send Policy 8610-455 to the Board of Directors for approval. Director Reno moved and Director Mitchell seconded the motion. The motion was carried unanimously.	Policy 8610-455 to be sent to Board of Directors for approval after HR meets & confers with the unions	
Policy 8610-426 Performance Evaluations	The Committee reviewed Policy 8610-426 and agreed to the proposed revisions. Chair Kellett called for a motion to send Policy 8610-426 with revisions to the Board of Directors for approval. Director Mitchell moved and Director Reno seconded the motion. The motion was carried unanimously.	Policy 8610-426 to be sent to Board of Directors December meeting for approval.	
Policy 8610-463 Workplace Violence	The Committee reviewed Policy 8610-463. Chair Kellett called for a motion to send Policy 8610-463 to the Board of Directors for approval. Director Mitchell moved and Director Reno seconded the motion. The motion was carried unanimously.	Policy 8610-463 to be sent to Board of Directors December meeting for approval.	
Policy 8610-427 Fair Treatment For Supervisory & Management Employees	The Committee reviewed Policy 8610-427 and agreed to the proposed revisions. Chair Kellett called for a motion to send Policy 8610-427 to the Board of Directors for approval. Director Mitchell moved and Ginny Carson seconded the motion. The motion was carried unanimously.	Policy 8610-427 to be sent to Board of Directors December meeting for approval.	

Topic	Discussion	Action Follow-up	Person(s) Responsible
7. Work Plan	The work plan was reviewed.		Chair Kellett
8. Committee Communications	None		Chair Kellett
9. Date of next meeting	**TBD**		Chair Kellett
10. Adjournment	Chair Kellett adjourned the meeting at 1:30 p.m.		Chair Kellett

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 07/88 **SUBJECT: Performance Evaluations**

REVISION DATE: 10/12 **POLICY NUMBER: 8610-426**

Human Resources Committee Approval: ~~10/12~~11/15
Board of Directors Approval: ~~11/12~~TBD

A. PURPOSE:

1. To ensure that all employees receive a periodic performance evaluation and competency assessment.

B. POLICY:

1. Department Managers will complete an annual performance evaluation for all employees.
2. All managers must have ongoing communication with the employee to discuss performance relative to specific competencies and manager's expectations.
3. The evaluation tool consists of pre-determined standards against which the employee's performance is measured.
4. ~~Annual performance reviews for employees in benefited positions will be considered for a merit award. (Administrative Policy #475 – Employee Compensation)~~
   a. ~~4.~~ Employees covered under a recognized bargaining unit will be subject to the terms and conditions of their respective contract.

~~5.~~ 5. For individuals with clinical ~~privileges and~~ responsibility for the assessment, treatment, or care of patients, the job description and annual performance appraisals must address competencies appropriate to ages of the patients served. Employees must also have evidence of satisfactorily completing the minimal annual competency assessment.

~~6.~~4. 6. ~~Individuals without clinical privilege~~Non-clinical employees must meet the annual competency assessment based upon the job description and performance appraisal.

~~7.~~5. 7. Strict adherence to this policy is a management performance expectation. Noncompliance will be addressed in accordance with the TCHD policy for Code of Conduct and Performance Improvement. (Administrative Policy #424)

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 1/00 **SUBJECT: Workplace Violence**

REVISION DATE: 10/12 **POLICY NUMBER: 8610-463**

Human Resources Committee Approval: 11/15
Board of Directors Approval: TBD

A. **PURPOSE:**

Tri-City Healthcare District (TCHD) is committed to providing a work environment that is safe and free of threats or acts of workplace violence.

DEFINITIONS

Acts or Threats of Violence Defined. TCHD expressly prohibits conduct on TCHD premises that constitutes unlawful violence or a credible threat of violence.

"Unlawful Violence" means any assault or battery, or stalking as prohibited in Section 646.9 of the Penal code, but shall not include lawful acts of self-defense or defense of others.

"A credible threat of violence" means a knowing and willful statement or course of conduct that would place a reasonable person in fear for his/her safety, or the safety of his/her immediate family, and that serves no legitimate purpose.

General examples of conduct prohibited by this policy include, but are not limited to, the following:

A. Threatening to harm or harming an individual or his/her family, friends, associates, or their property.
B. Fighting or challenging another individual to a fight.
C. Intimidation through direct or veiled verbal threats, or through physical threats, such as obscene gestures, grabbing, and pushing.
D. Making harassing or threatening telephone calls; sending harassing or threatening letters, , texts, emails, or other correspondence.
E. Intimidating or attempting to coerce an employee to do wrongful acts that would affect the business interests of TCHD.
F. Harassing surveillance or stalking, which is engaging in a pattern of conduct with the intent to follow, alarm, or harass another individual, which presents a credible threat to the individual and causes the individual to fear for his/her safety, or the safety of his/her immediate family, as defined in *Civil Code* section 1708.7.
G. Making a suggestion or otherwise intimating that an act to injure persons or property is appropriate behavior.
H. Use of a personal or TCHD-issued tool in a threatening manner toward another.
I. Unauthorized possession of firearms (loaded or unloaded), weapons, or any other dangerous devices on TCHD property. This includes "look-alike" weapons, such as toy guns. Weapons and dangerous devices may include, but are not limited to the following: blackjacks, slingshots, metal knuckles, explosive substances, dirks, daggers, gas- or spring-operated guns, knives, razor blades, and clubs

B. **POLICY:**

1. TCHD is committed to providing a safe, violence-free workplace and strictly prohibits employees, consultants, customers, patients, physicians, visitors, or anyone else on TCHD premises engaging in a TCHD-related activity from engaging in Unlawful Violence or making credible threats of violence. As part of this policy, TCHD seeks to prevent workplace violence before it begins and reserves the right to deal with behavior that suggests a propensity towards violence even prior to any violent behavior occurring.

C. REPORTING:

1. TCHD employees must report actual or suspected violations to their manager or to any supervisory employee. Supervisors must report actual or suspected violations to the Chief Human Resources Officer and to Security immediately. TCHD employees must report, to Human Resources, any domestic violence temporary restraining orders ("TROs") or injunctions in which the employees are named as petitioners or respondents.

D. INVESTIGATIONS:

1. All reports of Unlawful Violence or credible threats of violence will be investigated promptly and thoroughly and shall be reported to the appropriate authorities by the Security Department. Such investigations cannot be kept confidential, but TCHD will take reasonable steps to prevent retaliation of any kind against any TCHD who has reported Unlawful Violence or a credible threat of violence, or who has cooperated in any investigation of Unlawful Violence or credible threat of violence.

E. CORRECTIVE ACTION AND DISCIPLINE:

1. If TCHD determines that Unlawful Violence or a credible threat of violence has occurred, TCHD will take appropriate corrective action and will take disciplinary action against offending employees, up to and including termination. If such acts, or threats of, are by non employees, TCHD will take appropriate measures to ensure the safety of staff, including reporting all such incidents to the appropriate authorities.

F. EMPLOYEE ASSISTANCE PROGRAM:

1. Any employee who believes that he/she may have a problem that could lead to violent behavior is encouraged to use TCHD's Employee Assistance Program (EAP). The EAP is a professional, confidential counseling service that is available to all personnel and members of their household to assist in resolving emotional difficulties, marital and family conflict, stress, chemical dependence, conflicts at work, and other concerns. The EAP counselor can help to clarify a problem and to develop an action plan during the counseling session.
2. Further information regarding TCHD's Employee Assistance Program may be obtained from your supervisor or from the Human Resources Department.

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 04/86

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

REVISION DATE: 07/09; 08/12; 02/13; 10/13~~427~~

POLICY NUMBER: 8610-427

Human Resources Committee Approval: ~~10/13~~11/15
Board of Directors Approval: ~~10/13~~TBD

A. PURPOSE:

To provide an orderly mechanism for supervisors, managers, directors and above to receive fair treatment in connection with an intent to suspend or terminate their employment.

B. DEFINITION:

Fair Treatment Process: In the case of corrective actions involving disciplinary final written warning or intent to terminate, supervisors, managers, directors and above with more than 90 days of active employment shall be entitled to follow the process set forth below. A Human Resources representative shall be available to facilitate the Fair Treatment process.

C. PROCESS:

Supervisor/Manager Level Process

Step I: Meeting with Management

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

b. The employee's manager, beyond their direct supervisor/manager, and a Human Resources representative shall meet with the employee, and the manager shall respond to the employee within 5 working days (M-F) after the meeting with their decision.

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

Step II: Fair Treatment Form

a. If the employee still feels after Step I that the decision is unfair, the employee may commence a formal grievance process within 5 working days (M-F) of the decision by the employee's manager in Step I. The formal grievance process begins with the submission to Human Resources of a completed Fair Treatment form, signed by the employee and describing in specific detail the nature of the grievance and the facts giving rise to it. If the employee fails to submit the completed Fair Treatment form within the above time frame, the Fair Treatment process shall end.

i. A Human Resources representative shall forward a copy of the completed Fair Treatment form to the lead Human Resources official within 5 working days (M-F) of receipt of the form.

ii. The lead Human Resources official, or his or her designee, shall review, investigate, and analyze the matter and shall respond in writing with his or her decision no later than 5 working days (M-F) after concluding his or her analysis. The employee is deemed notified on the date the decision letter is postmarked.

Step III: Final Review by the CEO

a. If the matter is still unresolved to the employee's satisfaction after Step II, the employee may request review by the Chief Executive Officer. Human Resources shall present the completed Fair Treatment form to the Chief Executive Officer within 5 working days (M-F) of notification of the lead Human Resources official's decision. If the employee fails to request review by the Chief Executive Officer within the time frame specified for this Step III, the Fair Treatment process shall end.

b. The Chief Executive Officer shall review, investigate, and analyze the matter and render a decision within 5 working days (M-F) after concluding his or her analysis. The employee is deemed notified on the date the decision letter is postmarked. Decisions of the Chief Executive Officer are final and binding.

Process for Directors and Above

Step I: Meeting with Executive

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

b. The appropriate Executive shall meet with the employee and will respond within 5 working days (M-F) with his or her decision.

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

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

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

D. **REFERENCED FORM WHICH CAN BE REQUESTED FROM HR:**

1. Fair Treatment Form

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

Community Healthcare Alliance Committee (No meeting held in November, 2015)

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
November 17, 2015

Members Present	Director James Dagostino, Director Cyril Kellett, Director Julie Nygaard, Dr. Marcus Contardo, Dr. Frank Corona, Kathleen Mendez, Carlo Marcuzzi, 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	David Bennett, Colleen Thompson, Glen Newhart, Ray Rivas, Thomas Moore, Charlene Carty, Carol Smyth, Sharon Schultz, Jane Dunmeyer, Jody Root, (Procopio), Barbara Hainsworth
Members Absent:	Dr. John Kroener

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Dagostino called the meeting to order at 12:35 pm.		
2. Approval of Agenda		**MOTION** **It was moved by Director Nygaard, Mr. Lingenfelter seconded, and it was unanimously approved to accept the agenda of November 17, 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 October 20, 2015		Minutes were ratified **MOTION** **It was moved by Director Kellett, Mr. Keane seconded, that the minutes of**	

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		October 20, 2015, be approved without any modifications requested. Those abstaining were: Dr. Contardo, Dr. Corona, Ms. Mendez, Mr. Harrington and Mr. Keane.	
5. Old Business			
6. New Business			
a. Kathleen Mendez – Community Member • Second Term Requested	Director Dagostino conveyed that Kathleen Mendez has volunteered to serve a second term as a Community Member on the Finance, Operations and Planning committee. The second term would run from December 2015 through December 2017.	**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 approve Kathleen Mendez for a second term as a Community Member.**	Director Dagostino
b. Baxter Healthcare Proposal for Services	Tom Moore explained that this agreement was for 3-years, with two optional years, beginning in January 2016 and ending in December 2018. It is a pricing and usage agreement for IV solutions and tubing. He further explained that the total estimated savings over the 3-year term is $225,000, from the current expenditure.	**MOTION** **Dr. Contardo 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 Baxter Healthcare for IV solutions and tubing for a term of 36-months with 2 additional option years, beginning January 1, 2016 and ending December 31, 2018 for an estimated annual cost of $666,660, and a total cost not to exceed $1,999,980 for the 36-month term.**	Thomas Moore
c. Financials	Steve Dietlin presented the financials ending October 31, 2015 (dollars in thousands)		Steve Dietlin

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	Fiscal Year to Date Operating Revenue $ 111,628 Operating Expense $ 111,818 EROE $ 1,467 EBITDA $ 6,231 **TCMC –Key Indicators – FYTD** Avg. Daily Census 189 Adjusted Patient Days 37,674 Surgery Cases 2,232 Deliveries 908 ED Visits 22,490 **Current Month** Operating Revenue $ 27,720 Operating Expense $ 28,396 EROE $ (189) EBITDA $ 1,011 **Net Patient A/R & Days in Net A/R By Fiscal Year** FY Avg. Net Patient A/R (in millions) $ 40.6 FY Avg. Days in Net A/R $ 45.8 **Graphs:** • TCMC-Net Days in Patient Accounts Receivable • TCMC-Average Daily Census-Total Hospital-Excluding Newborns • TCMC-Adjusted Patient Days • TCMC-Emergency Department Visits • TCHD-EBITDA and EROE, Quarterly		

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
i. Work Plan – Information Only • Dashboard	Director Dagostino reported that these agenda items were for review only, but Committee members were welcome to ask questions. Director Dagostino solicited question pertaining to the dashboard. No questions were raised.	Due to the cancellation of the December 2016 Finance, Operations and Planning meeting, the two items appearing on the Work Plan for December (bi-monthly Aionex Bed Board / Throughput and the quarterly Neuroscience Institute, NSI Medical Directorships) were both moved to the January 2016 meeting, and the schedule modified accordingly.	Steve Dietlin
7. Comments by Committee Members		None	Chair
8. Date of next meeting	January 19, 2016		Chair
9. Community Openings (none)			
10. Oral Announcement of items to be discussed during closed session (Government Code Section 54957.7)			Jody Root
11. Motion to go into Closed Session		**MOTION** **Dr. Contardo moved, Dr. Corona seconded, and it was unanimously approved to go into Closed Session at 1:00 pm**	
16. Open Session		**MOTION** **Director Kellett moved, Dr. Contardo seconded, and it was unanimously approved to go into Open Session at 1:05 pm**	
17. Report from Chairperson of any action taken in	No report made.		

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
Closed Session (Authority: Government code, section 54957.1)			
18. Adjournment	Meeting adjourned 1:25 pm		

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: November 17, 2015
Baxter Healthcare Proposal for Services

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

Vendor's Name: Baxter Healthcare

Area of Service: Supply Chain Management

Term of Agreement: 36 months + 2 option years, Beginning, January 2016 – Ending, December, 2018

Maximum Totals:

Estimated Monthly Cost	Estimated Annual Cost	Total Term Cost Not to Exceed
$55,555	$666,660	$1,999,980

Description of Services/Supplies:

- Pricing agreement and usage agreement for IV solutions and IV tubing
- Estimated total savings over 3 year term is $225,000, from current spend

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	X	No		Not Applicable

Person responsible for oversight of agreement: Thomas Moore, Director, Supply Chain Management / Steve Dietlin, Chief Financial Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Baxter Healthcare for IV solutions and tubing for a term of 36 months with 2 additional option years, beginning January 1, 2016 and ending December 31, 2018 for an estimated annual cost of $666,660, and a total cost not to exceed $1,999,980 for the 36 month term.

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
November 19, 2015

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

Non-Voting Members Present: Tim Moran, CEO, Kapua Conley, COO/ Exec. VP , Sharon Schultz, CNE/Sr. VP and Cheryle Bernard-Shaw, Chief Compliance Officer.

Others present: Jody Root, General Counsel, Jami Piearson, Director of Quality and Regulatory, Marcia Cavanaugh, Sr. Director for Quality, Cli. Risk Mgt. & Patient Safety, Kathy Topp, Kevin McQueen, Nancy Myers, Tori Hong, Daniel Martinez, Chris Miechowski, Patricia Guerra and Karren Hertz.

Members absent: None.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Dagostino, called the meeting to order at 12:08 p.m. in Assembly Room 1.		Director Dagostino
2. Approval of Agenda	The group reviewed the agenda and there were no additions or modifications.	Motion to approve the agenda was made by Dr. Ma and seconded by Director Finnila.	Director Dagostino
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

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Ratification of minutes of October 2015.	Director Dagostino called for a motion to approve the minutes of the October 15, 2015.	Minutes ratified. Director Mitchell moved and Dr. Ma seconded the motion to approve the minutes from October 2015.	Karren Hertz
5. New Business a. Quality Outcomes Dashboard	The October outcomes dashboard was presented to the committee. Director Dagostino mentioned that the data is looking good; hospital is in the right direction. There was a hiccup in some areas which can be considered as an outlier because of the small numbers involved. The data on preventable VTE is an older data (September) and Marcia reported that they are currently working on improving this issue. It was noted that LWOT figures was down as the hospital volume was also down.	Informational.	Sharon Schultz and Marcia Cavanaugh
Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures:** 1. Chemotherapy Exposure, Spills and Handling of Linens Contaminated with Chemotherapeutic Agents and Body Fluids, Accidental Exposure To	Director Mitchell has a question on the location of the spill kits; Kevin stated that they are located in the utility rooms all throughout the hospital. Chemo waste is accepted by the sewer.	**ACTION:** The Patient Care Services policies and procedures were approved. Director Mitchell moved and Director Finnila seconded the motion to approve these policies	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
2. Clinical Alarm Management	There was a brief discussion on the need for staff to be diligent when it comes to alarm fatigue. Kevin mentioned that he recently attended a training and learned about the alarms' escalation system with changing tones and volumes to avoid alarm fatigue.	moving forward for Board approval.	
3. Disposal of Chemotherapy Waste Procedure	No discussion on this policy.		
4. Medication Administration Policy	The differentiation between Allied Health professionals and nurse practitioner was mentioned out.		
5. Potential Food and Drug Interactions, Patient Education Policy	Coumadin was the only drug that was identified for potential drug interactions since the other two changes too much.		
6. Risk Evaluation Mitigation Strategies (REMS) Policy	No discussion on this policy.		
7. Volunteers, Patient Care Services Departments Policy	There was a brief discussion on the liability factor associated with the work given by the volunteers.		
Administrative Policies and Procedures			
1. Alerts/Recalls/Notifications 229	No discussion on this policy.	**ACTION:** The Administrative policies and procedures were approved and are moving forward for Board approval. Dr. Contardo moved and Director Mitchell seconded the motion to	Patricia Guerra
2. Computer Hardware, Software and Services, Purchase of 615	Some minor editorial changes were done.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
		approve these policies.	
3. Disciplinary Action for Breaches of Confidentiality of Restricted Electronic Information 609	This policy that centers on a disciplinary action is considered to be more of an IT-related policy. There was consensus that this policy needs to be consistent across the board and the HIPPA policy needs to be referenced as well.	**ACTION:** This policy needs to be cross checked with the other disciplines for consistency purposes. Cheryle to look further into this; this policy is being pulled out for further review.	Patricia Guerra
4. Information Technology Standard 611	No discussion on this policy.		
5. Software License Agreement 605	It was identified that this policy deals more of the enterprise software.		
Unit Specific Engineering			
1. Designing and Installing Utility Systems	The location of the hospital's fuel tank for the generator was clarified to be in the parking lot. Chris mentioned that the generators are ran once a month for testing. It has diesel which is low in the inflammability scale. Dr. Contardo reiterated that diesel/ fuel gets contaminated when they get old. Chris to look into this.	**ACTION:** The unit specific policies for Engineering were approved as moved by Dr. Contardo and seconded by Dr. Worman.	Patricia Guerra
2. Emergency Power Systems	There was a recommendation to add clinical lab to the list of systems fed by emergency electrical power.		
3. Humidity Level Control 2017	In light of the humidity issues in the OR in		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	the past, it was identified that the anesthesia location is currently aligned to the CMS standard.		
4. Initial testing of new utility components	The premise of the manufacturer testing the new equipment should be incorporated in this policy. Director Finnila mentioned that the utility system in this policy should be defined.		
5. Mapping the Distribution of Utility Systems Controls	Chris M. stated that boilers are still existing in the hospital as they are essential in providing heat throughout the hospital.		
6. Operation of Fire and Smoke Dampers	It was noted that detectors need to be checked at least before the required six (6) years equipment maintenance check.		
Environment of Care			
1. Acquisition of Furniture and Furnishings	The directors confirmed that these first tow policies were both Joint Commission licensing requirements.	**ACTION:** The EOC Policies were approved; Dr. Contardo moved and Dr. Johnson seconded the motion to approve these policies.	Patricia Guerra
2. Providing a Safe Environment			
3. Waste Management	Dr. Johnson clarified that soiled wastes go to the regular trash and saturated ones go to the red bag.		
Neonatal Intensive Care (NICU)			
1. Admission and Discharge Criteria for the NICU	There was a clarification made that the initial assessment that needs to be done by NP or physician (and not RN) is a CMS requirement. Nancy also mentioned that the physicians are aware of the NICU	**ACTION:** It was recommended by the committee to put the transfer requirements to be written or posted as a reference in the unit.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	requirements for transfer to a tertiary unit.		
2. Exchange Transfusions Double and Partial Volume	Patricia reported to the group that Mosby uses generic procedures and policies cannot be deleted unless Mosby allows it.	**ACTION:** The NICU policies were approved ; Director Mitchell moved and Director Finnila seconded the motion to approve the policies.	Patricia Guerra
Pharmacy 1. Medication Precautions 2. Monitoring Effects of Medications on Patients	No discussion on this policy. Both of these policies are being deleted and incorporated into PCS Administration policy.	**ACTION:** The Pharmacy policies were approved as moved by Director Finnila and seconded by Director Mitchell.	Patricia Guerra
Rehabilitation 1. Goals & Objectives – 103	This policy is being deleted; no discussion made.	**ACTION:** The Rehab policy was approved as moved by Director Finnila and seconded by Director Mitchell.	Patricia Guerra
Security 1. Closed Circuit Television System 512 2. Code Adam - Infant Abduction 503 3. Code Red - Security Department Response 504 4. Exterior Campus Rounding 227	The Security policies were presented and there was a discussion on the codes and how the information on the codes should be disseminated throughout the hospital.	**ACTION:** The Security policies and procedures were approved and are moving forward for Board approval. Director Mitchell moved and Dr. Worman seconded the motion to approve these policies.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Staffing 1. Disaster Call Back List Policy	There was no discussion on this policy.		Patricia Guerra
6.Discussion Related to Policies That May Not Require Committee Approval (follow-Up Discussion from Board Retreat)	PAC Chair Dagostino opened up the topic of the committee's effectiveness in reviewing the policies in PAC as it relates to the Board, the physicians and the C-Suite as well as Nursing. A productive discussion ensued as the committee gave their input on this topic. *Physicians- Dr. Worman mentioned that the flow of information contained in these policies are helpful for the physicians. New information is passed on and it provides consistency on patient care with the doctors and nurses. Dr. Ma said that the MDs are in favor of streamlining the review process and avoiding unnecessary work as they have a thick packet that they review in MEC. But they all agree that PAC is a good avenue to discuss some essential policies on a thorough basis.. *Nursing- Sharon had mentioned that MEC approves the policies as consent agenda and due to time constraints and the thickness of the packet, the policies are not being looked at a very close level. PAC provides that thorough look.	**ACTION:** Director Dagostino will bring this information to the Board and will give feedback next meeting.	Director Dagostino

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	*BOD- Director Finnila commented that the other party's perspective (BOD, MDs, Nursing) is important; more sets of eyes reviewing the policies provide a productive input and the in-depth discussion that some polices bring about in PAC are very valuable to the organization and the BOD as well. Director Mitchell concurred with Director Finnila. Director Dagostino commented that many use the policy discussion as an education tool to understand the complexities of hospital operations. *C- Suite- Even though traditionally in other organizations, only the internal people in the Operations review the hospital policies, it is still helpful and collaborative for PAC to continue what it is doing. It was also mentioned that even though we have three (3) governing bodies – Joint Commission, CMS and Title 22; only Title 22 states that a Board needs to review the nursing policies or policies directly relating to patient care. Jody Root added that we need to check with licensing on how to interpret this regulation and later be evaluated by the BOD.		
8. Closed Session	Director Dagostino asked for a motion to go into Closed Session.	Dr. Contardo moved, Director Finnila seconded and it was	Director Dagostino

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
		unanimously approved to go into closed session at 1:05 PM.	
9. Return to Open Session	The Committee return to Open Session at 2:25 PM.		Director Dagostino
10. Reports of the Chairperson of Any Action Taken in Closed Session	There were no actions taken.		Director Dagostino
11. Comments from Members of the Committee	No Comments.		Director Dagostino
11. Adjournment	Meeting adjourned at 2:24 PM		Director Dagostino

PROFESSIONAL AFFAIRS COMMITTEE
November 19th, 2015

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Chemotherapy Exposure, Spills, and Handling of Linens Contaminated with Chemotherapeutic Agents and Body Fluids, Accidental Exposure To	3 year review	Forward to BOD for approval
2. Clinical Alarm Management	NEW	Forward to BOD for approval
3. Disposal of Chemotherapy Waste Procedure	3 year review, practice change	Forward to BOD for approval
4. Medication Administration Policy	Practice change	Forward to BOD for approval with revisions
5. Potential Food and Drug Interactions, Patient Education Policy	3 year review, practice change	Forward to BOD for approval
6. Risk Evaluation Mitigation Strategies (REMS) Policy	DELETE	Forward to BOD for approval
7. Volunteers, Patient Care Services Departments Policy	3 year review	Forward to BOD for approval
Administrative Policies & Procedures		
1. Alerts/Recalls/Notifications 229	Practice change	Forward to BOD for approval
2. Computer Hardware, Software and Services, Purchase of 615	3 year review, practice change	Forward to BOD for approval with revisions
3. Disciplinary Action for Breaches of Confidentiality of Restricted Electronic Information 609	3 year review, practice change	Pulled for further review
4. Information Technology Standard 611	DELETE	Forward to BOD for approval
5. Software License Agreement 605	3 year review, practice change	Forward to BOD for approval
Unit Specific		
Engineering		
1. Designing and Installing Utility Systems	NEW	Forward to BOD for approval
2. Emergency Power Systems	NEW	Forward to BOD for approval with revisions
3. Humidity Level Control 2017	3 year review, practice change	Forward to BOD for approval
4. Initial Testing of New Utility Components	NEW	Forward to BOD for approval with revisions
5. Mapping the Distribution of Utility Systems Controls	NEW	Forward to BOD for approval
6. Operation of Fire and Smoke Dampers	NEW	Forward to BOD for approval
Environment of Care		
1. Acquisition of Furniture and Furnishings	3 year review, practice change	Forward to BOD for approval
2. Providing a Safe Environment	NEW	Forward to BOD for approval
3. Waste Management	3 year review, practice change	Forward to BOD for approval

PROFESSIONAL AFFAIRS COMMITTEE
November 19th, 2015

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Neonatal Intensive Care (NICU		
1. Admission and Discharge Criteria for the NICU	3 year review	Forward to BOD for approval with revisions
2. Exchange Transfusions Double and Partial Volume	DELETE	Forward to BOD for approval with revisions
Pharmacy		
1. Medication Precautions	DELETE	Forward to BOD for approval
2. Monitoring Effects of Medications on Patients	DELETE	Forward to BOD for approval
Rehabilitation		
1. Goals & Objectives – 103	DELETE	Forward to BOD for approval
Security		
1. Closed Circuit Television System 512	3 year review, practice change	Forward to BOD for approval
2. Code Adam - Infant Abduction 503	3 year review, practice change	Forward to BOD for approval
3. Code Red - Security Department Response 504	3 year review, practice change	Forward to BOD for approval
4. Exterior Campus Rounding 227	3 year review, practice change	Forward to BOD for approval
Staffing		
1. Disaster Call Back List Policy	DELETE	Forward to BOD for approval

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**CHEMOTHERAPY EXPOSURE, SPILLS, AND HANDLING OF LINENS CONTAMINATED WITH CHEMOTHERAPEUTIC AGENTS AND BODY FLUIDS, ACCIDENTAL EXPOSURE TO RADIOACTIVE BODY FLUIDS**
Purpose:	To outline staff responsibility and management of chemotherapy spills, radioactive body fluid exposures, and handling of contaminated linens.
Supportive Data:	To prevent staff exposure to chemotherapy and radiopharmaceuticals
Equipment:	Chemotherapy Spill Kit

A. **POLICY:**

1. Many drugs used in the treatment of cancer are considered to be hazardous to health care workers.
   a. The term hazardous refers to drugs/chemicals requiring special handling because of potential health risks.
2. Staff working with chemotherapy drugs and the body fluids of patients that have received chemotherapy shall adhere to this procedure and reference Patient Care Services Disposal of Chemotherapy Waste procedure.
   a. Body fluid includes sweat, saliva, emesis, urine, feces, semen, vaginal fluid, or blood.
3. Do not use chemical inactivators due to the potential for dangerous by-products.
   a. Exception: Sodium thiosulfate is used to inactivate nitrogen mustard.

B. **PROCEDURE FOR SPILL MANAGEMENT:**

1. For chemotherapy spills greater than 400 mL in any department:
   a. Open spill kit and immediately post a sign that warns others of the presence of cytoxic spill (included in kit).
   b. Remove personnel and patients from the immediate area.
      i. Immediate area is approximately 20-foot perimeter.
   c. If spill occurs in a patient's room, evacuate patient(s) from the room and close door.
   ~~a.~~**d.** Nursing to contact Environmental Services (EVS) **supervisor at 760-644-6973**.
      i. EVS to contact EOC Safety Officer regarding the chemotherapy spill at ~~760-926-0225 (pager).~~**760-590-0352.**
2. For chemotherapy spills less than 400 mL:
   a. Non-Oncology Nursing Units Responsibilities for spills on hard surfaces estimated at less than 400 mL
      i. Open spill kit and immediately post a sign that warns others of the presence of cytoxic spill (included in chemo spill kit).
      ~~ii.~~**i.** Contact EVS Supervisor of the chemotherapy spill 760-644-6973.
   b. EVS Responsibilities for spills on hard surfaces estimated at 400 mL or less:
      i. Open spill kit and immediately post a sign that warns others of the presence of cytoxic spill (included in chemo spill kit).
      ii. Don personal protective equipment in the following order:
         1) N-95 mask (For additional mask(s) please use the N-95 masks located on the unit.)
         2) First pair of chemotherapy gloves
         3) Chemotherapy gown with the cuffs over the first pair of gloves
         4) Second pair of chemotherapy gloves over the cuffs of the gown
         5) Splash goggles or face shield
         6) Protective Shoecovers
      iii. Place spill pillows from spill kit in a "V" position on outer perimeter of spill to prevent spreading of fluid.
      iv. Place one towel from the spill kit over spill to absorb fluid.

Department Review	Clinical Policies & Procedures	Pharmacy and Therapeutics	Nursing Executive Council Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
3/00, 10/06, 5/09, 2/12, **9/15**	4/12, 8/15	**09/15**	4/12, **09/15**	5/12. **10/15**	6/12, **11/15**	6/12

v. Pick up saturated towel and spill pillows and place in small chemotherapy waste bag.
vi. Use brush to sweep any glass or fragments into scoop and place in small chemotherapy waste bag with discarded towels and spill pillows.
vii. Use the DIMENSION 3 procedure of the EVS guidelines to complete the cleaning.
viii. After DIMENSION 3 cleaning, use remaining towels to wipe up the rinse and fully dry area. Place towels in small chemotherapy waste bag and seal.
ix. Place sealed bag in Spill Kit box and seal the box with bright orange chemotherapy waste label.
x. Remove personal protective equipment in the following order.
1) Outer pair of gloves
2) Chemotherapy gown
3) N95 mask
4) Splash goggles or face shield
5) Protective Shoecovers
6) Final pair of gloves
xi. Place personal protective equipment in large chemotherapy waste bag along with spill kit box and seal the bag.
xii. Place sealed bag in the designated chemotherapy waste area on the unit.
xiii. Complete the Hazardous Drug Exposure Report and give to the supervisor of the EVS department.
xiv. The EVS supervisor shall submit copies of the Hazardous Drug Exposure Report to Employee Health Services and to the EOC Officer.

c. Oncology Unit/Pharmacy Responsibilities for spills on hard surfaces <u>estimated between 200 mL and 400 mL:</u>
i. Open spill kit and immediately post a sign that warns others of the presence of cytoxic spill (included in chemo spill kit).
ii. Delegate to a co-worker to contact EVS Supervisor of the chemotherapy spill. and/or EOC Safety Officer regarding the chemotherapy spill. EVS is responsible for spills on the oncology and pharmacy units that is between 200 mL and 400 mL.
1) 760-644-6972 (Day Shift) or pager 760-926-0841
2) 760-644-6973 (Evening Shift) or pager 760-926-0832
3) 760-644-6974 (Night Shift) or pager 760-926-0834
4) ~~760-926-0225~~ **760-590-0352** (EOC Officer~~-pager~~)

d. Oncology Unit/Pharmacy (responsibilities for spills on hard surfaces <u>estimated at less than 200 mL)</u>
i. Open spill kit and immediately post a sign that warns others of the presence of cytoxic spill (included in chemo spill kit).
ii. Contact or delegate a co-worker to contact Environmental Services (EVS) Supervisor of the chemotherapy spill.
1) 760-644-6972 (Day Shift) or pager 760-926-0841
2) 760-644-6973 (Evening Shift) or pager 760-926-0832
3) 760-644-6974 (Night Shift) or pager 760-926-0834
iii. Don personal protective equipment in the following order:
1) N-95 mask (For additional mask(s) please use the N-95 masks located on the unit.)
2) First pair of chemotherapy gloves
3) Chemotherapy gown with the cuffs over the first pair of gloves
4) Second pair of chemotherapy gloves over the cuffs of the gown
5) Splash goggles or face shield
6) Protective Shoecovers

iv. To clean up a spill from a hard surface <u>estimated as less than 200 mL:</u>

1) Place spill pillows in a "V" position on outer perimeter of spill to prevent spreading of fluid.
2) Place one towel from the spill kit over spill to absorb fluid.
3) Pick up saturated towel and spill pillows and place in small chemotherapy waste bag.
4) Use brush to sweep any glass or fragments into scoop and place in small chemotherapy waste bag with discarded towels and spill pillows.
5) EVS must use the DIMENSION 3 procedure of their EVS guidelines to complete the cleaning.
6) After EVS has completed the DIMENSION 3 cleaning, use remaining towels to wipe up the rinse and fully dry area. Place towels in small chemotherapy waste bag and seal.
7) Place sealed bag in Spill Kit box and seal the box with bright orange chemotherapy waste label.
8) Remove personal protective equipment in the following order:
   ~~(i)~~**a)** Outer pair of gloves
   ~~(ii)~~**b)** Chemotherapy gown
   ~~(iii)~~**c)** N95 mask
   ~~(iv)~~**d)** Splash goggles or face shield
   ~~(v)~~**e)** Protective Shoecovers
   ~~(vi)~~**f)** Final pair of gloves
9) Place personal protective equipment in large chemotherapy waste bag along with spill kit box and seal the bag.
10) Place sealed bag in the designated chemotherapy waste area on the unit.
11) Complete the Hazardous Drug Exposure Report and give to the clinical manager on the nursing unit.
12) The clinical manager shall submit copies of the Hazardous Drug Exposure Report to Employee Health Services and to the Environment of Care (EOC) Safety Officer.

C. **<u>PROCEDURE -- EXPOSURE AND PREVENTION RELATED TO CHEMOTHERAPY AGENTS AND BODY FLUIDS:</u>**

1. In the event of skin exposure to chemotherapeutic agent; remove any contaminated garment and immediately wash contaminated skin with soap and water.
2. In case of eye exposure, immediately flush the eye with saline solution or water for at least five minutes.
3. All linen exposed to a chemotherapy agent or body fluid of a patient that is currently receiving or has received chemotherapy in the past 48 hours, must be placed (using chemotherapy gloves and gown) in a Yellow chemotherapy waste bag and tagged by the EVS with a "Special Handling Ticket" before adding it to the general hospital linen.
4. Contact EVS when chemo waste linen bag is ~~¾~~ **2/3** full. EVS will place the chemo waste linen bag in a regular hospital blue linen bag and will place a special handling ticket on the outside of the blue linen bag before it can be placed in the general hospital linen.

~~2.~~**5.** Place any disposable cytoxic contaminated materials into a sealed, leak proof chemo waste plastic bag. Use puncture proof **chemotherapy waste** containers for sharps~~, or~~ breakable items **and/or items that are saturated with body fluids**. **See Patient Care Services Disposal of Chemotherapy Waste Procedure.**

~~5.~~**6.** All containers will be clearly labeled citing the hazardous nature of the contents-Chemotherapy.

~~6.~~**7.** Report any cytotoxic exposures or spills to your supervisor.

~~7.~~**8.** Report any employee exposure to employee health services and/or emergency department.
   a. Fill out Illness/Injury Investigation Report

~~8.~~**9.** Report any patient exposure to the patient's healthcare provider and per institution policy.

D. **PROCEDURE - PRECAUTIONS WHEN HANDLING BODY FLUIDS OF A PATIENT RECEIVING CHEMOTHERAPY(Precautions need to be taken during and 48 hours after last Chemotherapy Dose):**

1. Wear appropriate personal protective equipment (PPE) which may include the following:
   a. N-95 mask
   b. Double chemotherapy gloves
   c. Chemotherapy gown
   d. Splash goggles or face shield
   e. Protective ~~Shoecovers~~**shoecovers**
2. Disposing of body fluid
   a. Dispose of body fluids in the toilet.
   b. DO NOT USE THE TOILET SPRAYER. Rinse containers with a cup of water to prevent splashing
   c. Before flushing toilet, cover open toilet with chux. (New chux to be used with each flush).
   d. Flush toilet twice
   e. Place personal protective equipment and chux in chemotherapy waste bag.
   f. Non-Oncology contact EVS to dispose of chemo waste bag when they become ¾ of the way full.
   g. Oncology unit will place sealed chemo waste bag in the designated chemotherapy waste area on the unit.
3. All linen exposed to a chemotherapy agent or body fluid of a patient that is currently receiving or has received chemotherapy in the past 48 hours, must be placed (using chemotherapy gloves and gown) in a Yellow chemotherapy waste bag and tagged by the EVS with a "Special Handling Ticket" before adding it to the general hospital linen.
4. Skin care of incontinent adult receiving chemotherapy
   a. Clean patients skin well after voiding or having a bowel movement
   b. Apply protective barrier ointment or cream before diapering
5. All disposable equipment (i.e. foley catheter, bedpan, graduated cylinder, and diapers) used in caring for chemotherapy patients must be disposed of in a chemotherapy waste container and placed in the designated chemotherapy waste area on the unit.

E. **PROCEDURE - RADIOACTIVE BODY FLUIDS, EXPOSURE RELATED TO:**

1. In the event of exposure from the body fluid, immediately remove any contaminated garment or shoes being careful to avoid contact with substance.
2. Place contaminated articles in red radioactive marked containers in room.
3. Place as much distance from contaminated articles and self as possible.
4. Immediately wash contaminated skin with soap and water.
5. Alert Radiation Safety Officer and manager via in room phone or call light, of radiation exposure.
6. Do not leave room unless cleared by Radiation Safety Officer.
7. Report any employee exposure to employee health department or emergency department.
   a. Fill out appropriate injury form
8. Report any patient exposure to the patient's healthcare provider and per institution policy.

F. **RELATED DOCUMENTS:**

1. PCS Disposal of **Chemotherapy Waste Procedure**

G. **REFERENCES**

1. ONS Chemotherapy and Biotherapy Guidelines and Recommendations for Practice, 20, Fourth Edition
2. Center for Disease Control and Prevention. Occupational Exposure to Antineoplastic Agents and Other Hazardous Drugs. http://www.cdc.gov/niosh/topics/antineoplastic/December 12, 2014

3. Medical Waste Management Act January 2015 California Health and Safety Code Sections 117600 – 118360
4. "Preventing Occupational Exposure to Antineoplastic and Other Hazardous Drugs in Health Care Settings." National Institute for Occupational Safety and Health (NIOSH), 2014. http://www//cdc/gov/niosh/docs/2004-165/#c. "Kendall Chemobloc Procedure." Tyco Healthcare. 2006 www.tycohealthcare.com
5. Oncology Nursing Society. Manual for Radiation Oncology Nursing Practice and Education, 4th Edition, 2012. Print

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: NEW **SUBJECT: Clinical Alarm Management**

REVISION DATE(S):

Clinical Policies and Procedures Approval Date(s):	**09/15**
Nurse Executive Committee Approval Date(s):	**09/15**
Medical Staff Department/Division Approval Date(s):	**n/a**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**10/15**
Professional Affairs Committee Approval Date(s):	**11/15**
Board of Directors Approval Date(s):	

A. **DEFINITION(S):**

1. Clinical alarms: Alarms on equipment or devices used for physical or physiological monitoring to protect the patient.
2. Alarm fatigue: Desensitization of clinicians due to exposure to excessive alarms.
3. Nuisance Alarms – non actionable alarms which do not require medical intervention.

B. **POLICY:**

1. This policy ensures the effectiveness of clinical alarm systems by providing regular preventative maintenance and testing of alarm systems; assuring that alarms are activated with appropriate settings and are sufficiently audible with respect to the distances and competing noise within the unit; and defines the roles and responsibilities for alarm management.
2. Patients requiring medical equipment with clinical alarms will be placed in the appropriate patient care settings: (Refer to the Admission Criteria policy in the Patient Care Services Policy Manual.)
3. Alarm signals and parameter management: Failure to hear or respond to critical alarms may lead to unintended patient harm.
   - **a.** Alarms on clinical monitoring and intervention systems will be maintained in the "on" position and sufficiently audible to staff.
     - ~~a.~~**i.** **Alarms will be turned on by the clinician initiating the clinical monitoring.**
     - ~~i.~~**ii.** Alarms may not be turned off. Alarms will be "on" as long as the equipment is being used for the patient.
       1) Alarms may be suspended during direct patient care.
       2) All alarms must be resumed prior to the caregiver leaving the room.
       3) Alarms will not be set to such extremes that they fail to detect significant changes in a patient's condition.
   - b. Alarm parameters:
     - i. Alarm parameters should be initially set at the manufacturers default settings or to area/unit specific criteria.
     - ii. Parameters may be adjusted by a licensed clinician (within their scope of practice) based on the patient's clinical condition to reduce nuisance alarms and alarm fatigue.
       1) The licensed clinician may set alarms within closer parameters, but never any less than the documented standard.
     - iii. Staff at the beginning of each shift~~/~~ **or** when care is initiated will **ensure alarms are on and** ~~check~~ **review** the patient's alarm parameters~~and audibility.~~**, including alarm volume.**

iv. Patient and/or family education regarding clinical alarms and parameters will be done by the RN/clinician as needed throughout the shift to decrease alarm induced anxiety and increase patient involvement in their care.

4. Responsible personnel
   a. The Clinical Alarm Management Team and Medical Executive Committee (MEC) are responsible for establishing alarm management guidelines based on manufacturer's recommendations and published best practices.
   b. Directors and managers, or designee, are responsible for assessing staff competency and for providing training in the operation of medical **and monitoring** equipment ~~and monitoring systems~~ to include the use of alarm systems.
   c. Registered nurses (RN) are responsible for the ~~assessment and reassessment of their patients and, therefore, the majority~~ **setting and validating** of clinical alarm**s.** ~~function, settings, and audibility.~~
   d. A Monitor Technician (MT) will notify an RN or Advanced Care Technician (ACT) immediately when a patient's cardiac rhythm is not visible on the central monitor station.
      ~~c.~~**i. The MT shall not change default cardiac settings or make parameter adjustments unless directed by the RN.**
   ~~d.~~**e.** Respiratory therapists are responsible for setting and validating ventilator equipment, alarm limits, function, and audibility.
   ~~e.~~**f.** Licensed ancillary staff members (i.e. radiology technologists, MRI/CT specialists, Nuclear Medicine technologists) may within their scope of practice be responsible for setting and validating alarm limits, function, and audibility.
   ~~f.~~**g.** Clinical engineering (biomedical) is responsible for preventative maintenance.
   ~~g.~~**h.** All clinical staff shall respond promptly to any alarm intended to protect the patient receiving care.
   ~~h.~~**i.** Other personnel are responsible for alerting the appropriate clinician of a clinical alarm, but not adjusting unless within the scope of their training.
   ~~i.~~**j.** All staff are responsible to identify the source of an alarm and notify the appropriate clinical staff for evaluation and intervention.

5. Alarm audibility:
   a. The volume level of clinical alarms must be sufficiently audible with respect to distances and competing noise to be heard by the responsible clinicians in the immediate patient care area. The layout of the unit may impact the ability to hear certain alarms and require one or more of the following actions.
      i. Alarm volume to be adjusted upward at certain times of the day based upon the noise level and activity in the patient care area.
      ii. The patient's room/physical location may n~~eed to~~ be moved to ensure audibility of the alarms.
      iii. ~~Zone charting~~ **An area for charting may be set up closer to the patient's room to ensure audibility of alarms (zone charting).**
      iv. Door to patient's room kept open, or partially open with the exception of select patient situations (i.e. isolation precautions, **custody patients,** fire alarms, or specific patient/family requests).
      v. In the event that the door to the patient room is closed, alarm audibility will be validated by the RN outside the closed door.
   b. Critically ill patients must have cardiac monitors and/or ventilators visible from outside the patient room.
      i. If the door to the patient's room is required to be closed, the curtain in the room will be kept partially open to allow for adequate visibility of the patient and the monitoring device.

6. Maintenance and testing of alarm systems
   a. ~~Clinical~~ Engineering is responsible for the preventative maintenance of all medical equipment and alarm devices. (Refer to the Equipment Management Plan)
   b. Clinical Engineering will maintain a current inventory of all medical equipment.

c. Alarm malfunctions and apparent malfunctions must be reported **to Biomedical Engineering** via the online work order system found on the TCMC Intranet.
   i. Equipment with malfunctioning or apparent malfunctioning alarms must be taken out of service and evaluated by Biomedical Engineering personnel. **. Refer to policy 8610-396: Incident report –Quality Review Report (QRR).**

C. **RELATED DOCUMENT(S):**
1. **NICU Procedure: Pulse Oximetry**
2. **NICU: Standards of Care**
3. **Patient Care Services Policy: Admission Criteria**
4. **Patient Care Services Policy: Pulse Oximetry**
5. **Patient Care Services: Standards of Care, Adult**
6. **Pulmonary Procedure: Mechanical Ventilation (Initial Set Up Protocol, Management and Troubleshooting)**
7. **Telemetry Unit Specific Policy: Management of Telemetry Patient 6150-108**
8. **Telemetry Unit Specific Procedure: Monitoring Telemetry Patients Using the DASH 3000**
9. **Women's & Newborn Services: Standards of Care,**
10. **Women's & Newborn Services: Standards of Care, Newborn**
11. **Women's & Newborn Services: Standards of Care, Postpartum**

D. **REFERENCE LIST:**
1. The Joint Commission Perspectives, July 2013, Vol.33, Issue 7.
2. ECRI Institute: Strategies to Improve Alarm Safety, 2014

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**DISPOSAL OF CHEMOTHERAPY WASTE**
Purpose:	To outline the nursing responsibility and management of proper disposal of chemotherapy waste
Supportive Data:	Oncology Nursing Society's Chemotherapy and Biotherapy Guidelines and Recommendations for Practice ~~3rd~~ 4th Edition 2014~~1~~
Equipment:	Chemotherapy Safe Personal Protective equipment Puncture –proof container labeled "chemotherapy" container Gloves specified for use with chemotherapy agents Large yellow bag marked "Chemotherapy waste" Gown specified for use with Chemotherapy Agents

A. **PROCEDURE:**

1. Place puncture-proof chemotherapy container **and large yellow chemotherapy waste plastic bags marked "Chemotherapy Waste"** in patient's room upon initiating chemotherapy treatment.
2. Always use chemotherapy safe personal protective equipment when handling chemotherapy waste.
3. **Place any disposable cytoxic contaminated materials into a yellow chemotherapy waste plastic bag. Use puncture proof chemotherapy waste containers for sharps, breakable items and/or items that are saturated with body fluids.**
4. ~~Place contaminated needles and syringes in a puncture-proof container labeled "Chemotherapy Waste.~~
4. Place contaminated Intravenous (IV) tubing, IV bags, and all non-sharp materials in the large yellow plastic bag marked "Chemotherapy Waste."
5. Tie off large yellow chemotherapy waste bag carefully gathering top portion of bag with one hand and slowly pull downward on gathered portion until internal air in bag resists further pulling down. Place yellow chemotherapy waste bag in puncture proof container labeled "Chemotherapy Waste."
6. Upon completion of treatment, place puncture-proof ~~needle~~ **chemotherapy** container in chemo waste room. If the container is less than 2/3 full, place lid gently on top.
   a. For areas without a chemo waste room, contact Environmental Services (EVS) for removal.
7. Completely close lid when the container is 2/3 full or if a potential risk is perceived. Document on top of the container that the puncture proof container is full and date it.
8. Notify environmental services when chemotherapy puncture-proof waste containers are full. Chemotherapy containers must be removed from the chemo waste room within 24 hours.

Department Review	Clinical Policies & Procedures	Pharmacy and Therapeutics	Nurse Executive Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
6/03; 11/11	12/11, **08/15**	**09/15**	12/ 11, **09/15**	1/12, **10/15**	2/12, **11/15**	2/12

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE:	**8/01**	**SUBJECT:**	**Medication Administration**
REVISION DATE:	**6/02; 1/03; 6/03; 12/03; 2/04, 3/05; 3/06; 4/07; 3/08; 9/08; 04/09; 3/10, 1/11, 7/11, 4/12; 02/14**	**POLICY NUMBER:**	**IV.I**

Clinical Policies & Procedures Committee Approval:	**~~09/14~~08/15**
Nursing Executive Council Approval:	**~~10/14~~09/15**
Pharmacy & Therapeutics Committee Approval	**~~09/14~~09/15**
Medical Executive Committee Approval:	**~~11/14~~10/15**
Professional Affairs Committee Approval:	**~~01/15~~11/15**
Board of Directors Approval:	**01/15**

A. **DEFINITIONS:**

1. Titrating Orders – orders in which the dose is either increased or decreased in response to the patient's clinical status. See Patient Care Services (PCS) Titrating Medications Policy.
2. Taper Orders – orders in which the dose is decreased by a specified amount with each dosing interval.
3. Indefinite Hold Medication Order – order for discontinuation of the medication (refer to PCS Automatic Stop Orders Policy).
4. Barcode medication administrator (BCMA) device [point of care (POC)] Solution designed to support positive patient identification using bar code technology. It is based on Cerner Millennium® Mobile technology and is deployed using hand-held devices with integrated bar code scanners.
5. Scheduled medications include all maintenance doses administered according to Tri-City Medical Center (TCMC) medication administration timeframes (e.g., QID, TID, BID, daily, weekly, monthly, and annually). Scheduled medications DO NOT include:
   a. STAT AND Now doses
   b. First doses and loading doses
   c. One-time doses
   d. Specifically timed doses (e.g., antibiotic for surgical patient to be given a specified amount of time before incision, drug desensitization protocols)
   e. On-call doses (e.g., pre-procedure sedation)
   f. Time-sequenced or concomitant medications (e.g., chemotherapy and rescue agents, n-acetylcysteine and iodinated contract media)
   g. Drugs administered at specific times to ensure accurate peak/trough/serum drug levels.
   h. Investigation drugs in clinical trials.
   i. PRN medications.
6. STAT-medications to be given as soon as possible and within 30 minutes of availability of the medications.
7. Time-critical scheduled medications are those where early or delayed administration of maintenance doses of greater than 30 minutes before or after the scheduled dose may cause harm or result in substantial sub-optimal therapy of pharmacological effect. Examples of time-critical medications/medication types may include, but are not limited to:
   a. Antibiotics
   b. Anticoagulants
   c. Insulin
   d. Anticonvulsants
   e. Immunosuppressive agents
   f. Pain medication

g. Medications prescribed for administration within a specified period of time of the medication order
h. Medications that must be administered apart from other medications for optimal therapeutic effect (i.e. ciprofloxacin and multivitamin)
i. Medications prescribed more frequently than every 4 hours

8. Non-time-critical scheduled medications are those where early or delayed administration within a specified range of 1 hour should not cause harm or result in substantial sub-optimal therapy or pharmacological effect.
9. Controlled Substance: is a drug, compound, mixture, preparation or substance included in Schedule II, III, IV, or V.

B. **POLICY:**

1. Medication Order Process
   a. Medications shall be administered only upon the order of medical staff members or allied health professionals who have been granted clinical privileges to write such orders under the guidelines of their respective scopes of practice.
      i. Medications shall be administered according to the guidelines set forth in Administering Medication per Scope of Practice.
      ii. See PCS Physician/Provider Orders Policy for information on ordering medication including telephone/verbal orders and PRN medications
   b. Medication orders shall be reviewed by pharmacists before administration by a licensed healthcare provider, unless a physician is overseeing administration of the medication, i.e. "Non-Profile" Pyxis areas.
      i. See Pharmacy Unlabeled Uses of FDA Approved Medications Policy for information on additional information on unlabeled use of medications
   c. Registered Nurses (RN) shall verify all new medication orders for accuracy using Nurse Review each time an order is added to the Electronic Medication Administration Record (eMAR) by the pharmacist per PCS Physician/Provider Orders Policy. The paper MAR is to be used ONLY if the eMAR is unavailable to staff.
      i. Respiratory Care Practitioners may conduct medication review for all nebulized and inhaled medications if the RN has not completed Nurse Review and one of the above medications is due for administration.
      ii. Under the supervision of a physician, physician assistant, or other appropriate licensed person, medical assistants in an outpatient setting may administer medications, except controlled substances, in several ways to a patient, including simple injections, ingestion or pre-measured medications.
      iii. Medical assistants who receive the appropriate training are allowed to administer injections of scheduled drugs only if the dosage is verified and the injection is intramuscular, intradermal or subcutaneous. The supervising physician or physician assistant must be on the premises as required in section 2069 of the Business and Professions Code, except as provided in subdivision (a) of that section. However, this does not include the administration of any anesthetic agent.
   d. A nurse may obtain medications not yet reviewed by a Pharmacist through the Pyxis override function only if need is deemed urgent or emergent.
      i. Urgent indications include those in which significant patient harm could result from a delay secondary to a pharmacist's review of the order.
      ii. Emergent indications include situations in which life, limb, or eyesight is threatened.
      iii. In each individual case, the need for the override must outweigh the risk of omitting the pharmacist's review of the order.
   e. If orders are received with more than one set of ranges (dose and frequency), then the healthcare professional must clarify the order with the physician.
      i. If clarification is not obtained before the dose is needed, the RN shall implement range orders at the smallest ordered dose and the longest time interval between

doses, if repeated dosing would be required. However, if the patient assessment indicates a clinical need for more aggressive intervention, then the individual implementing the range-dosed medication may initiate treatment at a higher dosage or administer the medication at the more frequent time interval within the parameters of the order.

ii. Adjustments within the dose range are based on:
1) Patient assessment
2) Prior dose administered
3) Time interval between doses
4) Effectiveness of prior doses

f. The RN shall assess the patient and if therapy is not meeting clinical needs or desired response, the physician shall be contacted for dosage and/or frequency adjustment.

g. All continuous infusions of controlled substances shall have the medication in a secured device (for example lock box or locked infusion pump).

2. Medication Administration Process

a. The Electronic Medication Administration Record (eMAR) or paper MAR shall be evaluated at the beginning of each shift and PRN to:
i. Verify medications to be administered during the shift.
ii. Review and document review of allergies in the medical record.
iii. Medication orders shall be reviewed by pharmacists before administration by a licensed healthcare provider, unless a physician is overseeing administration of the medication, i.e. "Non-Profile" Pyxis areas or the medication is deemed is urgent or emergent.
iv. Conduct Nurse Review (RN Sign-off) on any medications that have not yet been reviewed (identified with the icon of Eyeglasses) per PCS Physician/Provider Orders Policy.

b. Once BCMA application on hand-held devices is implemented the departments shall use BCMA for medication administration.

c. Medications brought from home may be administered only on the order of a physician per PCS Medication Brought in by Patient Policy.
i. A pharmacist shall positively identify the medication, initial the "Medication Checked by Pharmacy" label, and affix it to the medication container.

d. Prior to administration of subcutaneous insulin or heparin, the amount ordered and prepared shall be verified by a 2nd RN or licensed practitioner per PCS Medication High Risk/High Alert Policy.
i. Identification of the patient shall take place in the patient's room
ii. Behavioral Health Unit will not be required to validate in patient's room due to safety issues
iii. Document first and last name and title of second practitioner who verified the medication via BCMA device or electronic medical record.

e. Prior to administration of intravenous insulin, heparin, , 10% magnesium sulfate, tissue plasminogen activator (tPA) and patient controlled analgesia (PCA), or any medication given through an epidural, the amount ordered, amount prepared, initial infusion rate, and any changes in infusion rate shall be verified by a second RN or licensed practitioner per PCS Medication High Risk/High Alert Policy.
i. Validation process shall take place in the patient's room
ii. Document initiation and dose changes on eMAR/paper MAR. Document first and last name and title of second practitioner who verified under the comments section.
1) Document epidural/PCA assessment in IView.

f. For maximum amounts of solution to be administered intramuscularly in one site see Intramuscular Administration Amount per Site.

g. Medication shall be administered immediately by the licensed healthcare provider withdrawing the medication from an ampule or vial. If not administered immediately by the licensed staff, syringe must be labeled appropriately.

i. Non-controlled - medications shall be withdrawn from a single dose vial at bedside.
ii. Controlled Medication – requiring waste upon removal shall be performed according to PCS Controlled Substance (Narcotics) Management Policy and PCS Wasting Narcotics via Pyxis Machine Procedure.

h. Medication from ampules shall be prepared and labeled appropriately prior to entering patient room.

i. Medication from multi-dose vials shall be prepared and labeled appropriately prior to entering patient room or operating room.
i. Only vials clearly labeled by the manufacturer for multiple dose use can be used more than once.
ii. Limit use of a multi-dose vials to a single patient whenever possible.
iii. Multi-dose medications used for more than one patient are stored and accessed away from the immediate areas where direct patient contact occurs.
iv. If a multi-dose vial is taken into a patient room/operating room, it can only be used for that patient and must be discarded after use.
v. When multiple dose vials are used more than once, use a new needle and new syringe for each entry.
vi. Disinfect the vial's rubber septum before piercing by wiping (using friction) with an approved antiseptic swab. Allow the septum to dry before inserting a needle or other device into the vial.
vii. All multi-dose vial once opened or punctured, shall be labeled with an expiration date of 28 days or the manufacturer's date or packet insert recommendations, whichever is shorter.

j. Label all medications, medication containers (i.e., syringes, medicine cups, basins), or other solutions on and off the sterile field in perioperative and other procedural settings. Refer to PCS Labeling Medication On and Off the Sterile Field Procedure.

k. Never administer medications from the same syringe to more than one patient, even if the needle is changed or you are injecting through an intervening length of IV tubing.

l. Do not enter a medication vial, bag, or bottle with a used syringe or needle.

m. Never use medications packaged as single-dose or single-use for more than one patient. This includes ampules, insulin pens, bags, and bottles of intravenous solutions, and sterile water bottles.
i. Use a single-dose/single-use vial for a single patient during the course of a single procedure
ii. Discard the vial after this single use, used vials should never be returned to stock on clinical units, drug carts, anesthesia carts etc
iii. If a single dose/single use vial must be entered more than once during a single procedure for a single patient to achieve safe and accurate titration of dosage, use a new needle and new syringe for each entry
iv. Select the smallest vial necessary when making treatment decisions to reduce waste

n. Always use aseptic technique when preparing and administering injections.

o. For patients age 13 years and younger, the <u>maximum</u> IV solution volume for administration is <u>500 mL</u>.

p. Educate the patient/family/significant other according to comprehension level. Education should include:
i. Drug name
ii. Dose
iii. Purpose
iv. Ask if they have any questions/concerns about taking the medication especially new or first time medications.
v. Side effects of medications.
1) Adverse drug reactions or side effects may occur with the first dose or any subsequent dose.

vi. Licensed healthcare providers shall provide teaching materials (drug leaflets, handbooks, videos, lectures, demonstration, and equipment) to all patients (parents, significant others) to prepare them for successful self-medication.
vii. Document all teaching on the Education – All Topics Form.

q. Discuss any unresolved, significant patient/family concerns about the medication with the patient's physician, prescriber (if different from the physician), and/or relevant staff involved with the patient's care, treatment, and services. Document in the medical record.

r. The licensed healthcare provider shall accurately document medication at the time of administration.

s. Scheduled medications shall be administered within 1 hour prior to the order time and 1 hour after the order time.

t. If a medication cannot be given at the time ordered, the appropriate reason shall be documented on the eMAR/paper MAR.

u. When administering medications from a standardized procedure, the health care provider shall enter the order electronically or document the title of the standardized procedure used and the name and dose of the medication administered on the physician's order sheet. This order shall be scanned to pharmacy.
i. Sample order entry: "Standardized Procedure: Hypoglycemia Management, glucagon 1 mg IM times one."
ii. Exception: Orders generated by screening in Cerner

v. If a medication is not administered or used, it shall be returned or wasted within 1 hour or at the end of procedure per Patient Care Services Controlled Substance (Narcotics) Management Policy.

3. Self Administration/Non-Staff

a. Persons who administer medications, but are not staff members (including the patient if self-administering), must demonstrate ability to safely administer medication before being allowed to self-administer medications. This includes understanding medication name, type, reason for use, how to administer medication (including process, time, frequency route and dose) and anticipated action/side effects of medication administered
i. If they cannot demonstrate the ability to safely administer medications:
1) They will not be able to self-administer until the ability is demonstrated
2) Licensed healthcare providers will provide teaching using Tri-City Medical Center approved drug leaflets, handbooks, videos, lectures, demonstration, and equipment to all patients (parents, significant others) to prepare them for successful self-medication
3) Discharge planning shall include a follow-up plan as needed.

4. Monitoring Effects of Medications on Patients

a. Effects of medications on patients are monitored to ~~access~~ assess the effectiveness of medication therapy and to minimize the occurrence of adverse events.
i. Each patient's response to medication administered is monitored according to his or her clinical needs.
ii. Ongoing patient medication monitoring will use a collaborative approach between patient care providers, physician, pharmacists and the patient, family or caregiver.

~~a.~~b. Monitoring will address the patient's response to the prescribed medication and actual or potential medication-related problems.

c. The results of patient medication monitoring will be used to improve the patient's medication regimen and/or other clinical care and treatment processes.
~~4)~~i. The physician/Allied Health Professional will be notified if the medication therapy is not achieving the desired effect

~~4.~~5. Medication Handling, Storage, and Disposal

a. All medications received from the pharmacy shall be placed in approved storage areas as soon as possible, not to exceed 30 minutes from the time of receipt.

b. Any medication removed from the medication storage area:
   i. Shall remain with the individual at all times and shall not be left unattended including flushes and vials.
   ii. Shall not be left on or in any area exceeding 80°F. This includes the pockets of the healthcare provider.
   iii. No medications, including flushes and vials, shall be left at the bedside.

c. Access to medications and syringes are limited to appropriate staff via locked or computerized controlled access.

d. In all inpatient areas, insulin pens, creams, inhalers, eye drops and other medications that are not stored in the Pyxis medication station must be kept in patient-specific bins in a locked cabinet in the medication area.
   i. The primary nurse will be responsible for transferring these medications when a patient is transferred to another unit or room.
   ii. The primary nurse will be responsible for returning un-used medications or disposing of opened medications when a patient is discharged from the hospital.
   iii. The primary nurse must clean the medication bin with a sani-wipe after patient transferred or discharged.

~~iii.~~**e. A device holder will be used when administering a medication from a pre-filled syringe.**

~~e.~~**f.** Any intravenous solutions spiked outside of a laminar flow hood must be initiated/administration started within 1 hour of being spiked.

~~f.~~**g.** Nursing personnel shall only compound or admix when not feasible for pharmacy to do so (i.e. emergency or product stability is short). Refer to Patient Care Services procedure *Admixture, Intravenous*). Medication preparation is performed by using aseptic technique as appropriate in a clean, uncluttered, functionally separate area, to minimize the possibility of contamination.

~~g.~~**h.** Unused/Intact Medication removed from the Medication Pyxis and not administered shall be returned to the Pyxis "Return Bin" with the exception of refrigerated and some designated controlled substance medication.
   i. For non-controlled medications that are too large, place into the red external "Return to Pharmacy" bin.
   ii. For controlled substances that are too large to be returned to the Medication Pyxis, contact pharmacy for assistance.

~~h.~~**i.** At discharge, unused intact medications shall be returned to the pharmacy.

~~i.~~**j.** For proper disposal of pharmaceutical waste,
   i. See Administrative Policy #276 Handling of Pharmaceutical Waste, Expired Medications, and Expired IV Solutions.
   ii. See the Patient Care Services procedure Hazardous Drugs for hazardous drug disposal and waste.

~~j.~~**k.** Patient specific medications maybe delivered by TCMC personnel as designated per Pharmacy

~~2.~~**6. Medication Error/Near Miss Reporting – see Administrative Policy Incident Report - Quality Review Report (QRR) RL Solutions – Policy #8610-396**

C. **PROCEDURE:**

1. For Departments Using BCMA:
   a. Prior to administering a medication, the licensed healthcare provider shall:
      i. Verify correct patient
         1) Use two patient identifiers (see PCS Identification, Patient Policy)
      ii. Verify medications due per eMAR
         1) Verify RN review completed, no eyeglasses icon, in all areas (except ED)
         2) Review allergies **to make sure all information is current and correct before administration of any medications.**
         ~~2)~~**3)** ~~and/or~~**Review for any** contraindication(s) for administering medication

a. Prepare medications for one patient at a time with the patient's current, updated eMAR for accuracy.
   i. Verify correct dose, route and time
   ii. Verify expiration date on medication package
   iii. Visually inspect medication integrity (i.e.,**discoloration,** particulates, **turbidity when a medication should be clear**) **or** torn packaging **may be~~,~~** signs of medication deterioration
   iv. Take all medication in their **original** packages into patient room to be scanned. When any medication is removed from package for mixing, crushing, or splitting, the package must be taken into patient room.
      1) Medications shall be crushed and administered separately.
      2) Crusher shall be cleaned after each crush if medication cups are not used inside of crusher.
      3) Pill splitter shall be cleaned after each use
b. Retrieve hand-held device from the unit specific secure hand-held device storage area.
c. Scan the "Aztec" barcode on the patient ID band to ensure the right patient record is opened on the BCMA application.
d. If a patient ID band does not scan, the licensed healthcare provider may replace the patient ID band, or manually search for the patient on the hand-held device using the patient identifiers on the patient ID band. Scan each medication with the hand-held device to ensure additional medication "rights" **for mistake free medication** are identified.
   i. Verify correct:
      1) Patient
      2) Dose
      3) Time
      4) Medication
      5) Route/ Rate (if applicable)
      6) Documentation
      7) Reason
e. Assess and resolve any warning message(s).

2. Educate the patient/family/significant other and address any unresolved concerns about the medication.
   a. Name of the drug, the dose, and the purpose according to the patient's ability to comprehend.
   b. Side effects of medications.
      i. Adverse drug reactions or side effects may occur with the first dose or any subsequent dose.
   c. Licensed healthcare providers shall provide teaching materials (drug leaflets, handbooks, videos, lectures, demonstration, and equipment) to all patients (parents, significant others) to prepare them for successful self-medication.
   d. Document all teaching on the Education – All Topics Form.
3. Administer medications after the medications are scanned and all "rights" are assured to be accurate.
   a. STAT or one-time medications shall be given as soon as they are available and the exact time given shall be documented.
   b. The licensed health care provider administering oral medication shall remain with the patient until the medication is successfully administered.
4. Sign the medications on the hand-held device after the medication is given and/or successfully administered. Comments may be added as required.
   a. The BCMA application will automatically update the Cerner system (eMAR) with the data entered.

D. **<u>For Departments Not Using BCMA:</u>**
1. Prior to administering a medication, the licensed healthcare provider shall:

a. Verify correct patient
   i. Use two patient identifiers (see PCS Identification, Patient Policy)
b. Verify medications due per eMAR
   i. Verify RN review completed, no eyeglasses icon, in all areas (except ED)
   ii. Review allergies and/or contraindication(s) for administering medication

2. Prepare medications for one patient at a time with the patient's current, updated eMAR for accuracy.
   a. Verify correct dose, route and time
   b. Verify expiration date on medication package
   c. Visually inspect medication integrity (i.e., **discoloration,** particulates, **and turbidity when a medication should be clear) or** torn packaging **may be a** sign ~~of~~ **the** medication deterioration
   d. Medication may be withdrawn from vial at bedside and shall be administered immediately. If medicine is prepared in the Medication room – the syringe must be labeled appropriately.
   e. The medication "rights" are identified before the medication is administered. Verify the following are correct:
      i. Patient
      ii. Dose
      iii. Time
      iv. Medication
      v. Route/ Rate (if applicable)
      vi. Documentation
      vii. Reason
   f. Medications shall be crushed and administered separately. Crusher shall be cleaned after each crush if medication cups are not used inside the device.
3. Educate the patient/family/significant other and address any unresolved concerns about the medication.
   a. Name of the drug, the dose, and the purpose according to the patient's ability to comprehend.
   b. Side effects of medications.
      i. Adverse drug reactions or side effects may occur with the first dose or any subsequent dose.
   c. Licensed healthcare providers shall provide teaching materials (drug leaflets, handbooks, videos, lectures, demonstration, and equipment) to all patients (parents, significant others) to prepare them for successful self-medication.
   d. Document all teaching on the Education – All Topics Form.
4. Administer medications after all "rights" are assured
5. The licensed health care provider administering oral medication must remain with the patient until the medication is successfully administered.
6. The licensed healthcare provider shall then accurately document medication administration in the eMAR or paper MAR as soon as possible after the dose is given.

E. **OUTPATIENTS:**

1. Any medication brought to the hospital by a patient who is to receive outpatient testing is the sole responsibility of the patient.
2. The hospital shall not administer nor handle any medications brought into the facility by patients for outpatient testing.

F. **CHEMOTHERAPY ADMINISTRATION:**

1. Chemotherapeutic agents shall be administered by TCMC chemotherapy credentialed RNs per the Oncology Chemotherapy Administration.
2. Notify pharmacy and oncology unit if chemotherapeutic agents are to be administered in areas other than dedicated chemotherapy area.

G. **HAZARDOUS DRUGS, HANDLING OF:**
1. See PCS Hazardous Drugs Procedure

H. **FORMS (LOCATED IN PATIENT CARE SERVICES MANUAL; FORM / RELATED DOCUMENTS FOLDER):**
1. Medication: Administering Medication per Scope of Practice
2. Medication Administration Time Frames
3. Medication: Intramuscular Administration Amount per Site

I. **RELATED DOCUMENTS:**
1. Administrative Policy Incident Report - Quality Review Report (QRR) RL Solutions
~~1.~~**2.** Oncology Chemotherapy Administration
~~2.~~**3.** PCS Automatic Stop Orders Policy
~~3.~~**4.** PCS Controlled Substance (Narcotics) Management Policy
~~4.~~**5.** PCS Hazardous Drugs Procedure
~~5.~~**6.** PCS Identification, Patient Policy
~~6.~~**7.** PCS Labeling Medication On and Off the Sterile Field Procedure
~~7.~~**8.** PCS Medication Brought in by Patient Policy
~~8.~~**9.** PCS Medication High Risk/High Alert Policy
~~9.~~**10.** PCS Physician/Provider Orders Policy
~~10.~~**11.** PCS Titrating Medications Policy
~~11.~~**12.** PCS Wasting Narcotics via Pyxis Machine Procedure
~~12.~~**13.** Pharmacy Unlabeled Uses of FDA-Approved Medications Policy

Administering Medication per Scope of Practice

X indicates who may administer	IV	IV PUSH	IVPB	PO	SQ	IM	SL	Intra-dermal	Topical	Inhalant Aerosol
RN	X	X	X	X	X	X	X	X	X	X
LVN I/Licensed Psychiatric Technician				X	X	X	X	X	X	X
LVN II (IV-certified) May only administer electrolytes, vitamins, nutrients, blood, and blood products	X			X	X	X	X	X	X	X
Respiratory Care Practitioners								X		X
Physical Therapist									X	
Licensed Physical Therapy Assistant									X	
Radiologic Technologists under physician guidance*	X			X						
Nuclear Med Technician*	X									
EKG/Echo Tech under direct supervision of physician as part of EKG/Echo procedure							X			
Medical Technicians								X		
Student RCP under supervision										X
Medical Assistants				X	X	X	X	X	X	

*Only RN's may administer IV mediations via PICC and central lines.

Medication Administration Time Frames

Daily	-	0900
qam	-	0900
qhs	-	2100
bid	-	0900 - 2100
tid	-	0900 - 1500 - 2100
qid	-	0900 - 1300 - 1700 - 2100
q4h	-	0100 - 0500 - 0900 - 1300 - 1700 - 2100
q6h	-	0600 - 1200 - 1800 - 2400
q8h	-	0500 - 1300 - 2100
q12h	-	0900 - 2100

Specific Medications:
Coumadin - 1700
Standard capillary blood glucose checks AC and HS - 0800, 1130, 1730, and 2100
Standard capillary blood glucose checks every 6 hours - 0600, 1200, 1800, and 2400
Lithium - 2000
Digoxin - 1200
Diuretics - 0900 - 1700 (ordered BID)
Medications ordered with meals shall be given according to tray delivery times.
Respiratory medications shall be given per unit specific policy.
Bupropion, Venlafaxine, Modafinil, Methylphenidate: if ordered BID 09:00 and 14:00

In addition to the above standard administration times, the pharmacist shall designate the appropriate administration time for certain medications to optimize drug therapy. Some examples are as follows:
Proton Pump Inhibitors – BID 0600 – 2100
"Statins" – Daily 2100
Carafates – Q6 2400 – 0600 – 1100 – 1600

Intramuscular Administration Amount per Site

Age group (years)	Needle Length-max	Needle gauge	Volume-Max	Site(s)
Infant (0-1.5)	5/8 inch	25-27	0.5-1 mL: infant less than 1500 gm, maximum 0.5 mL	• Vastus lateralis • Rectus femoris
Toddler/ Preschool (1.5-3)	1 inch	22-23	1 mL	• Vastus lateralis • Rectus femoris • Dorsogluteal (for children who has been walking for at least one year)
Preschool (3-6)	1 inch	22-23	Deltoid: 0.5 mL All other sites: 1.5 mL	• Vastus lateralis • Rectus femoris • Dorsogluteal • Ventrogluteal (for children who have been walking for several years) • Deltoid (for children over 4 – 5 years of age due to small muscle mass)
School Age (6-15)	1-1 ½ inch	22-23	Deltoid: 0.5 mL All other sites: 1.5-2.0 mL	• Vastus lateralis • Rectus femoris • Dorsogluteal • Ventrogluteal • Deltoid
Adolescent (up to 21)	1-1 ½ inch	22-23	Deltoid: 1 mL All other sites: 2-2.5 mL	• Vastus lateralis • Rectus femoris • Dorsogluteal • Ventrogluteal • Deltoid
Adults	1-1 ½ inch	22-27(for aqueous solutions) 18-25 (for viscous or oil-based medications)	3 mL	

ISSUE DATE: 10/96

SUBJECT: Potential Food and Drug Interactions, Patient Education

REVISION DATE: 6/03, 8/05; 03/08; 03/11

POLICY NUMBER: V.B

Clinical Policies & Procedures Committee Approval:	~~01/11~~08/15
Nursing Executive Council Approval:	~~01/11~~09/15
Pharmacy & Therapeutics Committee Approval:	09/15
Medical Executive Committee Approval:	~~02/11~~10/15
Professional Affairs Committee Approval:	~~03/11~~11/15
Board of Directors Approval:	03/11

A. **POLICY:**

1. The Pyxis MedStation will prompt the nurse to assess the educational needs of the patient when one of the medications below has been added to a patient's profile and the nurse makes a withdrawal of the medication :
   ~~a. Tetracycline~~
   ~~b.~~**a.** Warfarin (Coumadin)
   ~~c. Monoamine Oxidase Inhibitors (Nardil, Parnate)~~
   ~~d. Selegiline in doses greater than 10 mg/day (Eldepryl)~~
   ~~e. Levodopa (Sinemet)~~
   ~~f. Potassium Sparing Diuretics (Aldactone, Dyrenium, Dyazide, Maxide)~~
   ~~g. ACE Inhibitors (Vasotec, Zestril, Lotensin, Monopril, Accupril)~~
   ~~**A list of common drug-food interactions and enteral nutrition-drug interactions shall be maintained on the TCMC Intranet in the "Clinical Reference" drop-down menu.**~~
2. Nursing may obtain a current Drug/Nutrient interaction education sheet from ~~**an authoritative druga**~~ **hospital approved information resource** ~~the on-line ADA Nutrition Care manual or print a copy from Micromedex "Care Notes."~~
3. Nursing will provide this information to the patient/family/caregiver if any of the above -medications are started in the hospital and are intended for continued use at home and as deemed necessary from the patient assessment.
4. Patient education and counseling on drug/nutrient interactions may also be initiated by a physician order or another health care professional after assessment of knowledge deficits, and/or by the patient/caregiver request.
5. Nursing may make a consult request from Clinical Pharmacist and/or Clinical Dietitian for additional patient education as indicated.
6. Documentation of counseling and materials provided will be documented in the patient education section of the patient record and in the patient's discharge instructions.

Tri-City Medical Center
Oceanside, California

DELETE from PCS manual – move to Pharmacy manual

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 07/11	**SUBJECT:** Risk Evaluation and Mitigation Strategies (REMS)
REVISION DATE: 6/14	**POLICY NUMBER:** IV.H

Clinical Policies & Procedures Committee Approval:	~~07/11~~ ~~06/14~~08/15
Nursing Executive Council Approval:	~~07/11~~09/15
Pharmacy & Therapeutics Committee Approval:	09/15
Medical Executive Committee Approval:	~~08/11~~10/15
Professional Affairs Committee Approval:	~~09/11~~11/15
Board of Directors Approval:	~~09/11~~12/15

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

~~1. Risk Evaluation and Mitigation Strategies (REMS) are strategies and recommendations put in place by the Food and Drug Administration (FDA) in conjunction with the pharmaceutical industry and healthcare providers to ensure that "Elements to Assure Safe Use" (ETASU) are in place for certain drug and biological products which the FDA has determined "pose a serious and significant public health concern". In most cases, these products require the distribution of FDA-approved patient medication information that is necessary to patients' safe and effective use of the drug products (a Medication Guide).~~

~~a. Section 208.1 (a) states, Medication Guides apply primarily to human prescription drug products used on an outpatient basis without direct supervision by a health professional and are applicable to both new and refill prescriptions.~~

~~2. The FDA can exercise "enforcement discretion" for individual drug and biological products when they are administered by a healthcare provider (i.e. inpatient hospital). If any patient requests a Medication Guide, it must be provided to the patient, regardless of inpatient or outpatient status.~~

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

~~1. Tri City Medical Center will comply with all REMs required by the FDA as they pertain to the inpatient hospital setting.~~

~~2. A list of drugs/biological products that require REMs for inpatient use will be maintained on the TCMC Intranet, in the "Clinical Reference" drop-down menu.~~

~~3. As other drugs and/or biological products are identified by the FDA requiring REMS in the inpatient hospital setting, Tri City Medical Center will update the REMS references on the Intranet.~~

~~**FORMS (LOCATED IN THE PATIENT CARE SERVICES MANUAL; FORMS FOLDER):**~~

~~4. **Risk Evaluation and Mitigation Strategies, Medications and Biological .**~~

ISSUE DATE: 12/01

SUBJECT: Volunteers, Patient Care Services Departments

REVISION DATE: 3/03, 6/03, 8/05, 01/09

POLICY NUMBER: IV.E

Clinical Policies & Procedures Committee Approval:	**~~09/11~~09/15**
Nursing Executive Council Approval:	**~~10/11~~09/15**
Medical Executive Committee Approval Date(s):	**n/a**
Professional Affairs Committee Approval:	**~~01/12~~11/15**
Board of Directors Approval:	**01/12**

A. **POLICY**:

1. Volunteers at Tri-City Medical Center are available to assist patients, families, and healthcare providers in the Patient Care Services Units/Departments.
2. Services that may be provided by Patient Care Services volunteers may include but are not limited to the following:
   a. Intensive Care Unit (ICU): Assist, screen, and comfort visitors. Watch for the arrival, or transfer out, of patients and assist in record keeping of these arrivals and transfers. Escort visitors to the patient's room according to the guidelines of the ICU.
   b. Courtesy Shuttle: Drive a covered vehicle around the hospital campus to assist people who want a ride to or from their car or the bus stop.
   c. Customer Relations: Assist in checking in patients for surgery; answer no medical questions, escort patient and family to Pre-Op Hold area. Keep track of where the family can be located during the surgery process.
   d. Surgery: Escort patients and families, store personal effects, prepare gurneys, stock blanket warmers, clean equipment as directed, order linen and supplies, discharge patients in wheelchairs, pick up/deliver paperwork, serve food/drinks, and assemble blank patient packets.
   e. Emergency Department: Act as liaison between visitors, patients, and the medical staff. Offer non-medical assistance to the medical staff, assist the medical secretaries and clerical staff in registration area, change gurneys, keep supplies on hand, make quantities of coffee, assemble medical and surgical packets, assist in taking patients to their rooms, and stand by for any errands.
   f. Employee Health Office: Fill out and file receipts, log over-the-counter medications to employees and volunteers, stock supply cabinets, and open and check in the new merchandise.
   g. Escort Service: Escort patients to the proper departments, deliver documents to various areas of the hospital, keep the waiting area neat, interact with patients in the waiting room and when assisting to appropriate areas of the hospital.
   h. Gift Shop: Assist all customers in the sale of gift shop items~~, and staff vendor sales~~.
   i. Imaging: Liaison between staff, families, and patients. Receive patients as they arrive for procedures, escort patients to the dressing room, see to patient comfort while they are waiting or recovering from imaging procedures, assist with paperwork for the radiology staff and follow department and Health Insurance Portability and Accountability Act (HIPAA) guidelines for checking-out films.
   j. Laboratory: Assist nursing units with a pick-up and delivery service and make rounds as requested. Dispense specimens from the lab triage tubs. Assist with paperwork at the laboratory front office and the triage unit.
   k. Women's & Children's Services: Hand out juice or food trays, fill water pitchers, strip or make beds, watch/rock newborns, run errands, make up home packets when patients discharged, and push mothers and babies in a wheelchair to front door.

~~l. Pharmacy: Deliver medications and medical supplies to all departments and take returned medications back to the Pharmacy.~~

~~m.~~**l.** Pulmonary Rehabilitation: Assemble new patient orientation packets; assemble Asthma and Chronic Obstructive Pulmonary Disease (COPD) education packets; assemble new patient class notebooks**. Help with answering phones and simple clerical duties.**

~~n.~~**m.** ~~Reception~~**Information Desk**: Relay hospital information to the public in accordance with HIPAA guidelines, assist security in providing visitors badges, give directions to visitors, receive patient mail and assign room numbers, deliver mail to patients, receive and deliver floral arrangements, and answer questions.

~~o.~~**n.** Registration: Serve as liaison with the Admitting Office, assist incoming patients with completion of information form, and monitor patients for signs of undue discomfort or acute illness and report to Control Desk.

~~p.~~**o.** Telecare: Daily calls as support service to those who live alone (retired persons, widows/widowers, those convalescing from an illness).

~~q.~~**p.** Rehabilitation Services: Office clerical making up charts and/or patient packets, filing, restocking linens, transport, using a copier, make phone calls to patients and process surveys.

~~r.~~**q.** Women's' Diagnostic Center: Clerical services ~~provide in contacting next day patients.~~ **to m**~~M~~ake and distribute packets to patients. Mail computer generated positive letters to patients.

~~s.~~**r.** Cardiac Rehabilitation: Provide both clerical and operational support as directed by staff

~~t.~~**s.** Acute Care Services & Telemetry: Assist with delivery of trays as instructed by nursing staff, visit with patients, assist with transporting discharged patients and transporting specimens to the lab. **Answer the phone and call lights during nursing rounds.**

3. Workshop members make puppets for children admitted to the hospital, tray favors for holidays, corsages for prospective mothers attending the Maternity Teas, stuffed toys for Emergency Department, and **lovey dolls for the Neonatal Intensive Care Unit infants** ~~boots and hats for newborn babies~~**.**
   a. Volunteers may be ~~used as~~ assigned **tasks** by **the** Assistant Nurse Managers/designee.
4. Off Campus volunteer support
   a. Tri-City Wellness Center Carlsbad Physical Therapy and Cardiac Rehabilitation: ~~Check in patients in the entrance lobby in addition to escorting new ones to their treatment areas.~~ Assist in clerical duties as directed by staff.
   b. Tri-City Wound Care and Occupational Therapy Carlsbad: Meet and greet new patients and maintain lobby area.
   c. ~~161 Thunder Wound Care/Physical Therapy: Office clerical making up charts and patient packets, filing and other duties as directed by staff.~~

ISSUE DATE: 01/90

SUBJECT: ALERTS/RECALLS/NOTIFICATIONS

REVISION DATE: 6/94; 12/95; 5/96; 7/97; 3/00; 5/03; 3/06, 2/07; 7/09; 8/10; 06/13;

POLICY NUMBER: 8610-229

Administrative Policies & Procedures Committee Approve:	**~~06/13~~8/15**
Professional Affairs Committee Approval:	**~~08/13~~11/15**
Board of Directors Approval:	**08/13**

A. **PURPOSE:**

1. To provide a plan of action to be taken on product recalls to protect the safety and ~~well-~~**well-**being of all patients, staff and visitors whenever information regarding a product-related hazard is brought to the attention of the Medical Center.
2. This policy applies to equipment, systems, medical products, food products and pharmacy recalls, field corrections, safety notices and alerts that are presented to the organization via letter, facsimile, telegram, or email.

B. **POLICY:**

1. Any person notified of a recall/alert by a manufacturer shall notify Risk Management to facilitate processing of this information. The recall procedure shall be implemented by Risk Management/Patient Safety Officer who will distribute the notice to the appropriate individuals for follow up.
2. The **National ~~Alert Recall~~Recall Alert Center** ~~ECRI~~**(NRAC)** electronic Recall Alert -notices will be automatically circulated via email to designated individuals assigned to their specialty areas:
   a. Persons designated for follow-up will be contacted via email and provided recall alert notices. Status of the response to the recall shall be documented in the ~~ECRI~~**NRAC** ~~Alert Tracker~~**documentation** system and/or reported back to Risk Management/Patient Safety Officer after completion in the form of an email response.
      i. Definitions for ~~ECRI~~**NRAC** Actions Taken:
         1) ~~Not Applicable~~**Do Not Have Product**: When an assigned user finds that an alert does not affect his/her area(s) of responsibility, they will record a ~~Not Applicable~~**Do Not Have Product** entry with **any** ~~Action~~ **actions** ~~Taken~~**taken**. Action Notes may be used to explain generally what the individual did to rule out the alert.
         2) ~~Applicable-Open~~**Have Product**: Assigned users will ~~make an~~**select** ~~Applicable-~~**Have Product** – Open entry as soon as they have determined that their area of responsibility is, or — likely is affected by an alert. In such entries, they shall record what is known about quantities and location of affected and/or suspected product, and plan of action for addressing (e.g., removal of product, repair of product, and/or retraining of users). Additional ~~Applicable-Open~~ entries shall be made to update progress and/or explain delays in resolution of the alert (e.g., back ordered parts, user training scheduled in the future).
         3) ~~Applicable-Closed~~**Viewed Still Pending**: Assigned users will ~~make-an~~**select** ~~Applicable-Closed~~**Viewed Still Pending** entry each time an

alert **has been reviewed, but the investigation is still ongoing.** ~~affecting their area(s) of responsibility has been resolved. In this final entry, the following information shall be recorded: quantity of affected product (if known), means of resolving or determining that other personnel have resolved, and notation of any relevant information sources not noted in previous entries (e.g., Work Order numbers, return authorization numbers).~~

3. Risk Management/Patient Safety Officer will report the actual items recalled, along with other pertinent information supplied by management personnel, to the Environmental Health and Safety Committee **(EHSC)** for review. ~~on a monthly basis.~~
   a. Urgent intervention shall be addressed with the department director/designee.
4. Recall Classification: The FDA categories all recalls in to one of three classes according to the level of hazard involved.
   a. CLASS I recalls are for dangerous or defective products that predictably could cause serious health problems or death. A response ~~should~~ **shall** be made within ~~1~~ **2** business day of receipt of such notice, unless the Risk Manager or Patient Safety Officer determines otherwise and sets an alternate time for response.
   b. CLASS II recalls are for products that might cause a temporary health problem or pose a slight threat of a serious nature. A response ~~should~~ **shall** be made within 24 ~~– 72~~ **96** hours of receipt of such notice, unless the Risk Manager or Patient Safety Officer determines otherwise and sets an alternate time for response.
   c. CLASS III recalls are for products that are unlikely to cause any adverse health reaction, but that violate FDA regulations. A response ~~should~~ **shall** be made within 10 business day of receipt of such notice, unless the Risk Manager or Patient Safety Officer determines otherwise and sets an alternate time for response.

~~Action Priority: ECRI assigns action priority to each ongoing Alert that is published to guide recall response efforts:~~

~~Critical Priority hazards or ongoing actions cover problems that, if unresolved, are likely to result in patient or user death, severe injuries or permanent health problems, or other significant adverse consequences. Response time is the same as Class I.~~

~~High Priority hazards or ongoing actions cover problems that, left unresolved, may cause patient or user death, serious injuries, or permanent health problems, significant financial losses for the healthcare facility, or severe equipment damage. Response time is the same as Class II.~~

~~Normal Priority hazards or ongoing actions cover problems that, if left unresolved, may cause patient or user injuries or other health problems, financial losses for the healthcare facility, or equipment damage. Although serious injuries or other significant adverse consequences may be possible, the probability of such consequences is low. Response time is the same as Class III.~~

~~Not Prioritized alerts cover actions designated as complete by the issuing manufacturer and/or regulatory agency. This type of alert is often "Information Only".~~

C. **OTHER:**

1. Pharmacy: Will process all recall/alert notices related to drugs/pharmaceuticals. Reporting will be through Pharmacy and Therapeutics Committee. Documentation of actions will be maintained in pharmacy and the ~~ECRI~~**NRAC** ~~Recall Alert Tracker~~**documentation** System.
2. Equipment: Will process equipment recall/alert notices through the Biomedical Department. Reporting will be through the Environmental Health and Safety Committee. Documentation of actions taken will be maintained in the Biomedical Department and the ~~ECRI~~**NRAC** ~~Recall Alert Tracker~~**documentation** System.
3. Products: Will process product recalls/alerts through Supply Chain and other Departments as appropriate. Reporting will be through the Environmental Health and Safety Committee. Documentation of actions taken will be maintained in ~~ECRI~~**NRAC** ~~Recall Alert Tracker~~**documentation** system.
4. Lab: The Clinical Lab will process all recall/alert~~s~~ notices related to blood and tissue.

Documentation of action taken will be maintained in the Laboratory and the ~~ECRI~~**NRAC** ~~Recall Alert Tracker~~**documentation** system.

5. The Marketing Department will receive distribution when Risk Management determines the recall is of such significance that the media will be informed.
6. Exceptions: Items that are outside the scope of the electronic database (~~ECRI~~**NRAC** ~~Tracker~~) are routed through e-mail and tracked manually in Risk Management. These items may include, but are not limited to, dietary items, maintenance supplies, car seats, EVS supplies, toys, vehicles and Gift Shops items.

D. **REFERENCE:**

1. Medical Device Safety Act
2. The Joint Commission EC.6.10.6; EC.6.10.7
3. The ~~ECRI~~**NRAC E-Class** ~~Alert Tracker~~**Documentation** User's Manual
4. Clinical Laboratory Tissue Bank Procedure Manual, Recall of Tissue

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
~~Management of Information~~Information Technology

ISSUE DATE: 3/04	**SUBJECT:** Computer Hardware, Software, and Services, Purchase of
REVISION DATE: 2/05; 11/08	**POLICY NUMBER:** 8610-615

Department Approval Date(s)	**10/15**
Administrative Policies & Procedures Committee Approval:	**~~11/08~~10/15**
~~Operations Team Committee Approval:~~	**~~12/08~~**
Professional Affairs Committee Approval:	**~~01/09~~11/15**
Board of Directors Approval:	**01/09**

A. **PURPOSE:**

1. To ensure the acquisition and use of computer hardware, software and services is coordinated and cost effective.

B. **POLICY:**

1. All computer hardware, software, and services will be requested, evaluated, and purchased according to ~~the procedures described herein~~**this policy**.
2. Budget for computer hardware, software and services
   a. Based on historical records, estimated life span of equipment, and available budget dollars, the Information Technology Department, with the approval of the Vice President, Finance, annually creates capital and operating budgets for computer hardware, software and services for:
   b. Personal Computer upgrades and replacements throughout TCHD.
   c. ~~Printer~~ **~~Vereco, Inc.~~Approved contractor** upgrades and replace~~ments~~ **printers and faxes** throughout TCHD.
   d. Information Technology hardware, software and services to support enterprise applications such as email, Affinity, security and telephones.
3. The Information Technology Department budgets for the ongoing maintenance of hardware, software, and services needed to support TCHD applications. These budgets are prepared by the Information Technology Department ~~Director~~, and approved by ~~Vice President, Finance~~**Chief Operating Officer (COO)**.
4. Departments planning for expenditures not included in the annual Information Technology budget may do so after a technical assessment has been completed by the Information Technology Department, upon receiving approval and scheduling from the Information Technology Steering Committee, and upon receiving approval from the **appropriate C-Suite member**~~departmental Vice President~~. Among budget items of this kind are new departmental systems, major upgrades to departmental systems, or major systems investments associated with a changing business.
5. Requirements for approval may include a detailed cost/benefit analysis, an evaluation of the strategic or customer service benefits of the project, and prioritization of the project by the Information Technology Steering Committee.

C. **INFORMATION TECHNOLOGY STANDARDS:**

1. The Information Technology Department ~~publishes~~ **utilizes** standards **from vendors and best practices** for TCHD computer hardware and software. These standards are ~~distributed and~~ updated regularly.
2. All computer equipment and services must be purchased under the guidelines and ~~approval~~ **supervision of** ~~processes documented in~~ the TCHD Information Technology Standards.

D. **INFORMATION TECHNOLOGY PURCHASES:**

1. All computer hardware and software items must be submitted to the Information Technology Department ~~director~~, who will technically review the request to assure that the requested item meets TCHD standards.
2. If the request is not a capital request, it will be technically reviewed and, if approved, forwarded to Purchasing.
3. If the request is a capital request of ~~$10,000~~**5,000** or less, it will be technically reviewed and, if approved, forwarded to the Vice President, Finance for approval. Finance will assign a budget number, log the asset, and send the completed form to Supply Chain Management Department.
   a. If the request is a capital request in excess of ~~$10,000~~**5,000**, it must be approved by the Director's Vice President. It will then be technically reviewed and, if approved, forwarded to the Vice President, Finance for approval and assignment of a budget number, as per Administrative Policy **8610-**252**, Purchase of Budgeted Capital Assets**.
4. Purchases of computer hardware software and services will follow all TCHD purchasing policies and procedure.

E. **REFERENCES:**

1. **Administrative Policy 8610-252, Purchase of Budgeted Capital Assets**

DELETE – Policy no longer applies. Information Technology Department does not publish standards.

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 12/00

SUBJECT: Information Technology Standards

REVISION DATE: 5/03; 2/05; 6/12

POLICY NUMBER: 8610-611

Department Approval Date(s)	10/15
Administrative Policies & Procedures Committee Approval:	~~06/12~~10/15
Professional Affairs Committee Approval:	~~07/12~~11/15
Board of Directors Approval:	07/12

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

~~1. The Tri-City Healthcare District (TCHD) Information Technology Department regularly publishes Information Technology standards. These standards are to be referenced by all TCHD departments when using the services provided by the Information Technology Department. Among the published standards are:~~

~~a. Workstation Standards (hardware and software)~~
~~b. Hospital-wide and Departmental Systems Standards~~
~~c. Network Standards (servers, Local Area Network, Wide Area Network, database management)~~
~~d. Access Standards (remote access, encryption, security)~~
~~e. Service Standards (business hours, nights, weekends, holidays)~~
~~f. Customer Support Standards (IT support, Super Users, Training)~~
~~g.~~

~~2.~~1. ~~The Information Technology will routinely publish an update of standards as described in the Policy. These standards shall be referenced by all TCHD departments when using the services provided by the Information Technology Department.~~

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Information Technology~~Management of Information~~

ISSUE DATE: 12/00 **SUBJECT:** Software License Agreements

REVISION DATE: 5/03; 2/05; 06/12 **POLICY NUMBER:** 8610-605

Department Approval Date(s):	**10/15**
Administrative Policies & Procedures Committee Approval:	**~~06/12~~10/15**
Professional Affairs Committee Approval:	**~~07/12~~11/15**
Board of Directors Approval:	**07/12**

A. **SCOPE:**
1. All Tri-City Healthcare District (TCHD) facilities and Authorized Users of the Tri-City Healthcare District (TCHD) network.

B. **PURPOSE:**
1. To ensure compliance to all software license agreement terms, conditions, and copyright laws.

C. **POLICY:**
1. It is the responsibility of all TCHD employees, contractors, agents, business partners and other organizations (Authorized Users) that use TCHD owned or controlled PCs or network systems, to protect the TCHD's interests as they perform their duties. This includes responsibility for assuring that commercial software acquired by the Company is installed and used only in accordance with the commercial software publisher's licensing agreements.
2. TCHD's Information Technology Department (IT) is responsible for enforcing this policy. These responsibilities include:
   a. Develop and administer user software license compliance awareness programs.
   b. Perform audits, of all PCs, laptops, and servers to ensure that TCHD complies with all software license agreements.
   c. Maintain records of software installed on each PC, laptop, or LAN server and ensure that a license or other proof of ownership is on file.
   d. Ensure that each PC, laptop, or LAN server software product is purchased according to TCHD policy, and with the approval of ~~the Director,~~ Information Technology.

D. **PROCEDURE:**
1. IT ensures that the following procedures are implemented in support of this policy:
   a. User Awareness: Develop and administer user software license compliance awareness programs to existing employees and to new hires.
   b. Audits: Perform scheduled audits of all PCs, laptops, and LAN servers to ensure the facility/department complies with all software license agreements.
   c. Written Records: When software is delivered, it is first delivered to IT for registration and inventorying. Software is registered in TCHD's name, and the department in which the software will be used. Due to personnel turnover, software will never be registered in the name of the individual user. IT maintains a register of all Company software and will keep a file of all software licenses.
   d. Acquisition of Software: All software acquired by the facility/department is purchased through the Purchasing Department. Software may not be purchased through user corporate credit cards, petty cash, and travel or entertainment budgets. Software acquisition channels are restricted to ensure that TCHD has a complete record of all software that has been purchased and can register, support, and upgrade such software accordingly.

e. Shareware: Shareware software is copyrighted software that is distributed freely through bulletin boards and online services. Registration of shareware products will be handled in the same manner as commercial software products.

f. Personal Software and Home Computers: Users are not permitted to install personal software on Company computers. ~~without prior approval from the Director, Information Technology.~~ Generally, TCHD owned software cannot be taken home and loaded on an employee's home computer if it also resides on the Company's PCs. If the user is to use software at home, the Company will purchase a separate license and record it as a Company-owned asset in the software register.

g. Upgrades: When upgrades to software are purchased, the old version is disposed of in accordance with the licensing agreement to avoid potential violation. Upgraded software is considered a continuation of the original license.

Tri-City Medical Center
Oceanside, California

ENGINEERING
EQUIPMENT

SUBJECT: Designing & Installing Utility Systems

ISSUE DATE: **NEW**
REVIEW DATE(S):
REVISION DATE(S):

Department Approval Date(s):	**08/15**
Environmental Health and Safety Committee Approval Date(s):	**10/15**
Medical Executive Committee Approval Dates(s):	**N/A**
Professional Affairs Committee Approval Date(s):	**11/15**
Board of Directors Approval Date(s):	

A. **POLICY:**

1. It is the policy of the Tri-City Health District (TCHD) to select and install utility equipment that best meets patient care and operational needs.

B. **PURPOSE:**

1. This is accomplished through a proactive approach of evaluating & selecting the best quality and most cost effective equipment utilizing qualified personnel for determining appropriate utility needs, designing well engineered and suitable mechanisms for utility provision, and assuring the safe operation of all new and existing equipment via aggressive adherence to a detailed preventative maintenance program. The Engineering Department will work in conjunction with professional engineers, qualified contractors and designers / architects, reputable vendors, internal infection control, personnel, nursing management and trained & professional facilities mechanics and engineers in order accomplish these tasks.

C. **PROCEDURE:**

1. The selection, acquisition, and installation of all critical utility equipment will be evaluated for specific use and location. The Capital Committee & Engineering Department will evaluate all requests of new utility systems based on the recommendations of the following individuals:
   a. Requesting department head(s)
   b. Engineering Management & Administration
   c. Hospital architect(s) & designers
   d. Professional Engineers and Installation Contractors with an extensive history working with health care utility systems.
   e. Infection Control practitioner
   f. Materials Management
   g. Code experts and outside consultants
   h. OSHPD (Office of Statewide Health Planning and Development)
2. These systems shall undergo a detailed review for appropriate design, specifications, and suitability for providing the advanced needs of current, state of the art patient care. Input from each of the above members shall be sought to ensure that each change or modernization of the current utility systems is designed to assure it meets the needs of occupants.
3. Each new utility, once acquired and installed, shall undergo a preoccupancy operational test prior to occupying and or using the newly installed utility equipment. Final use of new utility equipment in renovated spaces shall also undergo the approval of the appropriate regulatory agencies. In the event of a negative test result or the discovery of a system that is not

functioning properly, the Engineering Department shall reconvene those responsible individuals to oversee possible solutions.

4. Preventative Maintenance shall be performed at specified intervals as deemed appropriate by the manufacturer recommendation or alternate maintenance strategy. This maintenance will be the responsibility of trained, professional hospital maintenance. Increased testing and inspections of systems may occur due to the outcome of inspection or testing analysis.
5. In the event of adverse test results or the discovery of a system that is not functioning properly, the Engineering Department shall reconvene those responsible individuals to oversee possible solutions.

Tri-City Medical Center
Oceanside, California

ENGINEERING
EMERGENCY PREPAREDNESS

SUBJECT: Emergency Power Systems

ISSUE DATE:
REVIEW DATE(S):
REVISION DATE(S):

Department Approval Date(s):	**09/15**
Environmental Health and Safety Committee Approval Date(s):	**10/15**
Medical Executive Committee Approval Dates(s):	**N/A**
Professional Affairs Committee Approval Date(s):	**11/15**
Board of Directors Approval Date(s):	

A. **POLICY:**

1. Tri-City Healthcare District (TCHD) provides an uninterrupted supply of electrical power for providing patient, visitor, and staff safety.

B. **PURPOSE:**

1. The emergency electrical generators provide emergency power automatically upon failure of commercial power sources. The generators that provide the emergency power are maintained daily and tested monthly to assure a reliable source of emergency power. Automatic transfer switches are checked and operation verified with each test of the generators.
2. Fuel for these generators is maintained on site, and will allow at least 72 hours of independent power operations. Refueling arrangements are maintained with vendors to assure the level of fuel does not fall below this level.
3. The following systems are fed by Emergency Electrical Power:
   a. Alarms Systems
   b. All Elevators
   c. Bone, Blood, and Tissue Storage
   d. Egress Lighting
   e. Emergency & Urgent Care Areas
   f. Emergency Communication System
   g. HVAC Systems for all Patient Care Areas
   h. Illuminated Exit Signs
   i. Kitchen Services
   j. Medical Air Compressors
   k. Medical Vacuum Systems
   l. **Laboratory**
   m. Negative Pressure Rooms
   n. Nurseries
   o. Obstetrical Delivery Rooms
   p. Operating Rooms
   q. Recovery Rooms
   r. Steam Generation
   s. Surgical Vacuum Systems
   t. Power and Lighting for All Patient Care Areas not listed above

Tri-City Medical Center
Oceanside, California

ENGINEERING OPERATIONS

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Humidity Level Control~~ ~~Policy Number: 2017 Page 1 of 1~~
~~Department: Hospital-Wide~~	~~EFFECTIVE: 12/18/09~~ ~~REVISED: 8/11, 6/12~~

SUBJECT: Humidity Level Control

ISSUE DATE: 12/09
REVIEW DATE(S):
REVISION DATE(S): 8/11, 6/12

Department Approval Date(s):	**10/15**
Environmental Health and Safety Committee Approval Date(s):	**10/15**
Medical Executive Committee Approval Dates(s):	**N/A**
Professional Affairs Committee Approval Date(s):	**11/15**
Board of Directors Approval Date(s):	

A. **PURPOSE:**

1. **It is the policy of Tri-City Healthcare District to maintain temperature and humidity levels suitable for the care, treatment, and service provided in all anesthetizing locations.**~~To maintain the acceptable range in relative humidity level in surgery suites through out the facility.~~

B. **POLICY:**

1. The relative humidity **and temperature** levels in all **anesthetizing locations** ~~surgery suites in this facility~~ shall be maintained **as required by Centers for Medicare & Medicaide Services (CMS) State Operations Manual Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospitals – Survey Procedure 482.41 (c) (3); and CMS categorical LSC waiver detailed in the CMS Survey and Certification Group memo dated April 19, 2013 (Ref. S&C:13-25-LSC & ASC).** ~~between 35% and 60%.~~

C. **PROCEDURE:**

1. The Plant Engineering Staff is responsible for maintaining and tracking the relative humidity **and temperature** levels for all **anesthetizing locations.**~~surgery suites to minimize the fire and infection risks.~~
2. The Building Management System shall be programmed to track and record the relative humidity levels continuously and alert the duty plant engineer if the humidity level drops below ~~35~~**20%.** ~~or above 60%.~~
3. **Plant** Engineering staff shall take corrective actions and notify Surgery Department when the relative humidity level **drops below 20%.**~~in OR are out of range for duration of more than 30 minutes. (Please see the Plant Engineering's Corrective Action Procedures)~~

~~4.~~D. REFERENCES:

1. **Centers for Medicare & Medicaide Services (CMS) State Operations Manual Appendix A – Survey Protocol**
2. **Regulations and Interpretive Guidelines for Hospitals – Survey Procedure 482.41 (c) (3)**
3. **CMS categorical LSC waiver detailed in the CMS Survey and Certification Group memo dated April 19, 2013 (Ref. S&C:13-25-LSC & ASC)**

Tri-City Medical Center
Oceanside, California

ENGINEERING
EQUIPMENT

SUBJECT: **Initial Testing of New Utility Components**

ISSUE DATE: **New**
REVIEW DATE(S):
REVISION DATE(S):

Department Approval Date(s):	**09/15**
Environmental Health and Safety Committee Approval Date(s):	**10/15**
Medical Executive Committee Approval Dates(s):	**N/A**
Professional Affairs Committee Approval Date(s):	**11/15**
Board of Directors Approval Date(s):	

A. **POLICY:**
1. Each operational component of a utility system on the inventory will be tested to assure all performance and safety specifications are met prior to initial use.
2. **Utility Systems include, but are not limited to:**
   a. **Electrical**
   b. **HVAC**
   c. **Plumbing**
   d. **Steam and Boilers**
   e. **Medical Gas and Vacuum**
   f. **Communication**
   g. **Vertical and Horizontal Transport**

B. **TESTING ON DELIVERY:**
1. Each operational component of utility systems will be tested by Engineering Department prior to initial use.
2. All operational components will be inspected upon delivery for damage. Damaged goods will be returned to the supplier.
3. The Engineering Department and the vendor will unpack and inspect the equipment for any damages. In addition, the Engineering Department will determine if all required operating and service information were supplied with the equipment. If any damage is observed, or documentation is missing, the Engineering Department will notify the Purchasing Department. The Purchasing Department will notify the supplier to take necessary action.
4. The Engineering Department will conduct appropriate performance and safety inspections, and calibration checks. When it is determined that the equipment meets all requirements for performance and safety, the Engineering Department will release the equipment for use.
5. The completion date and results of the test will be documented and maintained by the Engineering Department.

C. **TESTING OF INSTALLED SYSTEMS:**
1. All fixed and mounted equipment will be installed as required by contract documents and authorities having jurisdiction.
2. The manufacturer, supplier, or the Engineering Department will install or mount the equipment as required by contract documents and authorities having jurisdiction.
3. All required power and signal lines will be installed and certified as specified and required by contract documents and authorities having jurisdiction.

4. All fixed and mounted equipment will be tested for performance and safety as specified in the contract documents and authorities having jurisdiction. **The manufacturer will be involved in the testing and certification as appropriate.** The Engineering Department and appropriate engineering staff will witness all certification testing and calibration not performed by hospital staff.
5. The completion date and results of the test will be documented and maintained by the Engineering Department.

Tri-City Medical Center
Oceanside, California

ENGINEERING
EQUIPMENT

SUBJECT: **Mapping the Distribution of Utility Systems Controls**

ISSUE DATE: **NEW**
REVIEW DATE(S):
REVISION DATE(S):

Department Approval Date(s):	**09/15**
Environmental Health and Safety Committee Approval Date(s):	**10/15**
Medical Executive Committee Approval Dates(s):	**N/A**
Professional Affairs Committee Approval Date(s):	**11/15**
Board of Directors Approval Date(s):	

A. **POLICY:**

1. It is the policy of the Tri-City Healthcare District (TCHD) to maintain drawings and documents mapping the distribution of utility systems that indicate the location of controls for the partial or complete shutdown of each utility system. These drawings will be maintained to further ensure, through training of Engineering Department personnel, that proper procedures are followed in the shutdown of any utility system component.
2. The drawings for TCHD are located in the plan room.

B. **PROCEDURE:**

1. Procedures specific to the following utility systems are located on the TCHD Intranet.
2. Utility Systems include, but are not limited to:
   a. Electrical
   b. HVAC
   c. Plumbing
   d. Steam and Boilers
   e. Medical Gas and Vacuum
   f. Communication
   g. Vertical and Horizontal Transport
3. When a utility system must be shutdown, notify Administration, Administrative Supervisor Team and the Department Directors of each affected Department.
4. Changes to the utility systems that affect the distribution of the service are documented on the appropriate maps.

Tri-City Medical Center
Oceanside, California

ENGINEERING
EQUIPMENT

SUBJECT: Operation of Fire and Smoke Dampers

ISSUE DATE: New
REVIEW DATE(S):
REVISION DATE(S):

Department Approval Date(s):	**09/15**
Environmental Health and Safety Committee Approval Date(s):	**10/15**
Medical Executive Committee Approval Dates(s):	**N/A**
Professional Affairs Committee Approval Date(s):	**11/15**
Board of Directors Approval Date(s):	

A. **POLICY:**
1. It is the policy of Tri-City Healthcare District (TCHD) to operate fire and smoke dampers 1 year after installation and then every 6 years to verify that they fully close.

B. **OPERATE FIRE AND SMOKE DAMPERS 1 YEAR AFTER INSTALLATION:**
1. Fire and Smoke dampers will be tested 1 year after initial installation
2. An ILSM (Interim Life Safety Measure) assessment needs to be performed and documented whenever a damper is reported as failed or when dampers are deemed inaccessible.
3. The completion date of the test is documented
4. When an area undergoes renovation, a set of mechanical drawings are provided indicating where new dampers have been installed.

C. **OPERATE FIRE AND SMOKE DAMPERS EVERY 6 YEARS:**
1. The hospital operates fire and smoke dampers at least every 6 years after the 1 year inspection to verify that they fully close.
2. An ILSM (Interim Life Safety Measure) assessment needs to be performed and documented whenever a damper is reported as failed or when dampers are deemed inaccessible.
3. The completion date of the test is documented.

~~TRI-CITY MEDICAL CENTER~~ ~~Safety Policies & Procedures~~	~~Section: Equipment Management~~ ~~Subject: Policy on Acquisition of Furniture, Furnishings and Related Supplies~~ ~~Policy Number 5011 Page 1 of Page 4~~
~~Department: Hospital Wide~~	~~EFFECTIVE: 11/87~~ ~~REVISED: 1/97; 7/00; 5/03~~

SUBJECT: Acquisition of Furniture, ~~and~~ and Furnishings ~~and Related Supplies~~

ISSUE DATE: 11/87 **POLICY NUMBER: 5011**
REVIEW DATE(S):
REVISION DATE(S):01/97, 07/00, 05/03

Department Approval Date(s):	**09/15**
Environmental Health and Safety Committee Approval Dates(s):	**10/15**
Medical Executive Committee Approval Dates(s):	**N/A**
Professional Affairs Committee Approval Date(s):	**11/15**
Board of Directors Approval Date(s):	

A. **PURPOSE**

1. To establish policies and procedures for the procurement or furniture, furnishings and fixtures, (other than medical furniture) to meet the replacement and additional needs throughout Tri-City ~~Medical Center~~**Healthcare District (TCHD).** ~~and to establish policies and procedures for the relocation of furniture and furnishings, both within and between buildings, throughout the facility.~~

B. **POLICY**

1. It is the policy of ~~Tri-City Medical Center~~**TCHD** that when acquiring furniture, furnishings, and related supplies that only fire safe materials will be allowed into the facility. ~~as follows:~~
~~a.~~**2.** Furnishings in ~~Tri-City Medical Center~~ **TCHD** will be determined from the standpoint of utility, durability, maintaining cleanliness and therapeutic and aesthetic value of color and design.
~~b.~~**3.** Outside consultants and/or ~~Tri-City Medical Center~~ **TCHD** resources will be utilized for interior decorating or interior design services, when indicated.
~~c.~~**4.** It is the policy of ~~Tri-City Medical Center~~ **TCHD** that all furniture, curtains, draperies, carpeting, wastebaskets, shelving, and miscellaneous furnishings meet National Fire Protection Association (NFPA®) fire safety codes.

~~All requests for new items specified in paragraph 2(c) will be requested by utilizing the Capital Purchase Requisition to the Director of Materials describing needs, justifications and specific locations. Purchasing will forward all requests to the Director of Engineering for approval or disapproval for compliance with NFPA fire safety codes. The Director of Engineering will indicate approval / disapproval on the memorandum with a concurrence signature and will indicate any reason(s) for disapproval.~~

~~To expedite the approval process, selected material may be approved in advance by the Director of Engineering. Documentation to support prior approval will be retained by the Director of Engineering and the name of the approving official and date of approval must appear on the request submitted by Purchasing Service.~~

~~To expedite the approval and procurement process, all Services are encouraged to research their needs and request items that meet the NFPA fire safety codes.~~

~~Requests for relocation of existing furniture and furnishings, both within and between buildings of the facility, will be requested by memorandum to the Director of Purchasing describing needs and specific locations. Under no circumstances will movement of furniture and/or furnishings be accomplished without prior notification and approval by the Director of Materials.~~

C. **RESPONSIBILITY:**

1. ~~The Director of Materials~~**Supply Chain** is responsible for obtaining approvals and procuring all new furniture, furnishings, fixtures and related supplies. ~~and for relocation of all existing furniture and furnishings within the facility.~~
2. Department ~~Director/~~Managers are responsible for the protection and safeguarding of furnishings assigned to their areas.
3. The Director of Engineering is responsible for structural development on approved remodeling projects and for installation/removal of fixtures permanently attached to structures.
4. ~~The Director of Guest Services is responsible for coordination of the wall washing program in cooperation with the Director of Engineering with painting/wallpapering schedules.~~The ~~Environment of Care/Safety Officer~~**Director of Safety/Environment of Care (EOC)** is responsible for approving or disapproving requests in accordance with the NFPA.

D. **PROCEDURE:**

1. **All requests for new items will be requested through Supply Chain Management describing needs, justifications and specific locations. The request must have prior "C Suite" approval.**
2. **Supply Chain Management will forward all requests to the Director of Safety/EOC for approval or disapproval for compliance with NFPA fire safety codes.**
3. ~~5.~~**To expedite the approval process, selected material may be approved in advance by the Director of Safety/EOC. Documentation to support prior approval will be retained by the Supply Chain Management.**

~~D.~~**E. IMPLEMENTATION:**

1. ~~The i~~Interior furnishings ~~governed by this memorandum~~ consist of, but are not limited to; upholstered furniture, waste and trash receptacles, interior finishing such as wall, ceiling, and floor coverings, carpets and wallpaper, drapes, curtains and other textiles.
2. *Upholstered Furniture:* All furniture possessing a combustible capability must be certified or bear a statement or tag that it meets, or was tested under, the requirements of the National Fire Protection Association 260 or 261 Standard and California TB133 requirements. These are the test methods for determining the resistance of upholstered furniture to ignition by smoldering cigarettes. **This only applies to areas of the facility that lacks sprinklers. Areas with sprinklers are exempt per the Oceanside Fire Chief. Upholstered furniture paddings must maintain the flammability requirements of California Bureau of Home Furnishings Technical Bulletin 117 (TB 117) certification.**
3. *Draperies, Curtains and Similar Furnishings:* Drapes, cubicle curtains, etc., (hanging fabrics or textiles) are to be flame resistant, and must have been tested to meet the requirements of the NFPA-701 "Standard Methods of Fire Tests for Flame Resistant Textiles and Films".
4. *Waste and Trash Receptacles and Carts:* Wastebaskets, trash and similar containers such as carts shall be of non-combustible or other approved materials as follows:
   a. **No trash or garbage container (except those uses exclusively for transport) will be larger than 32 gallons.**~~Containers of less than 10-gallon capacity used for ordinary Class A combustibles may be used uncovered.~~

~~b. Containers of more than 10 gallons capacity shall be equipped with tight fitting covers, or other means of confining combustion with the container, and the containers must not melt or deform if the contents ignite or the container is exposed to heat or fire.~~

~~c. Any size trash container that is used for disposal of materials subject to spontaneous combustion, generation of flammable vapors or intense burning must comply with 4.c.2), above.~~

5. *Carpeting:* All new carpeting purchased for installation ~~in our health care~~**TCHD** facilities shall~~meet the following safety requirements. Newly installed interior floor finish in corridors and exits shall~~ be Class I in accordance with NFPA Standard 253, "Standard Method of Test for Critical Radiant Flux of Floor Covering Systems Using a Radiant Heat Energy Source."
6. *Fire Retardant Coatings:* When articles used for interior finishing's have a fire retardant coating, users must ensure such materials retain their retardance under service conditions. When in doubt, users shall contact the Director of ~~Engineering~~ **Safety/EOC** who will verify that the treatment complies with NFPA 703, "Standard for the Fire Retardant Impregnated Wood and Fire Retardant Coatings for Building Materials."
7. Highly Flammable Furnishings and decorations:
   a. Furnishings or decorations of a highly flammable or explosive character are prohibited from being ~~brought in~~ displayed or ~~otherwise~~ used in this ~~Medical Center~~**facility**.
   b. Textile materials having a napped, tufted, looped, woven, non-woven, or similar surface shall not be applied to walls or ceilings unless meeting requirements of proper testing for flame spread.
   c. Cellular or foamed plastic materials shall not be used as interior wall or ceiling finish.
8. Heat Producing Appliances*:* Equipment will be installed and maintained in accordance with their manufacturers' instructions, applicable NFPA Standard and testing laboratory acceptance criteria.
9. Supportive Documentation of Flammability Ratings**:**
   a. Documents or certifications ~~attesting to~~**indicating** a product's flammability rating are required to be retained in an easily retrievable manner to satisfy ~~agency or outside safety inspectors or JCAHO surveyors.~~**all regulatory agencies.**
   b. ~~Accordingly, d~~**D**ue to the inordinate purchases of furniture, interior decorations, etc., by various services, all purchasers of such products will establish and maintain a documentation file for presentations to inspectors. This file must contain an accurate description of the products purchased, their location within the ~~Medical Center~~**facility**, and any documentation, certificates, or manufacturer's literature ~~testing~~ **referring** to the product's conformance to the requirements of the fire retardation tests as specified ~~in this memorandum~~.

~~E. **TECHNICAL SUPPORT:**~~

~~1. In those instances where purchasers are in doubt as to the suitability of a product being introduced into this facility for meeting the intents of this memorandum, they shall consult with and be guided by the information and advice of the Director of Engineering.~~

~~2. In order to ensure that if any product introduced into the hospital without having undergone the above process of evaluation, the Safety Officer shall target questionable items during the hazard surveillance tours, regularly performed hospital-wide. Failure for Managers or Department Directors to provide the required, acceptable documentation, the product (s) shall be removed from the facility / building.~~

F. **REFERENCE(S):**

1. **National Fire Protection Association 260 or 261 Standard and California TB133**
2. **California Bureau of Home Furnishings Technical Bulletin 117 (TB 117)**
3. **NFPA - 701 "Standard Methods of Fire Tests for Flame Resistant Textiles and Films"**
4. **NFPA Standard 253, "Standard Method of Test for Critical Radiant Flux of Floor Covering Systems Using a Radiant Heat Energy Source"**

~~1.~~5. **NFPA 703, "Standard for the Fire Retardant Impregnated Wood and Fire Retardant Coatings for Building Materials."** ~~JCAHO® Accreditation Manual for Hospitals; National Fire Protection Association 260, 261 & 701~~

SUBJECT: Providing a Safe Environment

ISSUE DATE: NEW
REVIEW DATE(S):
REVISION DATE(S):

Department Approval Date(s):	**09/15**
Environmental Health and Safety Committee Approval Dates(s):	**10/15**
Medical Executive Committee Approval Dates(s):	**N/A**
Professional Affairs Committee Approval Date(s):	**11/15**
Board of Directors Approval Date(s):	

A. **POLICY:**

1. It is the policy of the Tri-City Healthcare District (TCHD) to develop and implement plans, programs and processes which will promote a safe and functional environment.

B. **PROCEDURES:**

1. To accomplish this objective, the facility has instituted a series of initiatives to reduce the risk of system failure and also to ensure staff knowledge relative to emergency procedures to be taken in the event of a failure.
2. Specifically, programs are in place that include, but are not limited to, risk assessments, preventive maintenance and testing, environmental tours and staff education. The following are specific areas reviewed:
   a. Interior spaces shall meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.
   b. For patients who remain in the care of the hospital for more than 30 days, such as the Acute Rehabilitation Unit (ARU) and Behavioral Health Unit (BHU).
      i. Space has been provided for recreation and social interactions
      ii. Outside areas suitable to patient's age, physical or mental conditions
   c. Storage space has been provided to meet the patient's needs.
   d. Lighting is suitable for care, treatment, and services and the specific activities being conducted.
   e. Ventilation provides for acceptable levels of temperature and humidity
   f. Areas used by patients are clean, sanitary, and free of offensive odors.
   g. Emergency access provision is provided to all locked and occupied spaces.
   h. Furnishing and equipment are maintained to be safe and in good repair.
   i. The status of the environment will be reviewed during the Environmental Tours process and reviewed by the Director of Safety/Environment of Care (EOC). Deficiencies and corrective actions will be reviewed by the Director of Safety/EOC and reported to the Environmental Health and Safety Committee (EHSC) as appropriate.

SUBJECT: Waste Management

ISSUE DATE: 09/01
REVIEW DATE(S):
REVISION DATE(S): 10/03, 01/07, 07/09

Department Approval Date(s):	**10/15**
Environmental Health and Safety Committee Approval Dates(s):	**10/15**
Medical Executive Committee Approval Dates(s):	**N/A**
Professional Affairs Committee Approval Date(s):	**11/15**
Board of Directors Approval Date(s):	

~~**ISSUE DATE: 9/01** **SUBJECT: Waste Management**~~

~~REVISED: 10/2003, 1/2007, 7/2009 STANDARD NUMBER: IC. 10.1~~

~~**Department Approval Date(s):**~~
~~**Infection Control Committee Approval: 10/12**~~
~~**Medical Executive Committee Approval: 11/12**~~
~~**Professional Affairs Committee Approval:**~~
~~**Board of Directors Approval: 11/12**~~

A. **POLICY:** ~~Introduction~~

1. The Medical Waste Management Act provides the legislative definition of medical waste (California Health and Safety Code, Section 117690). In lay terms, waste must satisfy three critical criteria in order to be classified as medical waste. These three criteria are:
   a. The material must actually be a waste product.
      i. This precludes materials that have intrinsic value (such as outdated pharmaceuticals that are returned for credit) from being classified as a medical waste.
   b. The waste can be either biohazardous or sharps waste.
      i. Various forms of waste are defined as biohazardous because of the actual or presumed presence of pathogenic microorganisms. Such wastes as laboratory waste and fluid blood fall into this category and are therefore biohazardous waste. Trace amounts of chemotherapeutic agents, outdated pharmaceutical wastes and tissues with trace amounts of fixatives also fall into the category of biohazardous waste. Objects that have been used in invasive procedures such as hypodermic needles and broken glass items contaminated with blood or other biohazardous waste are considered to be sharps waste.
   c. The waste must be produced as a result of a specified action in the delivery of health care.
      i. The Medical Waste Management Act (section 117690) defines this as the "...diagnosis, treatment, or immunization of human beings..."

~~B. Biohazardous~~

~~1.~~**2.** Most waste generated during the direct patient care is not biohazardous. Examples of biohazardous waste that might be generated at our facility that requires special disposal includes:

~~2.~~**a.** Human specimen cultures, culture dishes and devices used to transfer, inoculate and mix cultures from medical and pathology laboratories.

~~3.~~**b.** Surgery specimens or tissues suspected of being contaminated with infectious agents known to be contagious.

~~4.~~**c.** Waste containing recognizable fluid blood, fluid blood products, and containers or equipment containing fluid blood.

~~5.~~**d.** Waste containing materials that are required to be isolated by the infection control staff, attending physician and surgeon or local health officer to protect others from highly communicable diseases (such as smallpox or the hemorrhagic fevers: Ebola, Lassa, Marburg, or Crimean-Congo).

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

1. Segregation of other medical waste is accomplished by staff (see Appendix A). All regulated medical waste will be collected within the area of origin in a biohazard bag or sharps container as appropriate.
2. Biohazardous bags are disposable, red in color, impervious to moisture with strength sufficient to preclude ripping, tearing, or bursting under normal conditions of usage and handling. They must pass the 165-gram dropped dart impact resistant test as prescribed by Standard D 1709-85 of the American Society for Testing and Materials and certified by the bag manufacturer.
   a. Red biohazardous bags shall be securely tied at the top so as to prevent leakage or expulsion of solid or liquid during storage, handling or transport.
   b. All items in a red bag must be managed as biohazardous. Red-bagged waste are handled by a contract service as biohazardous and never sent to the landfill.
3. Storage
   a. Red biohazardous bags shall be placed in rigid containers for storage, handling and transport.
   b. Containers holding red biohazardous bags shall be leak-resistant have tight fitting covers and are kept in good repair. These containers are not required to be red in color but must be labeled on the cover and sides with the words "Biohazard"
   c. The bag shall be legibly labeled with the hospital's name, address, and phone number and easily visible on the outside of the bag
   d. Any enclosure or designated collection area used for the storage of medical waste containers shall be secured so as to deny access to unauthorized persons. Signs worded "Caution-Biohazardous Waste Storage Area- Unauthorized Persons Keep Out" in English and Spanish. must be posted on the entry doors.
4. Transportation to Final Storage
   a. Covers are required where biohazardous material is being stored after collection or during transport.
   b. Intermediate holding areas for red-bagged wastes are located on the floors. Daily, Environmental Services staff will check waste levels and when necessary, transport all wastes, including red-bagged wastes to the holding area for pick-up by the contract**ed** service~~, Med-Serve Environmental~~ **provider**.
   c. Biohazardous wastes may be stored on the premises no longer than seven days.
   d. Biohazardous wastes stored for final disposition and transport offsite must be stored in secured storage area so as to deny access to unauthorized persons. Storage areas shall be marked with warning signs on or adjacent to exteriors of doors or gates and provide protection from animals, vermin and natural elements.
   e. This area will display prominent warning signs in English: "Caution: Biohazardous waste storage area. Unauthorized persons keep out." and in Spanish: "Cuidado: Zona de residos infectados. Prohibida la entrada a personas no authorizadas." Warning signs

shall be readily legible during daylight from a distance of at least 25 feet. This area will be well ventilated and kept clean at all times.

f. Unless protected by disposal liners, reusable rigid containers shall be washed and decontaminated by a hospital-approved disinfectant every time they are emptied.

g. During transport, medical wastes shall be separated from other wastes in the same vehicle by use of containers or barriers.

5. Certain hazardous wastes may be solidified for disposal. An EPA approved product (i.e. Isosorb) is used to solidify contents of suction canisters. After treatment is done, this waste must be put in a red bag to be discarded.
6. Patients' rooms shall have waste containers lined with regular plastic bags. Environmental Services staff accomplishes disposal of waste from patients' rooms.
7. Sharps waste:
   a. All used needles and syringes will be disposed of at the point of origin in an appropriate sharps collection container. All sharps container will be checked for fill level daily and exchanged appropriately by our outside vendor or Environmental Services Department.
   b. Sharps waste shall be contained in sharps containers, which are rigid, puncture-resistant, leak-resistant when, sealed, labeled with biohazard signs and red in color. Full sharps containers shall be tightly lidded. Tape may not serve as lid. Sealed sharps containers may be placed in red biohazard bags.
   c. The container shall be legibly labeled with the hospital's name, address, and phone number and easily visible on the outside of the container.
8. Each newly hired Environmental Services employee will receive orientation to the procedure for the in-house collection, transportation, and storage of regulated and non-regulated waste at the medical center prior to his/her first day on the job. Training must include legal definitions, separation and proper storage, transportation, treatment and disposal of biomedical waste. Training will be the responsibility of the supervisor in charge of this area.

~~D.~~C. RELATED DOCUMENTS:

1. **Administrative Policy: Handling of Pharmaceutical Waste, Expired Medications, and Expired Iv Solutions 276**

~~E.~~D. REFERENCE:

1. Ordinance No. 7646 of San Diego County, Department of Health Services regulating the storage and disposal of medical wastes
2. Medical Waste Management Act, Sections 117600-118360 in Chapter 6.1, California Health and Safety Code.
3. Self-Assessment Manual for Proper Management of Medical Waste. Ca DHS and the California Healthcare Association, 2nd Ed., 1999

Decision Table for Medical Waste

Type of Waste	Red Bag	Regular Bag	Sharps Container
Fluid blood, blood elements, vials of blood, specimens for culture, used culture media, and stock cultures.	X		
Bloody body fluids or disposable drapes **saturated and/or** dripping with bloody body fluids such as CSF, synovial, pleural, pericardial, amniotic.	X		
Bloody body fluid filled containers from nursing units, ED, PACU, outpatient areas not treated with Premicide.	X		
Materials used to clean up fluid blood or bloody body fluid spills that are dripping.	X		
Surgical specimens.	X		
Wound dressings, bandages, wrappings **saturated and/or** dripping with blood.	X		
Food waste such as soda cans, paper cups, cutlery, including food or service items from isolation rooms.		X	
Empty urine and stool containers, empty colostomy and urinary drainage bags, empty bedpans, breathing circuits, surgical drapes.		X	
Flexi-Seal Fecal Management Bags	X		
Gastric washings, dialysate, vomitus, feces, urine, diapers. Please empty in toilet.		X	
Tracheal and bronchial secretions, sputum, IV tubing without the needles.		X	
Soiled but not dripping items such as dressings, bandages, cotton balls, peripads, chux, cotton swabs.		X	
Suction Canisters, treated with solidifying agent.	X		
Used gloves, aprons, masks, goggles, respirators.		X	
Broken glass, guide wires.			X
Uncapped Needle/syringe units, needles, scalpels, vials from live or attenuated vaccines.			X

SUBJECT: **ADMISSION AND DISCHARGE CRITERIA FOR THE NICU**

ISSUE DATE: **06/07**
REVISION DATE(S): **04/09, 06/11**

NICU Department Approval Date(s):	**06/14**
Perinatal Collaborative Practice Approval Date(s):	**~~06/14~~08/15**
Division of Neonatology Approval Date(s):	**~~06/14~~08/15**
Medical Executive Committee Approval Date(s):	**~~07/14~~10/15**
Professional Affairs Committee Approval Date(s):	**~~08/14~~11/15**
Board of Directors Approval Date(s):	**08/14**

A. **PURPOSE:**
1. To define the criteria for admission and discharge to the Neonatal Intensive Care Unit (NICU).

B. **GENERAL INFORMATION:**
1. Patients shall be admitted under the care of a California Children's Services (CCS) paneled attending neonatologist.
2. All admissions to the NICU are arranged with the NICU Assistant Nurse Manager and/or relief charge Registered Nurse (RN).
3. Patients up to adjusted 44 week post conceptual presenting with a diagnosis of a non-communicable nature may be admitted to the NICU at the discretion of the Neonatologist on call and depending on staff and bed availability.
4. The patient being admitted from the community must be screened for **clinical symptoms** of Respiratory Syncytial Virus (RSV) and influenza.
5. The back transport from another facility must have a completed negative Methicillin-resistant Staphylococcus Aureus (MRSA) screen prior to acceptance of admission.
6. The attending physician shall be notified of patient arrive in the unit.
7. All Patients admitted to the NICU shall have a patient history completed and documented in the patient's medical record. An initial assessment **by a Physician or Nurse Practitioner** shall be completed within 30 minutes of admission and documented within 4 hours of admission.
   a. This admission assessment is done and documented on patients admitted from any area of the hospital as well as transfers from other facilities.
8. Ongoing assessments are completed based on the patient's acuity and documented in the patient's medical record.

C. **ADMISSION CRITERIA:**
1. Respiratory system:
   Admission criteria may include but not limited to the following:
   a. Apnea requiring monitoring and observation
   b. Respiratory instability (tachypnea, grunting, cyanosis, etc.)
2. Cardiac system: Patients with severe, life threatening or unstable cardiovascular disease. Conditions include but are not limited to:
   a. Newly diagnosed or suspected arrhythmias.
   b. Hemodynamic instability.
   c. Suspected complex congenital heart defects.
3. Endocrine/Metabolic: Patients with life threatening or unstable endocrine or metabolic disease or active life threatening bleeding. Conditions include but are not limited to:

a. Inborn errors of metabolism with acute deterioration requiring respiratory support, management of intracranial hypertension or ionotropic support.
b. Other severe electrolyte abnormalities such as hyperkalemia, severe hypo - or hypernatremia, hypo - or hyperglycemia requiring intensive monitoring.
c. Severe metabolic acidosis requiring bicarbonate infusion, intensive monitoring or complex intervention to maintain fluid balance.
d. Acute Intraventricular Hemorrhage (IVH).
e. Post-hemorrhahagic hydrocephalus
f. Twin-to-twin transfusion
g. Anemia of the newborn
h. Hyperbilirubinemia
i. Thrombocytopenia

4. Other:
a. Patients requiring a medical subspecialist.
b. Patients requiring advanced imaging with interpretation on an urgent basis including computer tomography, magnetic resonance imaging, and echocardiography.
c. Patients less than 2000 grams.
d. Patients with gestational age less than 35 completed weeks (35 6/7).
e. Patients with suspected or confirmed sepsis.
f. Any patient requested by a referring physician.
g. Patients with suspected or confirmed genetic malformations requiring stabilization, surgical intervention and/or consultation with subspecialist.
h. Patients with suspected or confirmed necrotizing enterocolitis.

D. DISCHARGE CRITERIA:

1. Transfer to other in-patient facility:
a. Based on level of care required and bed availability; and/or where the infant's family lives, an infant may be transferred to a tertiary NICU for completion of care.
b. The infant shall be referred to an attending Neonatologist.
c. These babies may include but are not limited to the following:
i. Cardiac disease requiring surgical intervention and subspecialist follow up.
ii. Patients requiring surgical intervention.
iii. Neurologic disease needing subspecialist intervention and follow up.

2. To Home:
a. Completion of discharge teaching.
b. Stable cardio respiratory status. No apnea or bradycardia episodes requiring intervention within 5 to 7 days of discharge.
The following infants will require home cardio respiratory monitoring:
i. SIDS sibling history.
c. Stable nutritional status
d. Ability to maintain temperature without artificial heart source
e. Stable medication regimen.
f. Completed assessment of outpatient neurodevelopmental needs.
g. Hearing screening.
h. Confirmed outpatient physician follow-up.

E. REFERENCES:

1. American Academy of Pediatrics. (2008). Hospital Discharge of the High-Risk Neonate: Committee on Fetus and Newborn. Pediatrics; 122 (5) 1119-1127.
2. American Academy of Pediatrics and the American Congress of Obstetrician and Gynecologists. (2012). Guidelines for Perinatal Care (7th ed.), 321-382.

Tri-City Medical Center	Women's

DELETE – Procedure going to follow Mosby's Exchange Transfusions (Neonatal)

PROCEDURE:	**EXCHANGE TRANSFUSIONS, DOUBLE AN**
Purpose:	To define the procedure for assisting a Physician with a double or partial exchange transfusion in the neonate.
Equipment:	1. Indwelling UAC or UVC line 2. Disposable exchange transfusion tray, including 3. Gauze 4. 2 % Chlorhexidine Gluconate swabs 5. Resuscitation equipment 6. Sterile gloves, gown, and mask 7. Blood warmer 8. Ordered blood product. 9. Glucose monitor 10. Limb restraint 11. Appropriate lab collection tubes
Issue Date: 9/07	Revision Date: 6/09, 6/11, 8/12

A. **Supportive Data:**

1. A double-volume exchange transfusion is a method of exchanging infant's blood for fresh banked blood by slowly withdrawing the infant's blood and replacing it with donor's blood in small, equal increments. The procedure is performed to remove antigen positive, antibody coated red blood cells and replace them with antigen negative cells, correct anemia, relieve congestive heart failure, remove accumulated bilirubin and other toxic substances.
2. Partial-volume exchange transfusions are performed to decrease the hematocrit and whole blood viscosity in polycythemic neonates with hyperviscosity or to correct severe anemia. The blood should be exchanged ml for ml with a volume expander to lower the hematocrit, to reduce the hyperviscosity of the blood, if the central hematocrit is greater than 70% and the infant is symptomatic.
3. Symptomatic infants with a venous hematocrit greater than 65% or asymptomatic infants with a hematocrit of greater than 70% may require treatment to reduce the hematocrit to less than 60%. Fresh frozen plasma, plasmanate, 5% albumin, and saline have been used as replacement fluids for whole blood withdrawn. To collect severe anemia, PRBCs are used as replacement fluid for whole blood withdrawn. Infants with an HCT less than 35% may be given PRBCs (25-80 mL/kg) to raise their HCT to greater than 40%, if possible.

B. **PROCEDURE:**

1. Perform hand hygiene.
2. Confirm patient identity using two-identifier system. Refer to Patient Care Services "Identification, Patient" (IV.A) policy
3. Ensure that all relevant studies and documents, including informed consent, are available.
4. Participate in a "time out" to verify correct patient, procedure, and site.
5. The infant should be under a radiant warmer, and a temperature probe should be in place throughout the procedure.
6. Check transfusion blood with another nurse to verify patient identity, blood product, and physician's order. Set up blood warmer per manufacturer's instructions and warm blood to body temperature (36-37° Celsius).
7. Put on personal protective equipment.

Department Review	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
8/15	8/15	N/A	10/15	11/15	8/13

8. If needed, assist with obtainment of vascular access.
9. Assist with setup of the instrument and exchange transfusion tray and maintenance of a sterile field. Aseptic technique should be maintained throughout the procedure to minimize risk of infection.
10. While wearing sterile gloves, remove the disposable blood waste bag from the sterile tray.
11. Connect the tubing in the following order:
    a. Blood component bag
    b. Blood filter
    c. Blood tubing
    d. Blood warmer tubing
12. Connect blood tubing and blood warmer tubing to blood and prime tubing to eliminate air. The physician, utilizing sterile technique, will:
    a. Attach the indwelling catheter(s) to a four-way stopcock
    b. Attach the extension tubing set in the prep tray to the stopcock. This tubing will then be handed off to be connected to the blood waste bag. Additional extension sets may be connected to the original extension tubing if needed for additional length.
    c. Attach the blood filter tubing to the four-way stopcock This tubing is then handed off to be placed through blood warmer and then connected to the blood bag
13. Hang the blood waste bag at the bottom of the radiant warmer
14. Document an accurate account of time, volumes withdrawn, volumes transfused, vital signs, and medications administered. Document vital signs every 15 minutes throughout procedure.
15. The physician will withdraw and transfuse small amounts of blood slowly. If performing a partial-volume exchange, the volume should be calculated by the physician and divided into 3 – 4 equal aliquots of 5-10 mL/kg, not to exceed 20 mL.
16. When the physician removes the first aliquot of blood, the physician will hand the blood to an assistant to send specimens for laboratory tests determined by the clinical indications for the procedure.
17. Monitor blood glucose frequently throughout and after the procedure.
18. Gently agitate the blood transfusion bag every 10 to 15 minutes.
19. Inform the physician when transfused blood volumes reach 90-, 190-, 240 ml, etc.
20. Send specimens to laboratory throughout procedure as ordered. Label all specimens as *Pre-exchange* or *Post-Exchange.*
21. When exchange transfusion has ended, send last withdrawn sample for laboratory studies, as ordered.
22. At the end of the procedure, depending on physician's order, discontinue vascular access catheter or infuse fluids through line.
23. Place used supplies in appropriate receptacle.
24. Remove gloves and perform hand hygiene.
25. Document the procedure in the patient's medical record.

C. **DOCUMENTATION:**

1. Process used for patient identification and procedure verification
2. Procedure performed and the physician who performed the procedure
3. Date and time the procedure began and ended
4. Document the infant's vital signs every 15 minutes, activity, blood in and blood out, and medications given.
5. Glucose levels and other clinical laboratory results
6. Infant's tolerance of the procedure

D. **SPECIAL NOTES:**

1. Calcium gluconate 100 mg/kg may be given per a physician's order halfway through the procedure or at the end; because it is citrated, blood-bank blood may lower serum calcium levels.
2. The amount of blood taken and the amount given in a single aliquot should never be more than 10% of total blood volume.

3. Do not feed the infant before the exchange transfusion and for at least 4 hours afterward.
4. Check stools for reducing substances and blood after the exchange due to the risk of necrotizing enterocolitis (NEC).
5. Resume phototherapy per phototherapy procedure (when used) after the exchange is complete.
6. An IV should be infusing with dextrose during this procedure.

E. EXTERNAL LINKS:

F. REFERENCES:

1. John Hopkins Hospital, Robertson, J., & Shilkofski, N. (2005). *The Harriet Lane Handbook* (17th ed.). St. Louis: Mosby.
2. Kamanth, B., Thilo, E., & Hernandez, J. (2010). Jaundice. In G.B. Merenstein & S.L. Gardner (Eds.), Handbook of neonatal intensive care (7th ed., pp. 549-552). St. Louis: Mosby Elsevier.
3. Mundy, C. (2005). Intravenous immunoglobulin in the management of hemolytic disease of the newborn. Neonatal Netw, 24(6), 17-24.
4. Thompson, L. (2008). Whole blood exchange transfusion. In J. Verger & R. Lebet (Eds.), AACN procedure manual for pediatric acute and critical care (pp. 860-868). St. Louis: Mosby Elsevier.\

G. 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

DELETE – incorporate into PCS Medication Administration Policy

POLICY MANUAL

~~ISSUE DATE: 06/05~~ ~~SUBJECT: Medication Precautions~~

~~REVISION DATE: 07/06~~ ~~POLICY NUMBER: 8390-5005~~

Department Approval Date(s):	06/15
Pharmacy & Therapeutics Committee Approval Date(s):	06/05, 07/06, 07/09, 1/12, 09/15
Medical Executive Committee Approval Date(s):	06/05, 07/06, 07/09, 1/12, 10/15
Professional Affairs Committee Approval Date(s):	11/15
Board of Directors Approval Date(s):	06/05, 07/06, 07/09, 1/12

~~A. POLICY:~~

~~1. FIVE "RIGHTS" FOR MISTAKE FREE MEDICATION:~~

~~a. Right Patient:~~

~~i. Check name on:~~

~~1) Armband~~
~~2) Bed Tag~~
~~3) Medication Order~~
~~4) Room Chart~~

~~ii. Do they all match?~~

~~iii. As a second form of patient identification, check date of birth on:~~

~~1) Arm band~~
~~2) Medical record~~
~~3) Verbally check date of birth with patient (if possible)~~

~~iv. Do they match?~~

~~b. Right Medicine:~~

~~i. Read the label in good light and make sure it matches the medication order.~~
~~ii. Read label again before measuring.~~

~~c. Right Dosage:~~

~~i. The wrong amount of the right medicine can be a disaster.~~
~~ii. Check medication order carefully. Measure carefully.~~

~~d. Right Time:~~

~~i. Correct spacing of medication is vital for your patient's recovery.~~
~~ii. Check medication order.~~

~~e. Right Route:~~

~~i. Be sure the medication gets into the patients body the way it was intended to.~~
~~ii. Check medication order.~~

~~f. If you suspect an error, report to your supervisor. Prompt action may save a life.~~

~~2. Some Extra Precautions:~~

~~a. Pour liquids with label up to keep it from becoming obscured.~~
~~b. Visually inspect medication to assure stability. Presence of discoloration, particulates or turbidity (when the medication should be clear) may be indications of expired medications.~~
~~c. Keep all medications in original containers.~~
~~d. Be aware of dosage of different size tablets, pills and capsules.~~
~~e. Be aware of "look alike" packaging and medications. It is advisable to keep "look alike" medications in separate areas to avoid confusion.~~
~~f. Do not rush through medication administration processes. The time taken to assure correct administration may possibly save a patient's life (and your license!).~~
~~g. Always clarify any order you are unsure of with the Pharmacist, ordering physician or current approved literary resource. Do not ask another nurse that may inadvertently provide you with the incorrect answer. Go to the most definite source.~~
~~h. Always check medications from dispensing machines such as "Pyxis" machines. Errors *can* occur in an automatic dispensing environment. Never override the Pharmacist's or machine's controls.~~
~~i. Be aware of "high alert" medications and their maximum doses.~~

j. Heed the patient that states they may be receiving the incorrect medication, and perform the "five medication rights" a second time. Contact the patient's physician if the patient insists the medication is incorrect.
k. Orders written to "continue previous medications" or "continue medications as at home" are not allowed.
l. Make sure all allergy information is current and correct before the administration of any medications.
m. The use of abbreviations when ordering of medications should follow hospital policy. Any orders written for medications (including times, doses, etc.) that include abbreviations not approved by the institution, should be clarified with the ordering physician.
n. Clarify any questions related to transcription or legibility of medication orders.
o. Assure all medication delivery equipment is functioning properly.

Tri-City Medical Center
Oceanside, California

DELETE – incorporate into PCS Medication Administration Policy

PHARMACY~~POLICY~~ MANUAL

~~ISSUE DATE: 01/98~~ **~~SUBJECT: Monitoring Effects of Medications on Patients~~** [AMH1]

~~REVISION DATE: 01/05, 07/06,1/12~~ **~~POLICY NUMBER: 8390-6008~~**

Department Approval Date(s):	**04/15**
Medical Staff Department/Division Approval Date(s):	**n/a**
Pharmacy & Therapeutics Committee Approval:	**06/05, 07/06, 07/09, 1/12, 09/15**
Medical Executive Committee Approval:	**06/05, 07/06, 07/09, 1/12, 10/15**
Professional Affairs Committee Approval Date(s):	**11/15**
Board of Directors Approval:	**06/05, 07/06, 07/09, 1/12**

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

~~1. The effects of medications on patients are monitored to assess the effectiveness of medication therapy and to minimize the occurrence of adverse events. Each patient's response to medication administered is monitored according to his or her clinical needs. Ongoing patient medication monitoring will use a collaborative approach between patient care providers, physicians, pharmacists and the patient, family or caregiver.~~

~~2. Monitoring will address the patient's response to the prescribed medication and actual or potential medication-related problems. The results of patient medication monitoring will be used to improve the patient's medication regimen and/or other clinical care and treatment processes.~~

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

~~1. The patient care provider (nurse, respiratory therapist, physical therapist, etc.) will monitor and assess the effect of medications on the patient.~~

~~2. Monitoring and assessing the effect of the medication includes, but is not limited to:~~

~~a. Direct observation of the patient during assessments, evaluations or other patient contact to determine the patient's physiological response to the medication administered and any problems or adverse effects associated with the medication.~~

~~b. Review of:~~

~~i. Results of clinical diagnostic studies~~

~~ii. Results of Clinical Laboratory values/levels~~

~~iii. The medication profile~~

~~iv. Current clinically related data about the patient's condition and progress documented in the medical record (i.e., medical staff, nursing and other disciplines progress notes, notations on care plans, consultation reports)~~

~~c. Information about the patient's own perceptions about medication side effects, and when appropriate, perceived efficacy and/or sensitivities the patient may have to the medication.~~

~~3. When the patient is given a medication or medications including medications that are new to the patient, the patient will be monitored.~~

~~a. Patients may experience adverse reactions to medications that are new to their systems. Therefore when medications are administered to the patient, the care provider will physically observe and assess the patient after the patient receives the medication to assure there is no evidence of adverse effect.~~

~~b. For medications or categories of medications known to commonly produce side effects or sensitivities in patients (for example sulfa drugs), the patient will be physically observed for the known side effects and sensitivities.~~

~~c. The patient will receive a test dose for medications where this is both appropriate and available (i.e., some categories of antibiotics) for medications in an effort to identify an adverse drug reaction, allergy or sensitivity to the medication. The physician will order the test dose and monitoring will occur with appropriate documentation.~~

~~d. Other Clinical Laboratory studies may be ordered as appropriate to monitor the patient's response to medications to prevent unnecessary side effects or adverse reactions (i.e., peak and trough levels).~~

~~4.~~**1.** ~~The information obtained through patient medication monitoring and assessment will be documented in the patient's medical record.~~

TRI-CITY MEDICAL CENTER
4002 Vista Way, Oceanside, California

DELETE this policy. It is merged with the Mission Statement #100

REHABILITATION SERVICES POLICY MANUAL

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

SUBJECT: GOALS & OBJECTIVES
STANDARD NUMBER: 103
CROSS REFERENCE:
APPROVAL:

Department Approval Date(s):	**08/15**
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):	**11/15**
Board of Directors Approval Date(s):	

~~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 offer the highest quality of patient care consistent with the overall philosophy of the Medical Center.~~

~~2. To provide the optimum in health care services and programs that will contribute to the physical, psychological and emotional well-being of the people and community we serve.~~

~~B. OBJECTIVE~~

~~1. To render high quality rehabilitation services to assist each patient in reaching their maximum potential so they may assume their rightful place in society, while learning to live within the limits of their capabilities.~~

~~2.~~**1.** ~~To alleviate pain, restore function, and improve quality of life by using accepted and current techniques & approaches in physical, occupational, speech, audiology and therapeutic recreation. These include tests, measurements, procedures, modalities, treatment programs, and wellness education. Caregivers and family members are integrated into the treatment programs whenever possible. Therapeutic equipment is provided as appropriate~~.

Tri-City Medical Center
Oceanside, California

SECURITY
SAFETY

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: February 17, 1994~~ ~~Reviewed: 1/97, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 7/03, 10/11~~ ~~Approvals: Director of Security~~	~~Subject: Closed Circuit Television System~~ ~~Page 1 of 3~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM - # 512~~

SUBJECT: Closed Circuit Television System

ISSUE DATE: February 17, 1994 **POLICY NUMBER:** 512
REVIEWED DATE(S): 1/97, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 7/03, 10/11

Department Approval Date(s): **08/15**
Environmental Health and Safety Committee Approval Date (s): **09/15**
Professional Affairs Committee Approval Date(s): **11/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To assist all Security Department personnel with guidelines in the use of all Security Department Closed Circuit Television Systems (CCTV)

B. **POLICY:**
1. It is the policy of the Security Department that before a Security Officer will be authorized to operate the department's CCTV system the Officer will be given in-service training in the operation of the CCTV system.

C. **PROCEDURE:**
1. All Security Officers will be familiar with and able to demonstrate working proficiency with the Security Department's CCTV system.
2. All Security Department personnel, while assigned to the Emergency Department, will be responsible to use and operate the CCTV system in an approved manner. Any misuse or unauthorized operation will result in disciplinary action up to and including termination.
3. The Security Supervisor will be immediately notified of any detected condition, which requires the immediate attention or repair of the CCTV system.
4. ~~Location of Exterior Cameras.~~
   a. ~~BAMS North (PTZ)~~
   b. ~~BAMS South (PTZ)~~
   c. ~~Facilities (PTZ)~~
   d. ~~Facilities Southeast Corner Facing North~~
   e. ~~Ambulance Drive Up~~
   f. ~~Rehab – Wellness Garden~~

g. Main Lobby Breezeway
h. ER Breezeway West View
i. ER Breezeway East View
j. ER Entry Door
k. ER Patio Lower Level Glass door
l. Lobby Main Entry L1

5. Location of Interior Cameras
   a. **Main Hospital 1st Level**
      i. Cardiology Waiting Area
      ii. Central Elevator Tower
      iii. French Room Hallway West
      iv. French Room Hallway
      v. Radiology Hallway East #1
      vi. Radiology Hallway East #2
      vii. Station D Hallway East
      viii. Station D Hallway West #1
      ix. Station D Hallway West #2
      x. Lobby Exit to Wellness Garden
      xi. Surgery – Cardiology Exit
   b. **Main Hospital Lower Level**
      i. Engineering Hallway South
      ii. Engineering Hallway North
      iii. Employee Health Hallway North
      iv. Education Hallway North
      v. Central Tower South
      vi. Central Tower North
      vii. I.T. Hallway South
      viii. Material Hallway East
      ix. Pavilion Rear Elevator East
      x. South Tower Entrance South
      xi. South Tower North
      xii. Café Food Line
      xiii. Dining North Registers / entrance
      xiv. Dining East
         1) Row A
         2) Row B
         3) Row C
         4) Hot plate area
   c. **Cameras on the Floors**
      i. Pavilion tower
         1) 3 Pavilion Nurses Station Facing East
         2) 3 Pavilion Nurses Station Facing South
      ii. Maternity Overflow
         1) Nurse Station Facing North
         2) Nurse Station Facing East
         3) Back Hall Facing East
         4) Center Tower Elevator Lobby L2 Facing Back Entrance
         5) Center Tower Elevator Lobby L2 Facing Front Entrance
      iii. Maternal Child Health
         1) Elevator Entrance
         2) Main Lobby South Wall
         3) East Entrance, North Wall
         4) West Stairwell, Entrance Hallway
         5) Nursery door

~~6) Breezeway facing front desk~~

~~iv. Emergency Department~~

~~1) ER East Hallway~~
~~2) ER Station C facing Ambulance Bay door~~
~~3) ER Station C facing Station B~~
~~4) Waiting room facing south #1~~
~~5) Waiting room facing south #2~~
~~6) Waiting room facing north~~
~~7) ER main hallway facing waiting room door~~
~~8) Keypad door monitor for Registration~~
~~9) Registration camera facing Desk #4~~
1) ~~Registration camera facing door/safe~~

D. ~~ATTACHMENT~~FORM(S):

1. CCTV Locations Form

CCTV LOCATIONS FORM

Behavioral Health Unit locations [16 cameras total]:

Open Unit Patio's southeast corner
Open Unit Patio's southwest corner
Open Unit's Art Room / east exit door
Locked Unit Patio's southeast corner
Closed Unit southeastern corner ceiling
Closed Unit's Eastern Seclusion Room
Main Southern Entrance doors
Closed Unit's Western Seclusion Room
Open Unit's East-West Hallway
Open Unit's North-South Hallway by Medical Station
Open Unit West-East Hallway to Patio
Open Unit East-West Hallway by T.V. Room
Open Unit Dining Room's southwestern corner ceiling
Open Unit's T.V. Room
Open Unit Dining Room's northwestern corner ceiling
Closed Unit's southeastern corner ceiling [eastward-faced]

Emergency Department locations [18 cameras total]:

Interior or employee side of Registration Office
Station C and Charge Nurse's Desk to Rooms C28 and C29's Hallway
Registration Office / Quiet Room hallway
Stations A and D Hallway [southward to northward]
Lobby's southern wall pointed northward towards the television
Registration Office's Desk 4 [northern-most desk]
Lobby's interior side of the entry doors faced southward
Radio Room and Station C's Registration area
Radio Room faced eastwards to Stations C and B
Lobby's southern wall by Security Office faced northwards to Lobby's entry doors
Lobby television wall southward
Station B
Station A hallway beds
Administration Hallway
Lobby to Quiet Room hallway
Station D hallway's western camera faced eastward
Station D hallway's eastern camera faced westward
Station D / Ultrasound / Laboratory Department hallway faced westward

Exterior locations [22 cameras total]:

Loading Dock
Pavilion Tower rooftop downward to eastside visitor Parking Lot [Sector 6 / 10]
Pulmonary Rehabilitation to the Northside employee Parking Lot stairs [Sector 13B]
Sec. Y's / South Tower's roof faced southward towards Sector 1B [new Medical Offices Building]
Emergency Dept.'s awning [Sector 15] faced towards Westside parking lots [Sectors 9 / 11]
Ambulance Bay from northeast corner faced southwards
Oxygen Tanks storage area eastern of the Loading Dock [Sector 3]
Emergency Department Patio / Sector 15 [E.D.'s Loading and Unloading Zone] from Roof
Ambulance Bay from southwestern corner faced northwards
Emergency Department Patio [above ancillary services glass door]
Emergency Department's Unloading / Loading Zone awning northward
Emergency Department's Unloading / Loading Zone awning southward

Entry doors to Emergency Department Lobby and Station D from awning [eastward-faced]
B.A.M.S.'s roof northeastern corner
B.A.M.S.'s roof southeastern corner
Facilities Rooftop [faced westward]
Facilities or Plant Engineer Bldg. rear O2 tanks
Rehabilitation Wellness Garden
Eastside Main Entrance awning
Eastside Main Entrance's Loading / Unloading Zone [Sector 8]
Employee Break area southwest of the Electric Building [northern-more of the cameras]
Employee Break area southwest of the Electric Building [southern-more of the cameras]

Interior locations [(Level 1) 20 cameras total]:

Lost and Found to Patient Financial Services or Cashier Window
Lost and Found to Main Registration Offices
Eastside Main Lobby seats
Main Registration Hallway southward to eastside Main Entrance area
Main Lobby Volunteer's information desk and Security Department's desk
Gift Shop northeastern corner
Gift Shop southwestern corner to the Entrance
Gift Shop southeastern corner to the Entrance
Interior area of eastside Main Entrance by or outside Gift Shop and Pavilion Tower elevators
Cardiology Lobby
Center Tower elevators
French Room Hallway westward
French Room Hallway eastward
Radiology Hallway eastward
Radiology / S.P.R.A. Hallway eastward
O.B. elevator Level 1 by 1North
Surgery Hallway
Risk Management Hallway
Main Registration Hallway
In-Patient Radiology / Radio Lobby hallway

Interior locations [(Level Lower) 30 cameras total]:

Cafeteria Dining Room southwest corner to northwest corner
Cafeteria Dining Room northwest corner to northeast entrance
Cafeteria food line
Overhead of Cafeteria's northern Cashier to food line
Cafeteria's southern Cashier
Food & Nutrition Pantry northeast corner to west-north direction
Food & Nutrition Pantry southern-more to camera 1
Food & Nutrition Pantry western / back rows
Food & Nutrition Pantry entry
Rear Pavilion elevators
South Tower exit to Morgue area
Engineer Hallway southward
Engineer Hallway northward
Employee Health Department
Education Department
Back of [eastside] Kitchen southwards to E.V.S. Hallway
Back of [eastside] Kitchen northwards to Center Tower
I.T. main entry point
E.V.S. Offices to Purchasing
South Tower vending machines

Assembly Rooms
Kitchen back entry to Loading Dock area [Sector 3] *E.V.S. supply storage closet
Copy Room hallway
Dungeon mid-point westward
Dungeon eastern entry westward
Dungeon cage
Cafeteria Hallway westward to Pharmacy Department
P.B.X. Hallway northward
P.B.X. Office
Pharmacy pyxis area

Patient floor locations [19 cameras total]:

Obstetrics or Maternity Lobby's desk
Maternity Lobby's chairs
Labor and Delivery main doors
Postpartum Hallway to Maternity's Lobby
Labor and Delivery main interior Hallway
Maternity's Bridge from 2 South [Postpartum Overflow] to Maternity's Lobby
Newborn Nursery
Maternity Surgery area's northern stairs to the Rehabilitation Healing Garden
Labor and Delivery's western stairwell down to Women's Center
3 West / Neonatal Intensive Care Unit's overflow emergency exit
Neonatal Intensive Care Unit northern entry doors
Neonatal Intensive Care Unit southern entry doors
Postpartum Overflow or 2 South southward of Nurses Station front side northward to back side
2 South Nurses Station to southern entrance
2 South northern Hallway to northern entrance
Postpartum Overflow or 2 South northern door from exterior
Postpartum Overflow or 2 South's southern door from exterior
3 Pavilion Nurses Station faced eastward
3 Pavilion Nurses Station faced southward
~~**10)**~~**4**

Tri-City Medical Center
Oceanside, California

SECURITY
SAFETY

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: February 19, 1992~~ ~~Reviewed: 4/94, 10/97, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Code Adam – Security Department Response Plan for an Infant Abduction.~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM – # 503~~

SUBJECT: Code Adam – Security Department Response Plan for an Infant Abduction

ISSUE DATE: February 19, 1992 **POLICY NUMBER:** 503
REVIEWED DATE(S): 4/94, 10/97, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 7/03

Department Approval Date(s): **08/15**
Environmental Health and Safety Committee Approval Date(s): **09/15**
Professional Affairs Committee Approval Date(s): **11/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To establish the protection of infants from unauthorized or illegal removal from the Medical Center by any unauthorized person(s).

B. **POLICY:**
1. It is the policy of the Security Department to immediately implement the following procedures in the event that an infant is illegally removed from the Medical Center by any unauthorized person(s). Reference Administrative Policy #369 Code Adam (Infant Abduction).

C. **PROCEDURE:**
1. In the event of a suspected infant abduction all Security Department personnel will respond and implement the following:
   a. Obtain a complete description of the missing infant.
   b. Obtain a time frame for the abduction
   c. Obtain a complete description of the Abductor(s) and their direction or egress.
   d. Notify the Oceanside Police Department of the abduction and relay all information regarding the abduction.
   e. Offer any requested assistance from the responding Law Enforcement agency.
   f. Follow the Administrative Policy regarding an Infant Abduction.
2. All On-Duty Security Department personnel will report to the following locations to inspect any property or persons that may be the Abductor.
   a. The Security Supervisor, Designee, or Shift Lead Officer will assume the Security Incident Commander position and report to the location of the abduction ensuring that sections ~~3.1.1 to 3.1.6~~ **C.1. a-f** are completed.

b. A perimeter will be set up to observe all property exits and record the following information:
- **i. Vehicle descriptions**
- **ii. License plate number**
- **iii. Vehicle occupant descriptions**

c. Security Officers will be available to respond to staff requests of suspicious persons or packages.

~~b. The 1-Post Officer will report to the location of the abduction and assume the position of Security Incident Commander until such time that they relived by the Security Supervisor, Designee, or Shift Lead Officer.~~

~~c. The 2-Post Officer will report to the Main Lobby area of the Medical Center and inspect all Persons and Property who may be associated with the abduction, checking all property that may be able to conceal an infant.~~

~~d. The 3-Post Officer will report to the Emergency Department area of the Medical Center and inspect all Persons and Property who may be associated with the abduction, checking all property that may be able to conceal an infant.~~

~~e. All additional Security Department personnel will be assigned to an appropriate area of the Medical Center as needed. If available an Officer will be assigned to the Loading Dock Area of the Medical Center and inspect all Persons and Property who may be associated with the abduction, checking all property that may be able to conceal an infant.~~

~~f. All Security Department personnel will coordinate and assign all other staff members of the Medical Center who respond to the "Code Adam" announcement, documenting all actions and employees present.~~

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

1. Administrative Policy #369: **Code Adam (Infant Abduction)**

Tri-City Medical Center
Oceanside, California

SECURITY
SAFETY

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: May 27, 1991~~ ~~Reviewed: 10/97, 3/00, 8/01, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 10/97, 8/01, 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Code Red – Security Department Fire Response Plan~~ ~~Page 1 of 1~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 504~~

SUBJECT: Code Red – Security Department Fire Response Plan

ISSUE DATE: May 27, 1991 **POLICY NUMBER:** 504
REVIEWED DATE(S): 10/97, 3/00, 8/01, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 10/97, 8/01, 7/03

Department Approval Date(s): **08/15**
Environmental Health and Safety Committee Approval Date (s): **09/15**
Professional Affairs Committee Approval Date(s): **11/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**
1. To set fourth guidelines for Security Department personnel to utilize when responding to a Medical Center "Code Red" alert

B. **POLICY:**
1. All Security Department personnel will be responsible for the knowledge and proper performance of all Administrative and Security Department mandated duties, activities, and assignments associated with a Medical Center "Code Red" activation. Reference ~~Safety Policy~~ **Environment of Care Policy** #3005 Fire Plan-Code Red.

C. **PROCEDURE:**
1. When notified of a "Code Red" activation, all On-Duty Security Officers will immediately implement the following priority response protocol.
   a. If there are three or more On-Duty Security Officers, the Security Department will respond in the following manner.
      i. The 1-Post Officer will obtain a fire extinguisher and respond to the location of the reported "Code Red" and assist as needed.
      ii. The 2-Post will respond to the Medical Center entrance at the "Y" and await the arrival of the Fire Department and direct them to the appropriate Medical Center building entrance.
      iii. The 3-Post will respond to the appropriate Medical Center building entrance and await the arrival of the Fire Department and direct them to the location of the "Code Red".

iv. All additional Security Department personnel will respond to the location of the "Code Red" with a Fire Extinguisher and assist as needed.

~~b. If there are only two On-Duty Security Officers, the Security Department will respond in the following manner.~~

~~i. The 1 Post will obtain a fire extinguisher and respond to the location of the "Code Red" and assist as needed.~~

~~v.~~ v. ~~The 2 or 3 Post Officer will respond to the Medical Center entrance at the "Y" and await the arrival of the Fire Department and direct them to the appropriate entrance then direct them to the location of the "Code Red."~~

D. REFERENCE(S):

~~ii.~~**1. Environment of Care Policy #3005: Fire Plan-Code Red.**

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: April 16, 1991~~ ~~Reviewed: 6/94, 1/97, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Work Order Request~~ ~~Page 1 of 1~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM - # 227~~

SUBJECT: Exterior Campus Rounding ~~Work Order Request~~

ISSUE DATE: April 16, 1991 **POLICY NUMBER:** 227
REVIEWED DATE(S): 6/94, 1/97, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 7/03

Department Approval Date(s): **08/15**
Environmental Health and Safety Committee Approval Date(s): **09/15**
Professional Affairs Committee Approval Date(s): **11/15**
Board of Directors Approval Date(s):

A. **PURPOSE:**

1. To establish a procedure for **exterior rounding of the campus and follow-up actions to take if there are findings.**~~initiating a work order request to the Building Engineering Department~~.

B. **POLICY:**

1. It is the responsibility of all Security Officers to monitor and document any condition, at the Medical Center, which would be considered unsafe to any Patient, Visitor, **Medical Staff** or ~~Staff Member~~**Employees**.

2. While conducting exterior rounding the patrolling officer will notate any of the following:

- **a. Uneven walking surfaces or tripping hazards**
- **b. Any exterior lighting that is out**
- **c. Any down foliage or landscaping needs that may be a safety hazard**
- **d. Evidence of vandalism or break-ins**
- **e. Damaged or malfunctioning door locks**
- **f. Patient or visitor assistance**
- **g. Suspicious activity**
- ~~1.~~**h. Potential medical emergencies**

C. **PROCEDURE:**

1. For any medical emergencies, the Security Officer shall contact the PBX operator for either a rapid response team or Code Blue/Pink as indicated.

2. **For non-urgent medical the Security Officer shall contact the Emergency Department Charge Nurse for direction or assistance.**

~~1.~~**3.** Upon observing or detecting any unsafe condition**(s)**, the Security Officer ~~will~~ **shall** complete a work order on the TAMIS work order system through the intranet.

~~2.~~**4.** If the unsafe condition is of an extreme nature, the Security Officer will immediately notify the **Safety Officer or** on-duty engineer of the condition.

~~3.~~**5.** Place a printed copy of the work order page in the binder for Work Orders. Notate the work order on the item list.

Tri-City Medical Center
Oceanside, California

DELETE – incorporated into PCS Disaster Call Back List Policy

Staffing Manual

SUBJECT: Disaster Call Back List

ISSUE DATE: 4/03
REVISION DATE: 1/05, 12/05
REVIEW DATE: 6/03, 4/07, 4/10; 4/14

Department Approval Date(s): 07/15
Professional Affairs Committee Approval Date(s): 11/15
Board of Directors Approval Date(s): 02/14

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

~~1. The Staffing Resource Center will maintain an up-to-date Disaster Call Back List for all Tri-City **Medical Center** Healthcare District Departments.~~

~~2. This book will be kept in the Staffing Resource Center.~~

~~3.~~**a.** ~~Quarterly, a designated Staffing Resource Representative will **print a current employee list for all inpatient departments.** contact each TCHD Department and request a current phone list from the Director/designee.~~

~~a. This will be done via e-mail or interoffice mail.~~

~~b. It is the responsibility of the Manager/their designee to update these lists and return to Staffing within 1 month of receipt.~~

~~c. Once the updated lists are turned in, they will be placed in the Disaster Call Back Book and the older version will be destroyed.~~

~~1. Any Department that has several staffing changes prior to the quarterly update is encouraged to send an updated phone list to Staffing Resource Center.~~

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Governance & Legislative Committee Meeting Minutes
Tri-City Healthcare District
December 1, 2015

Members Present:	Larry W. Schallock, Chairperson; Director Ramona Finnila; Director RoseMarie V. Reno; Dr. Paul Slowik, Community Member; Blake Kern, Community Member; Dr. Marcus Contardo, Physician Member; Dr. Henry Showah, Physician Member; Dr. Gene Ma, Chief of Staff
Non-Voting Members:	Greta Proctor, General Counsel; Kapua Conley, COO; Cheryle Bernard-Shaw, CCO
Others Present:	Teri Donnellan, Executive Assistant; Sherry Miller, Manager, Medical Staff; Esther Beverly, VP/Human Resources; Glen Newhart, Chief Development Officer (Foundation); David Bennett, CMO; and Jim Dagostino, Board Member;
Absent:	Tim Moran, CEO; Al Memmolo, Community Member; Eric Burch, Community Member

	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. Mrs. Blake Kern 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. Showah to ratify the minutes of the October 6, 2015 Governance & Legislative Committee. The minutes were approved unanimously.**	Minutes ratified.	
5. Old Business –			
a. Review and discussion of amendment to Board Policy 15-027 – Prohibition of Literature on District Properties	In follow-up to discussion at last month's meeting, General Counsel stated Board Policy 15-027 – Prohibition of Literature on District Properties was amended to provide exceptions to the policy for employees and groups supported by or affiliated with the District for activities such as bake sales, craft fairs and similar charitable or non-commercial scale activities.		

Topic	Discussion	Action Follow-up	Person(s) Responsible

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	It was moved by Director Finnila to recommend approval of the amendments to Board Policy 15-027 Prohibition of Literature on District Properties, as presented. Ms. Blake Kern seconded the motion. The motion passed unanimously.	Recommendation to be sent to the Board of Directors to approve amended Board Policy 15-027 - Prohibition of Literature on District Properties; item to appear on next Board agenda and included in Board Agenda packet.	Ms. Donnellan
6. New Business a. Medical Staff Rules & Regulations 1) Department of Pediatrics	The committee reviewed the Department of Pediatrics Rules & Regulations. Director Finnila requested clarification on Section VIII H. as to why members of other departments can proctor an appropriate procedure but cannot proctor admissions. Ms. Miller clarified that an admission can be done retrospectively.		
2) Division of Cardiology	Dr. Ma explained the National Board of Physicians and Surgeons is an alternative re-certification board for physicians that have already been certified by American Board of Medical Specialties. He further explained that the American Board of Medical Specialties is now requiring 150 hour in Maintenance of Certification Modules to maintain Board certification which the members feel is onerous. He stated the Cardiology Division approved the option of recertification by the National Board of Physicians and Surgeons. Dr. Ma stated four of the cardiologists are grandfathered in and this requirement does not open the door to a lower quality of care. Dr. Contardo noted that there is a move in some specialties to take a different pathway for certification. Dr. Contardo also stated that grandfathering only applies to graduates of a certain year. Dr. Contardo expressed concern that the threshold for reappointment for several procedures is zero and a physician could potentially be reappointed without showing competence in those invasive cardiology		

Topic	Discussion	Action Follow-up	Person(s) Responsible

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	procedures. Ms. Miller stated our focus is on current competency however due to the fact that some of the requirements can be onerous we find alternative ways to maintain the competency such as bundling the number of cases, utilizing the same level of expertise with like procedures. Ms. Miller also commented that the concern brought forward should not affect approval of these Rules and Regulations. Dr. Contardo disagreed and stated the privileges do not share any of the same characteristics and there is no evidence that privileges are bundled as presented. Ms. Miller stated the Medical Staff will be moving forward in the coming months to review all privilege cards and change as necessary. Discussion was held regarding how Quality Assurance is involved. Ms. Miller explained the Quality Assurance Committee collects data and looks at peer review cases however they do not analyze the privilege cards or Rules & Regulations. Dr. Ma expressed concern that there is potential harm by being too aggressive and limiting the scope. He noted the importance of allowing departments to find that balance in the interest of patient care. Dr. Contardo stated the purpose is to prevent harm and privileges should be carefully vetted to prevent bad outcomes. It was suggested that the issue of zero thresholds for some privileges and including privileges on cards where that procedure may not be done any longer should be readdressed by the Division. **It was moved by Dr. Contardo to table the Cardiology Rules & Regulations for review of the privilege card and thresholds.** Dr. Slowik suggested that each Department/Division remove the privileges they are not doing. **It was moved by Director Finnila to approve both the Pediatric and Cardiology Rules and Regulations**	Recommendation to be sent to the Board of Directors to approve the	Ms. Donnellan

Topic	Discussion	Action Follow-up	Person(s) Responsible

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	with the caveat that the privilege card be redesigned in a relatively short period of time (60 days). Dr. Slowik seconded the motion. The motion passed unanimously.	Department of Pediatric Rules & Regulations as presented; item to appear on next Board agenda and included in Board agenda packet.	
b. Review and discussion of Medical Staff Policy #8710-518 – Medical Record Documentation	Ms. Sherry Miller stated the revisions presented today were made to match CMA requirements and move us forward to an electronic environment. **It was moved by Director Finnila to recommend approval of the amendments to Medical Staff Policy #8710-518 – Medical Record. Chairman Schallock seconded the motion. The motion passed unanimously**.	Recommendation to be sent to the Board of Directors to approve Medical Staff Policy #8710-518 as presented; item to appear on next Board agenda and included in Board Agenda packet	Ms. Donnellan
c. Review and discussion of Board Policy #14-037 CEO Succession Planning	Chairman Schallock stated in follow-up to the last meeting, Policy #14-037 was placed on today's agenda to consider a succession plan for the three positions that the Board hires, the CEO, CCO and General Counsel. It was suggested the following items be struck from the policy: ➢ Under II. Practice B., the clause requiring the Chair and Vice-Chair of the Board in consult with the Chief of Staff to evaluation the incapacitation before the issue is evaluated by the full Board. ➢ II. F. 4. d. ➢ II F. 4. e. ➢ II. F. 4. f. (though Ms. Bernard-Shaw pointed out this may make sense for the CCO position) General Counsel Ms. Proctor stated she did not believe the policy as written can be applied to the General Counsel or CCO position because parts of the policy are specific to the CEO. It was recommended that General Counsel amend the policy to reflect the changes discussed, consider changes as necessary to include the CCO and determine if a separate Board policy is necessary for	General Counsel to draft amendments as described and potentially recommend a policy to address succession planning for General Counsel; item to appear on next Committee agenda.	General Counsel

Topic	Discussion	Action Follow-up	Person(s) Responsible

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	succession planning of General Counsel.		
d. Review and discussion of Tri-City Governance Enhancement Plan 2015-2016	Chairman Schallock stated on November 12th the Board held a retreat with Board Facilitator, Dr. Jim Rice. Chairman Schallock explained the document contained in today's packet *"Tri-City Governance Enhancement Plan 2015-2016"* is the plan of action for the Board to consider over the next nine months to enhance their effectiveness and is provided today for the committee to be aware of. Chairman Schallock explained some of the items the Board hopes to address in the next nine (9) days, next nine (9) weeks and the next nine (9) months. Chairman Schallock noted one of the items listed is review of the Mission, Vision & Values Statement which the committee will begin to address later in today's meeting. Chairman Schallock also distributed a Governance Time Map which provides a snapshot of the time spent by both the Board and staff. Chairman Schallock also commented that there was discussion at the Retreat related to streamlining the Board committees and re-evaluating such things as policies that come forward to the Committees. Ms. Proctor stated that General Counsel is looking at licensing requirements to see what needs to be done at the Board and Board committee level in terms of policy approvals. Chairman Schallock stated with regard to UCSD, Mr. Moran has met with UCSD and will discuss timelines with the Board next week.	Information only.	
e. Review and discussion of Board Policy #15-045 Philanthropic Naming Policy	Mr. Glen Newhart, Chief Development Officer of the Foundation stated this is a new policy that has been developed to recognize donors for their significant contributions. Discussion was held regarding how the policy relates to new construction vs. renovations vs. modifications. **It was moved by Director Finnila to recommend approval of Board Policy #15-045 as presented.** Minor revisions were suggested as follows:		

Topic	Discussion	Action Follow-up	Person(s) Responsible

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	➢ Section II. A. – amend title to read "Selection of Names for **New** Buildings" ➢ Section II C – amend title to read ""Modification, **Renovation**, or Relocation of Property and Names". Mr. Newhart stated he is comfortable that the policy as written and amended is sufficient to guide the District in Philanthropic Naming Rights. **Director Finnila moved to amend the motion to recommend approval of Board Policy #15-045 amended as described. Dr. Contardo seconded the motion to amend. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve Board Policy #15-045 as presented and amended to include the revisions as described; item to appear on next Board agenda and included in Board Agenda packet	Ms. Donnellan
f. Review and discussion of District's Mission, Vision & Values Statement	Chairman Schallock stated as part of the Board's Governance Enhancement Plan the District's current Mission, Vision & Values statement is included along with a proposed statement and materials from other facilities that may be of interest in developing a new statement. Director Reno suggested a Board Workshop be set up for the Board to develop a new Mission, Vision & Values Statement as a whole. Dr. Slowik commented that a Mission Statement should reflect why we exist, while the Values Statement should reflect what we are striving to become. Dr. Slowik provided the following suggestions for a Mission and Values Statement: ➢ *"TCMC will promote, promise, and provide the highest standard of healthcare to every patient, every day, through integrated clinical practice utilizing the most advanced innovative diagnostic and therapeutic modalities."* ➢ *"TCMC also recognizes that the needs of each patient always comes first and the importance of*		

Topic	Discussion	Action Follow-up	Person(s) Responsible
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	safely delivering the highest quality of healthcare services with the utmost of compassion, respect and integrity in every step of the TCMC experience." Dr. Ma commented that he would lean towards a more succinct Mission Statement that staff can recite and gets to the core of why the staff show up every day. Chairman Schallock stated that a Strategic Planning Session is planned for January and suggested the Board address the Mission Statement at that work session. Director Finnila suggested the Board's Code of Conduct be readdressed to include a table of contents sheet.	The Mission, Vision & Values Statement will be addressed at the January Special Meeting of the Board.	Board
7. Discussion regarding Current Legislation	Chairman Schallock reported on two hot issues – Proposition 30 that would make temporary funding permanent and secondly, a ballot initiative by the SEIU to limit the salaries of CEO's and upper management to $450,000 across the state.	Information only.	
8. Review of FY2016 Committee Work Plan	The FY2016 Committee Work Plan was included in today's meeting packet for reference. Director Reno requested the ACHD Leadership Meeting scheduled for January 21-22, 2016 be added to the Work Plan.	ACHD Leadership Meeting to be added to Work Plan.	Ms. Donnellan
9. Committee Communications	Chairman Schallock stated today is his last meeting of this Committee. He explained the Board will elect new officers in December and the new Board Chair will move into the Chair slot in January. Committee members expressed their appreciation to Chairman Schallock for his time and effort on the committee as well as in the Board Chair's role.	Information only.	
10. Community Openings – None	There are currently no openings on the committee.		

Topic	Discussion	Action Follow-up	Person(s) Responsible

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11. Confirm date and time of next meeting	The committee's next meeting is scheduled for Tuesday, January 5th at 12:30 p.m.		
12. Adjournment	Chairman Schallock adjourned the meeting at 2:00 p.m.		

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I. **MEMBERSHIP**

The Department of Pediatrics consists of physicians who are board certified by the American Board of Pediatrics or are board-eligible; having completed an ACGME approved residency in Pediatrics, and who are actively progressing towards certification. Pediatricians who admit and care for neonates in the Neonatal Intensive Care Unit (NICU) must be members of the Division of Neonatology.

II. **FUNCTIONS**

The general functions of the Department of Pediatrics shall include:

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 (MEC) 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 Medical Quality Peer Review 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/ or request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);

I. Approve On-Going Professional Practice Evaluation (OPPE) indicators and formulate thresholds; and
   Formulate recommendations for Department rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

III. **DEPARTMENT MEETINGS;**

The Department of Pediatrics meets quarterly and no less than three (3) times per year or at the discretion of the Chair

Twenty-five percent (25%) of the Active Department members, but not less than five (5) members, shall constitute a quorum at any meeting.

IV. **DEPARTMENT OFFICERS**

A. The Department shall have 3 officers: a Chairperson, a Vice-Chairperson, and a Quality Review Representative. The officers must be members of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the Department. The Vice-Chairperson shall be the Chairperson-Elect and may also serve as the Quality Review Representative.

B. The Chairperson and Vice-Chairperson shall be elected every year by the Active members of the Department who are eligible to vote. The Chair shall be elected by a simple majority of the members of the Department. The notice for elections is given at least one month prior to the meeting date.

C. The Department Chair shall serve a one-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses Medical Staff membership or clinical privileges in the department. Department officers shall be eligible to succeed themselves if elected.

D. The Vice-Chairperson succeeds the Chairperson after his/her term has expired unless there is an objection by a majority of the Active members of the Department who are eligible to vote.

E. The Quality Review Representative serves a one-year term and is elected by the Active members of the Department who are eligible to vote. The Quality Review Representative serves as the Chair of the Pediatric Quality Review Committee (QRC), and attends Medical Staff QA/PI/PSC meetings. Every effort will be made to appoint members to the QRC from each major group and a representative from the unassigned call panel for ED.

V. DUTIES OF THE DEPARTMENT CHAIR

A. The Department Chair shall assume the following responsibilities:

1. Be accountable for the professional and administrative activities of the Department;
2. Ongoing monitoring of the professional performance of all individuals who have delineated clinical privileges in the Department.
3. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form.
4. Recommend to the Medical Executive Committee the criteria for clinical privileges in the Department;
5. Recommend clinical privileges for each member of the Department;
6. Assure that the quality, safety and appropriateness of patient care provided by members of the Department are monitored and evaluated; and
7. 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. Requests for privileges in the Department of Pediatrics are evaluated based on the practitioner's education, training, experience, demonstrated professional competence and judgment, active clinical performance, documented cases of patient care and are granted based on department specified criteria. Recommendations for privileges are made to the Credentials Committee and to the Medical Executive Committee. Practitioners practice only within the scope of their privileges as defined within these Rules and Regulations.

E. **Nurse Practitioners:** Nurse practitioner means a registered nurse who posseses additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in primary care and who has been prepared in a program. The nurse

practitioner shall function under standardized procedures or protocols covering the care delivered by the nurse practitioner. The nurse practitioner and his/her supervising physician who shall be a pediatrician will develop the standardized procedure or the protocols with the approval of the Department of Pediatrics.

F. Classifications of Newborns:

1. Level 1: Newborns greater than 2000 grams and 35 6/7 weeks GA, without any of the diagnoses or symptoms listed in VI (E)(2).
2. Level 2: Newborns needing intermediate or continuing care; criteria as follows:
   i. Weight greater than 2000 grams at birth, r/o sepsis during an observational period, if consistently stable without additional signs of illness.
   ii. Tachypnea, TTN, or other mild respiratory illness, otherwise stable, with oxygen needs <40%, and no oxygen needs over six (6) hours.
   iii. Hypoglycemia (without other risk factors such as suspected sepsis or respiratory distress) with a normal exam and stable vital signs, responsive to oral therapy.
   iv. Feeding problems in a newborn greater than 2000 grams and 35 6/7 weeks gestational age (GA), with no concerns about GI perforation or anomalies.
3. Hyperbilirubinemia requiring phototherapy, unlikely to require an exchange transfusion, otherwise stable, currently 35 6/7 weeks GA and 2000 grams.

If the infant status changes to meet the Level 3 criteria (per NICU unit-specific policy "Admission and Discharge Criteria for the NICU"), a neonatology consult is required. The consultation will be requested by the attending pediatrician who, in collaboration with the neonatologist, will determine if care should be transferred to a neonatologist.

Pediatrics Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Admit patients, Level 1 and Level 2 newborns	Training and evidence of current NRP/NALS or PALS certification	Six (6) cases	Evidence of current NRP/NALS or PALS certification
Consultation			
Newborn care, Level 1 and Level 2			
Perform medical history and physical examination (Newborn), including via telemedicine (F)	Training		N/A
Attendance at C-sections & vaginal deliveries, including newborn resuscitation	Training and evidence of current NRP/NALS certification	One (1)	Evidence of current NRP/NALS certification
Invasive Pediatrics Procedures			
Lumbar puncture	Training	Five (5) cases from Invasive Procedures category	N/A
Laryngoscopy	Training and evidence of current NRP/NALS		Evidence of current NRP/NALS certification

Pediatrics Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
	certification		
Circumcision	Training		N/A
Intubation, Infant	Training and evidence of current NRP/NALS certification		Evidence of current NRP/NALS certification
Intubation, Pediatric	Training and evidence of current PALS certification		Evidence of current PALS certification
Suprapubic aspiration	Training		N/A
Pediatric Cardiology Privilege Category			
Consultation, Pediatric Cardiology, to include neonates	Successful completion of a residency in Pediatrics and a fellowship training program in Neonatology or Pediatric Cardiology	Two (2) cases from this category	Ten (10) cases from this category
Cardiac defibrilation, to include neonates			
Echocardiography, to include neonates			
Elective cardioversion, to include neonates			
Electrocardiography (EKG/ECG), to include neonates			
Pericardiocentesis, to include neonates			
Holter monitor – 12 years and older	Successful completion of a residency in Pediatrics and a fellowship training program in Pediatric Cardiology		
Treadmills - 12 years and older			
Pediatric Surgery Privilege Category			
Consultation, Pediatric Surgery, to include neonates	Board certified by the American Board of Surgery in Pediatric Surgery	One (1) case	Evidence demonstrating activity performing pediatric surgery at another healthcare facility
Other			

Pediatrics Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Moderate sedation	See Policy 8710-517 and evidence of current NRP/NALS certification	See Policy 8710-517	See Policy 8710-517 and evidence of current NRP/NALS certification

VII. **REAPPOINTMENT OF CLINICAL PRIVILEGES**

A. Procedural privileges will 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 physician will be required to undergo proctoring for all procedures that were not satisfied. The physician will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

VIII. **PROCTORING OF PRIVILEGES**

A. Each 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 to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

B. All Active members of the Department will act as proctors. An associate may monitor 50% of the required proctoring. Additional cases may be proctored as recommended by the Department Chair. It is the responsibility of the Department Chair to inform the monitored member whose proctoring is being continued whether the deficiencies noted are based on current clinical competence, practice behavior, or the ability to perform the requested privilege(s). Colleagues who cover on-call for an assigned proctor should be aware, accessible, and amenable to providing proctoring in the place of that member, if needed.

~~C. THE MONITOR MUST BE PRESENT FOR THE PROCEDURE 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 VIDEO) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE PRACTITIONER'S COMPETENCE.~~

~~D.~~C. In elective cases, arrangements shall be made prior to scheduling i.e., the proctor shall be designated at the time the case is scheduled.

~~E.~~D. The member shall have free choice of suitable consultants and assistants.

~~F.~~E. When the required number of cases has been proctored, the Department Chair must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.

~~G.~~F. A form shall be completed by the proctor and should include comments on diagnosis, procedural technique, and overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available from the Medical Staff Office.

~~H.~~G. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Office.

~~I.~~H. Members of other departments, such as the Emergency Department or Anesthesiology Department, can proctor an appropriate procedure, but cannot proctor admissions.

~~J.~~I. It is the responsibility of the member to notify a proctor when one is needed.

IX. **EMERGENCY ROOM COVERAGE**

A. Department members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. Refer to Medical Staff Policy and Procedure 8710-520.

B. Any member who elects to provide follow-up care in his/her office must do so without regard to the patient's ability to pay and must provide a minimum level of care sufficient to respond to the patient's immediate needs.

C. Provisional or Courtesy Staff may participate on the unassigned call panel at the discretion of the Department chair.

X. **DEPARTMENT QUALITY REVIEW AND MANAGEMENT**

The Department of Pediatrics will have a Quality Review Committee (QRC) comprised of no less than four (4) Department members. The QRC chair is the Department's representative to the Medical Staff Medical Quality Peer Review Committee. QRC members are able to succeed themselves. The QRC will meet at least four (4) times per year. Refer to Section II "FUNCTIONS" above as applicable.

A. General Function

The QRC provides systematic and continual review, evaluation, and monitoring of the quality and safety of care and treatment provided by the Department members and to pediatric patients in the hospital.

XI. **NICU M&M COMMITTEE**

The Department of Pediatrics will have an NICU Mortality & Morbidity (M&M) Committee that meets at least quarterly to discuss neonatal cases and issues related to neonatal care. The NICU M&M shall be composed of the members of the Neonatology Division. Representatives from the Department of Obstetrics/Gynecology and nursing shall be invited. The Committee shall maintain a record of its activities and report to the Department of Pediatrics QRC.

APPROVALS:
Department of Pediatrics: 5/05/15
Medical Executive Committee: 5/18/15
Governance Committee: 6/01/15
Board of Directors: 6/25/15

Tri-City Medical Center
MEDICAL STAFF

Memo

To: **Medical Executive Committee**

From: **Medicine Department / Cardiology Division**

Date: **11/19/2015**

Re: **Cardiology Division Rules & Regulations Revision**

The National Board of Physicians and Surgeons is an alternative re-certification board for physicians that have already been certified by American Board of Medical Specialties. The American Board of Medical Specialties is now requiring 150 hours in Maintenance of Certification (MOC) modules to maintain board certification, which the members feel is onerous. The Cardiology Division approved the option of recertification by the National Board of Physicians and Surgeons at their November 4, 2015 meeting.

The Medicine Department's Active Staff unanimously approved the revision to the Cardiology Division Rules and Regulations on November 18, 2015 amending the Membership section regarding board certification requirements.

Note: The Cardiology Division's revision to their Rules and Regulations regarding the *Non-Invasive Procedures Interpretation Response Time* and *Sanctions for the Interpretation of Echocardiogram Exercise or Pharmacological Stress Test and ECG's* was 1) approved by the Medical Executive Committee in October; and 2) is pending approval by the Governing Board. The attached Cardiology Rules and Regulations include both revisions in "track changes" format.

I. **MEMBERSHIP**

A. The Division of Cardiology consists of physicians who are initially board certified in Cardiovascular Disease by the American Board of Internal Medicine or are progressing toward certification.

B. Applicants who are progressing toward board certification in Cardiovascular Disease by the American Board of Internal Medicine must complete formal training prior to applying for medical staff membership in the Division of Cardiology and must become board certified within five (5) years of the initial granting of medical staff membership, unless extended for good cause by the Medical Executive Committee.

C. Board certified members who were issued certificates in Internal Medicine ~~or~~ and Cardiology after 1989 are required to become re-certified ~~within five (5) years of their board certification expiration date~~ in order to maintain board certification status. Continued board certification may be in Cardiovascular Disease and/or a sub-specialty (e.g. Cardiac Electrophysiology) by the American Board of Internal Medicine or by the National Board of Physicians and Surgeons.

II. **FUNCTIONS OF THE DIVISION**

The general functions of the Division shall include:

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 Division 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 Division clinical practice;

D. Review and evaluate Division member adherence to:
   1. Medical Staff policies and procedures
   2. Sound principles of clinical practice

E. Submit written minutes to the QA/PI/PS Committee and Medical Executive Committees concerning:
   1. Division review and evaluation of 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 Hospital.

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Establish privileging criteria for participation on the Non-Invasive Cardiology panels and oversee the administration of such panels;

H. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;

I. Recommend/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);

J. Approval of On-Going Professional Practice Evaluation Indicators; and

K. Formulate recommendations for Division rules and regulations reasonable necessary for the proper discharge of its responsibilities subject to approval of the Department of Medicine Chiefs, the Medical Executive Committee, and Board of Directors.

III. **DIVISION MEETINGS**

The Division of Cardiology shall meet at least annually or at the discretion of the Chief. The Division will consider 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 Committee, and then to the Medical Executive Committee.

Twenty-five percent (25%) of the active Division members, but not less than two members, shall constitute a quorum at any meeting.

IV. DIVISION OFFICERS

A. The Division shall have a Chief who shall be a member of the Active Medical Staff and shall be board certified in Cardiovascular Diseases and qualified by training, experience, and demonstrated ability in the clinical areas covered by the Division.

B. The Division Chief shall be elected every year by the Active members of the Division who are eligible to vote. If there is a vacancy for any reason, the Department Chairman shall designate a new Chief, or call a special election. The Chief shall be elected by a simple majority of the members of the Division.

C. The Division Chief shall serve a one-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from the office, or loses his/her Medical Staff membership or clinical privileges in the Division. The Division officers shall be eligible to succeed themselves;

V. DUTIES OF THE DIVISION CHIEF

The Division Chief shall assume the following responsibilities:

A. Be accountable for all professional and administrative activities of the Division;

B. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division;

C. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form;

D. Recommend to the Department of Medicine and the Medical Executive Committee the criteria for clinical privileges in the Division;

E. Recommend clinical privileges for each member of the Division;

F. Assure that the quality, safety and appropriateness of patient care provided by members of the Division are monitored and evaluated; and

G. Other duties as recommended from the Department of Medicine or the Medical Executive Committee.

VI. CLASSIFICATIONS

The Division of Cardiology has established the following categories:

A. Physicians - Cardiology

Refer to Membership section above. Physicians may act as consultants to others and may, in turn, be expected to request consultation when:

1. Diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life-threatening illness;
2. Unexpected complications arise which are outside their level of competence;

3. Specialized treatment or procedures are contemplated with which they are not familiar.

B. Nurse Practitioner (NP) – Refer to the Allied Health Professionals Rules and Regulations for basic credentialing requirements.
Nurse practitioner means a registered nurse who possesses additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in primary care and who has been prepared in a program. The nurse practitioner shall function under standardized procedures and any protocols covering the care delivered by the nurse practitioner. The nurse practitioner and his/her supervising physician, who shall be a cardiologist, shall develop the standardized procedures and any protocols to be approved by the Division of Cardiology, Department of Medicine, Credentials Committee, Interdisciplinary Practice Committee, Medical Executive Committee, and Board of Directors.

Nurse Practitioner Privileges	**Initial Appointment**	**Proctoring**	**Reappointment (every 2 years)**
Collaborate in the diagnosis, evaluation and management of the patient	Refer to AHP Rules and Regulations for credentialing requirements	First ten (10) total cases from this privilege card need to be proctored by your supervising physician.	None
Perform history and physical examination			
Order or transmit an order for x-ray, other studies, ECGs, cardiac stress testing, echocardiography, therapeutic diets, physical/rehab therapy, occupational/speech therapy, respiratory therapy, and nursing services.			
Furnish medications following the Drugs and Devices protocol as described in the standardized procedures			
Emergency cardiac treatment			
Cardiac stress testing, under supervision of a cardiologist	Documentation of twelve (12) cases	Two (2)	Fifty (50)

C. Physician Assistant (PA) – Refer to the Allied Health Professionals Rules and Regulations for basic credentialing requirements.
A physician assistant may only provide those medical services, which he/she is competent to perform and which are consistent with the physician assistant's education, training and experience, and which are delegated in writing by a supervising physician who is responsible for the patients cared for by that physician assistant.

1. A supervising physician shall be available in person or by electronic communication at all times when the PA is caring for patients.
2. The supervising physician shall delegate to the PA only those tasks and procedures consistent with the supervising physician's specialty or usual customary practice and with the patient's health and condition.
3. The supervising physician shall observe or review evidence of the physician assistant's performance of all tasks and procedures to be delegated to the physician assistant until assured competency.

4. The physician assistant may initiate arrangements for admissions, complete forms and charts pertinent to the patient's medical record, and provide services to patients requiring continuing care.
5. The supervising physician must see patients cared for by the physician assistant at least once during their hospital stay.
6. A physician assistant may not admit or discharge patients.
7. Refer to the AHP rules and regulations for detailed explanation of supervising physician supervision requirements and co-signature requirements.

Physician Assistant Privileges

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Take a patient history; perform a physical examination and make an assessment and diagnosis therefrom; initiate, review and revise treatment and therapy plans, record and present pertinent data in a manner meaningful to the physician.	Refer to AHP Rules and Regulations for credentialing requirements	First (10) total cases from this privilege card need to be proctored by your sponsoring physician.	None
Order or transmit an order for x-ray, other studies, therapeutic diets, physical/rehab therapy, occupational/speech therapy, respiratory therapy, and nursing services.			
Order, transmit an order for, perform, or assist in the performance of laboratory procedures, screening procedures and therapeutic procedures.			
Recognize and evaluate situations that call for immediate attention of a physician and institute, when necessary, treatment procedures essential for the life of the patient.			
Instruct and counsel patients regarding matters pertaining to their physical and mental health. Counseling may include topics such as medications, diets, social habits, family planning, normal growth and development, aging, and understanding of and long-term management of their diseases.			
Initiate arrangements for admissions, complete forms and charts pertinent to the patient's medical record, and provide services to patients requiring continuing care, including patients at home.			
Initiate and facilitate the referral of patients to the appropriate health facilities, agencies and resources of the community.			

Administer medications to a patient, or transmit orally, or in writing on a patient's record, a prescription from his or her supervising physician to a person who may lawfully furnish such medication or medical device. The supervising physician's prescription, transmitted by the physician assistant, for any patient cared for by the physician assistant, shall be based either on a patient-specific order by the supervising physician or on written protocol which specifies all criteria for the use of a specific drug or device and may contraindications for the selection. A physician assistant shall not provide a drug or transmit a prescription for a drug other than that drug specified in the protocol, without a patient specific order from a supervising physician. At the direction and under the supervision of a physician supervisor, a physician assistant may hand to a patient of the supervising physician a properly labeled prescription drug prepackaged by a physician, a manufacturer, as defined in the Pharmacy Law, or a pharmacist. In any case, the medical record of any patient cared for by the physician assistant for whom the physician's prescription has been transmitted or carried out shall be reviewed and countersigned and dated by a supervising physician within seven (7) days. A physician assistant may not administer, provide or transmit a prescription for controlled substances in Schedules II through V inclusive without patient-specific authority by a supervising physician.	Current, valid DEA registration issued by the United States Drug Enforcement Administration		
Cardiac stress testing, under supervision of a cardiologist	Documentation of twelve (12) cases	Two (2)	Fifty (50)

D. Invasive Procedures by Cardiologists

1. The following Cardiac Catheterization Laboratory procedures are to be performed only by board certified cardiologists or those cardiologists who are progressing toward certification. All procedures are to be monitored by the Director of Invasive Cardiology or his/her designee.
2. Cardiac Catheterization Laboratory procedures will be reviewed by the Director of Invasive Cardiology, who will evaluate the applicant's technical skills and clinical judgment. The Director will submit a written report to the Cardiology Division, with the Division's recommendations to be forwarded to the Credentials Committee and to the Department of Medicine.

3. The Director of Invasive Cardiology will review the Percutaneous Transluminal Coronary Angioplasty program at least semi-annually and will report to the Cardiology Division and the Annual Summary to the QA/PI/PS Committee.
4. Current fluoroscopy certification is required for the following procedures:
   a) Cardiac Catheterization, including Angiography
   b) Insertion of Permanent Pacemaker
   c) Intra-Aortic Balloon Pump Insertion
   d) Myocardial Biopsy
   e) Electrophysiologic Testing
5. Procedure reports, per the Medical Records Policy & Procedures # 518, are to be dictated or written immediately following the procedure and is to be authenticated and signed by the physician

VII. PRIVILEGES

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office.
   1. By virtue of appointment to the Medical Staff, all physicians are authorized to perform occult blood testing and order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.

B. Request for privileges in the Division of Cardiology shall be evaluated on the basis of the member's education, training, experience, demonstrated professional competence and judgment, clinical performance and the documented results of patient care and monitoring. Recommendations for privileges are made to the Division of Cardiology/Department of Medicine, Credentials Committee, the Medical Executive Committee, and the Board of Directors.

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Admit Patients	Training	Initial six (6) cases	None
Consultation	Training		None

INVASIVE PROCEDURES

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Pericardiocentesis	Training	Two (2)	None
Venous cut-down & percutaneous central venous pressure catheters	Training	Three (3)	None
Insertion of temporary transcutaneous cardiac pacemaker	Training	Three (3)	None
Elective cardioversion	Training	Three (3)	None
Swan-Ganz catheter insertion & monitoring	Training	Three (3)	None
Cardiac catheterization (including Coronary	Training and three-	Five (5)	Forty (40)

arteriography right heart cath & pulmonary angiography)	hundred (300) cases; if more than 12 months since completion of training, documentation of forty (40) cases within two (2) years prior to application.		
Transesophageal echo-cardiography (including passing transducer)	Training / Course	Five (5)	None
Percutaneous arterial catheter insertion (radial, brachial, & femoral)	Training	Three (3)	None
Intra-aortic balloon pump insertion	Training	Two (2)	None
Permanent pacemaker insertion (single/dual/ biventricular chamber) and/or intra-cardiac defibrillator (single/dual/biventricular chamber)	Completion of fellowship training or twenty-five (25) cases within two (2) years prior to application.	Two (2)	Ten (10)
Percutaneous Angioplasty (PTCA), including stents	Training/two-hundred fifty (250) cases; if more than 12 months since completion of training, documentation of seventy-five (75) cases within two years prior to application.	Twenty-five (25)	Seventy-five (75), of which twenty (20) must be performed at TCMC
Myocardial Biopsy	Training / Course	Two (2)	None
Electrophysiologic Testing and Ablation, Complete	Training and one-hundred (100) cases within two years prior to application.	Five (5)	Forty (40)
Electrophysiologic Testing and Ablation, right-side only	Completion of subspecialty fellowship training or one-hundred (100) cases, with documentation of forty (40) cases within two (2) years prior to application.	Five (5)	Forty (40)
Rotational Atherectomy	Meet PTCA requirements plus Boston Scientific Certificate	Three (3)	Six (6)

C. Invasive Procedures by Non-Cardiologists

1. The Cardiology Division will monitor invasive procedures performed by Internal Medicine physicians who request privileges to perform the following procedures:
   a) Right Heart Catheterization with Swan-Ganz Pulmonary Artery Catheter;
   b) Central Venous Catheter Placement
   c) Temporary Transvenous Pacemaker Insertion
   d) Arterial Line Insertion
   e) Elective Cardioversion; and

2. To gain privileges for the above procedures, the Internal Medicine Physician must submit documentation of having performed at least five (5) of the requested procedures during residency training or during staff membership at another hospital.
3. The Director of Invasive Cardiology or his/her designee will monitor the first two (2) procedures performed. The Director of Invasive Cardiology or his/her designee shall submit a written report to the Division of Internal Medicine stating that:
   a) The applicant is qualified and competent to perform the procedure, or
   b) Further monitoring is recommended

D. Non-Invasive Procedures by Cardiologists

The following non-invasive procedures are to be performed only by board certified cardiologists or those cardiologists who are progressing toward certification. All procedures are to be monitored by the Director of Non-Invasive Cardiology or his/her designee.

NON-INVASIVE PROCEDURES

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
ECG	Training	Twenty-five (25)	Five-hundred (500) or TCMC active Reading Panel member as attested by the Division Chief or designee.
Stress Echo	Training	Five (5)	Ten (10)
Thoracic Echo	Training	Two (2)	Two-hundred (200), of which one-hundred (100) must be performed at TCMC or TCMC active Reading Panel member as attested by the Division Chief or designee.
Holter Monitor	Training	Two (2)	Forty (40), of which ten (10) must be performed at TCMC or TCMC active Reading Panel member as attested by the Division Chief or designee.
Treadmills	Training	Two (2)	Fifty (50) performed at TCMC or TCMC active Reading Panel member as attested by the Division Chief or designee.

E. Interpretation Response Time:

1. Requirements

a) **Availability:** Panel member will be available to the department until 12:00 p.m.

~~a)~~b) **ECG's**: Should be interpreted daily by the attending cardiologist. Unassigned ECGs are to be interpreted twice daily on weekdays and at least once daily on weekends and holidays by the assigned panel member or his/her designated panel member.

~~b)~~c) **Echocardiogram**: The final report is to be dictated within twenty-four (24) hours of the performance of the study.

~~c)~~d) **Exercise or Pharmacological Stress Test**:
If the scheduled cardiologist cannot be available within ~~fifteen (15)~~ twenty (20) minutes of the scheduled start time to supervise the test, it is his/her responsibility

to assure that another cardiologist can do so. The technician will page the cardiologist in a timely fashion before the test is scheduled to begin. If a cardiologist is not available, the patient will either be sent back to their room or to the outpatient area to wait for the cardiologist and it is the cardiologist's responsibility for communicating to the patient the timeliness issue. The final report is to be dictated the day of the study.

Sanctions for the INTERPRETATION OF Echocardiogram Exercise or Pharmacological Stress Test and ECG's:

To assure quality patient care, it is imperative that all members adhere to the above requirements. All deviations from these requirements are to be documented and communicated immediately to the Non-Invasive Medical Director and the Chief of the Cardiology Division.

~~d)~~e) Cardiologists who consistently fail to dictate reports within a timely manner will receive two (2) written warnings before an automatic sanction of six (6) months ineligibility for reading ~~any~~ panel non-invasive studies in the Department of Cardiology is imposed for the third offense. Division members being sanctioned twice in a three-year period will be sanctioned by at least one (1) year ineligibility for reading any non-invasive study in the Department of Cardiology, after which he/she may apply to the Cardiology Division for reinstatement.

VIII. **REAPPOINTMENT**

Procedural privileges will 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 reappointment requirements (this shall not supersede privilege-specific requirements as outlined in this document). 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 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 Division Chief to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

B. All Active members of the Division will act as proctors. An associate may monitor 50% of the required proctoring. Proctors are obligated to make themselves available either to proctor the member concurrently when applicable, or to thoroughly evaluate the practitioner's performance through retrospective chart review within seven (7) days after a proctor request has been made by the member. Additional cases may be proctored as recommended by the Division Chief. It is the responsibility of the Division Chief to inform the monitored member whose proctoring is being continued of noted deficiencies.

a) The Director of Invasive Cardiology, or his/her designee, will monitor invasive procedures.

b) Supervision of the applicant by the proctor will emphasize concurrent or, if needed, retrospective chart review and include direct observation of procedural techniques.
c) The cardiologist should not be granted Active Medical Staff privileges within the Division until the proctoring has been satisfactorily completed.

C. When the required number of cases has been proctored, the Division Chief must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.

D. The practitioner must notify the Director of Invasive Cardiology at the time a procedure is scheduled. If the Director of Invasive Cardiology is not available to observe the procedure, he/she should appoint a designee to observe the procedure.

E. If the procedure must be done as an emergency without proctoring, the Director of Invasive Cardiology must be informed at the earliest appropriate time following the procedure.

F. A form shall be completed by the proctor, and should include comments on preprocedure workup, diagnosis, preprocedure preparation, procedural technique, judgment, postprocedure care, overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available from the Medical Staff Office.

G. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Office.

IX. EMERGENCY DEPARTMENT CALL

A. Active Division members of the Cardiology Division may participate in the-Emergency Department Call Roster on a voluntary basis. Refer to Medical Staff Policy and Procedure 8710-520.

B. When a need is demonstrated, the Division Chief may request Courtesy and Associate staff members to participate in the Emergency Department Call Roster.

C. When it is discovered that a patient has been previously treated by a Cardiology Division staff member, that member should be given the opportunity to provide further care unless the patient or primary care physician requests otherwise.

D. If a physician has discharged a patient from his practice and the patient comes to the Emergency Department when the physician is on call, the physician is responsible for the disposition of the patient.

E. A physician on-call, who provides care for a patient in the Emergency Department, is responsible for the disposition of that patient for forty-eight (48) hours and must accept responsibility if said patient is readmitted to the Emergency Department within forty-eight (48) hours.

X. NON-INVASIVE CARDIOLOGY INTERPRETATION PANELS

A. Eligibility

The following is eligibility criteria for Cardiology Interpretation Panels:

1. The applicant must be an Active Medical Staff member of the Division of Cardiology; and,
2. Must use Tri-City Medical Center as his/her primary hospital; and
3. Must execute a standard agreement with the Tri-City Hospital District, after which he/she will be placed at the end of the panel rotation.

B. Panel Rotation

A panel will be created of eligible Cardiology Division members with Active Medical Staff privileges, as delineated above, who request for such duties. At the discretion of the Division

Chief, Provisional or Courtesy Division members may participate on the panel rotation with majority Division member approval.

1. One section will be to interpret the ECGs, signal average ECGs, and Holter Monitor examinations of patients not assigned to another Cardiology Division member (i.e., "unassigned" patients for which the attending physician does not specify a cardiologist).
2. A second section will be to interpret echocardiographic studies of "unassigned" patients for which the attending physician does not specify an interpreting cardiologist.
3. A third section will be to interpret stress tests for "unassigned" patients for which the attending physician does not specify an interpreting cardiologist.
4. Panel members will be scheduled for one-week periods from Monday at 0700 hours to the next Monday at 0700 hours during which they will be responsible for personally supervising or interpreting these tests on a timely basis. The term "timely" is defined in the "Interpretation Response Time" Section or by assigning another panel member to do so.

C. Conditions

The Cardiology Panel is restricted to seven (7) panel members unless there is an annual volume increase of 12.5% allowing sufficient volume for panel members to maintain expertise and provide quality of interpretations.

XI. **CARDIOLOGY CONSULTATIONS**

The Division of Cardiology accepts consultation requests for patients over the age of 18 years. Individual exceptions may be made at the discretion of the Cardiologist.

Approvals:

Division of Cardiology: ~~10/1/14~~ 10/07/15; 11/04/15
Department of Medicine: 10/21/14
Medical Executive Committee: 11/27/14
Governance Committee: 11/4/14
Board of Directors: 11/6/14

ISSUE DATE:	**7/01**	**SUBJECT:**	**Medical Record Documentation Requirements**
REVISION DATE:	**7/07, 3/08, 9/08, 6/09, 9/09 11/09; 7/11; 05/12; 08/12, 2/15, 10/15**	**POLICY NUMBER:**	**8710-518**
Medical Executive Committee Approval:		**02/15**	
Governance Committee Approval:		**03/15**	
Board of Directors Approval:		**04/15**	

A. **PURPOSE:**
1. To establish the policy, procedure, and responsibilities for the completion of medical records.

B. **POLICY:**
1. It is the policy of Tri-City Medical Center that all medical records are current, authenticated, legible, and complete.
2. The intent does not support delay of care or rendering of services to the patient.

C. **RESPONSIBILITIES:**
1. General responsibilities are delegated as indicated in the following subsections:
   a. Hospital administration, with medical staff approval, will determine the criteria for current, authenticated, legible, and complete medical records.
   b. The Medical Records/Health Information Department will monitor records to aid the physicians and other medical services in the Medical Center in trying to ensure that medical records meet the requirements for completeness as set in this policy.

D. **PROCEDURE:**
1. Electronic signature:
   a. It is expected that all members of the medical staff will authenticate documents maintained in Cerner electronically through use of a physician identifier.
   b. All members of the medical staff will be required to complete an Electronic Signature Certification Statement to document their acknowledgement of the proper use of their identifier in the authentication of documents.
   c. Dictated reports will be transcribed into the Medical Records Chartscript transcription system. Upon completion of transcription the report will be saved and sent electronically to the Cerner system (Clinical Notes folder).
   d. Paper-based documents will be scanned to the Clinical Notes section in Powerchart (Cerner) and will be signed electronically, if not already signed
   e. The Report Status in Cerner will be reflected as "Transcribed"
      i. Transcribed status reflects that the dictating physician has not yet authenticated the document.
   f. Physicians will utilize the Cerner Message Center function to authenticate transcribed documents in a timely manner.
   g. The Message Center feature supports the following actions to be taken by the physician:
      i. Sign/Review
         1) Physician reviews the transcribed/scanned document and selects the OK button that updates the status of the report from "Transcribed" to "Auth (Verified)."
         2) Only the responsible physician is eligible to sign a transcribed report.

a) Physician Assistants will sign their reports in addition to the report being signed by the supervising physician.
b) Resident reports will be signed by the supervising physician.
c) All mid-level practitioners (e.g., Nurse Practitioners, Midwives) sign their reports in addition to the report being signed by the supervising physician.

ii. Modify/Sign
1) Physician may modify the transcribed document PRIOR to signature to correct/clarify any elements of the report.
2) Modifications are to follow the structure of new information being Bolded and deleted information noted as a Strike-through
3) Once modified and signed any new revisions to the document are noted as an Addendum

iii. Refuse
1) Physician identifies that he/she is not responsible for the report as well as a reason for refusal and redirects the report to Medical Records/Health Information (Med Rec Inbox) for review and reassignment of the deficiency to the correct physician.
2) Electronic signature of the transcribed and scanned reports by the physician will update the Medical Records/Health Information Profile system to eliminate the signature deficiency assigned by the department.

2. **Written Signatures**
a. It is expected that all members of the medical staff will utilize acceptable written signatures, including credentials (e.g., MD, PA, NP, CNM) for all paper documents being authenticated.
i. This expectation relates to orders submitted for outpatient ancillary services as well as emergency, day surgery, and inpatient documentation.
b. Acceptable written signatures are as follows:
i. Legible full signature
ii. Legible first initial and last name
iii. Illegible signature over a typed or printed name
iv. Illegible signature where the letterhead or other information on the page indicates the identity of the signer
1) Example: an illegible signature appears on a prescription. The letterhead lists multiple physicians' names. One of the names is circled.
v. Initials over a typed or printed name
vi. Unsigned handwritten orders where other entries on the same page in the same handwriting are signed
c. Unacceptable written signatures are as follows:
i. Signature stamps alone
1) These are not recognized as valid authentication for Medicare signature purposes and may result in payment denials by Medicare.
ii. Reports or any records that are dictated and/or transcribed, but do include valid signatures "finalizing and approving" the documents are NOT acceptable for reimbursement. Reports or any records that are dictated and/or transcribed, but do include valid signatures "finalizing and approving" the documents are NOT acceptable for reimbursement.
iii. Unsigned typed note with provider's typed name
iv. Unsigned typed note without provider's typed/printed name
v. Unsigned handwritten note, the only entry on the page

3. The following criteria must be met before a chart is considered complete:
a. A medical record must be legible for each patient; its content shall be pertinent and current. This record shall include:
i. Identification data
ii. Legal status if mental health patient;

iii. Emergency care given prior to arrival if any;
iv. Findings of assessment;
v. Conclusions or impressions from history and physical;
vi. Diagnosis or diagnostic impression;
vii. Reasons for admission or treatment;
viii. Goals of treatment and treatment plan;
ix. Known advance directives;
x. Informed consent for procedures and treatment;
xi. Diagnostic and therapeutic procedures and tests and their results;
xii. Operative and other invasive procedures performed;
xiii. Progress notes;
xiv. Reassessments if needed;
xv. Clinical observations;
xvi. Response to care;
xvii. Consultation reports;
xviii. Every medication ordered; every dose administered and any adverse reaction;
xix. Every medication dispensed to inpatient at discharge or to ambulatory patient;
xx. All relevant diagnoses established during care;
xxi. Any referrals/communications to other providers.

4. All patient medical record entries must be legible, completed, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided.
   a. All handwritten documentation is to be without the use of Do Not Use Abbreviations.
      i. A reference of Do Not Use Abbreviations is available in multiple locations.
         1) Physician Order Forms
         2) Progress Notes
         3) TCMC Intranet – Administrative Policy 367
5. A complete history and physical examination shall be recorded by the attending physician within twenty-four (24) hours of admission and/or prior to any surgical or invasive procedure.
   a. When the report is dictated it must be completed within twenty (20) hours of admission to allow for transcription and charting of the document.
   b. Legible, handwritten history and physicals are acceptable provided they meet the documentation requirements.
   c. All history and physical examinations will be validated and authenticated by the attending physician with appropriate privileges.
6. The history and physical shall include the following elements:
   a. Chief complaint;
   b. Personal, past medical and surgical history;
   c. Allergy history;
   ~~b.~~d. Current medications;
   ~~c.~~e. Family history;
   ~~d.~~f. History of present illness;
   ~~e.~~g. All important findings resulting from ~~an assessment of all systems of the body~~a review of systems;
   h. Physical examination;
   ~~f.~~i. Diagnosis or diagnostic impression;
   ~~g.~~j. Plan of treatment.
7. A medical history and physical examination must be completed no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical must be completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.
   a. An updated examination of the patient, including any changes in the patient's condition must be completed and documented within 24 hours after admission or registration. This is to occur prior to surgery or for a procedure requiring anesthesia services, when the

medical history and physical examination are completed within 30 days before admission or registration.

b. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, oral maxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy.

c. If, upon examination, the licensed practitioner finds no change in the patient's condition since the H&P was completed, he/she may indicate in the patient's medical record the:
   i. H&P was completed
   ii. H&P was reviewed
   iii. The patient was examined and "No Change" has occurred in the patient's condition since the H&P was completed~~.~~.

d. The Physician Pre-Procedure Documentation form must be recorded on the patient's medical record prior to patient admission to the Operating Room or Procedural areas regardless of the date and time the history and physical was completed.

e. A history and physical document completed outside Tri-City Medical Center is required to reflect date and time of the examination.
   i. Dictated documents are to reflect the date and time of both the dictation and transcription.

8. A history and physical dictated over 30 days prior to admission is not valid and must be re-dictated

9. When the required history and physical examination is not recorded on the chart before the time stated for the operation, the operation shall be canceled until the surgeon has documented a history and physical in writing or documented that such a delay would constitute a hazard to the patient.

10. History and Physical for Hospital Outpatient Procedures:
   a) Ambulatory surgery patients undergoing anesthesia shall have a complete H&P as defined above prior to surgery.
   b) Hospital outpatients undergoing invasive procedures with a significant level of risk shall have at least a limited History and Physical.

11. A limited History and Physical shall contain the same elements as an H&P, except the review of systems and physical examination elements may be abbreviated to include only that which is relevant, appropriate or pertinent to the procedure or intervention to be performed.

~~10. A Limited History and Physical (Short form) may be completed for outpatient procedures and when the patient's length of stay is less than forty-eight (48) hours.~~
~~a. The following outpatient procedures require a documented history and physical:~~
~~i. Heart Cath~~
~~ii. Interventional Radiology/Invasive Imaging~~
~~iii. Outpatient Observation~~
~~iv. Same Day Surgery~~
~~v. Endoscopy~~
~~vi. Wound Care Center~~
~~b. PICC line procedures performed on outpatients require a copy of the physician order to support the patient's diagnosis and medical necessity for the procedure.~~
~~c. Diagnostic Imaging procedures (IMAGS) without anesthesia do not require a History and Physical.~~
~~d. A post-anesthesia evaluation for anesthesia recovery must be completed and documented by an anesthesiologist.~~

~~11.~~12. Dentists who are members of the Medical Staff may only admit patients if a physician member of the Medical Staff conducts or directly supervises the admitting history and physical examination (except the portion related to dentistry) and assumes responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside the limited license practitioner's lawful scope of practice.

a. A history and physical completed by the medical physician in addition to the history and physical completed by the dentist are necessary to be documented on the chart prior to any surgical procedure.

b. A qualified oral surgeon or podiatrist with specifically delineated clinical privileges may admit patients without significant underlying or potentially complicating medical problems, may perform the history and physical examination of those patients, and may assess the medical risks of proposed surgical procedures for such patients.

i. Completion of a history and physical examination by an oral surgeon or podiatrist who has the special privileges will NOT require completion of a history and physical by another qualified physician.

~~12.~~13. Medication reconciliation:

a. Admission

i. The admitting physician is required to review~~, complete~~, complete and reconcile ~~Admission Medication~~Admission Medication Reconciliation information in Cerner collected upon admission of the patient within 24 hours. .

ii. If new information is later obtained, the physician or nurse may update the Medication by History List in Cerner.

b. Transfer

i. All medications will be reviewed and revised as appropriate when patient is being transferred to the next level of care.

1) Electronic Orders

a) ~~a.)~~ The physician will access the Transfer Medication Reconciliation function and will reconcile each medication on the active medication list to either be continued or not continued for the next level of care.

~~c.~~

~~d.~~

~~e. Written Orders~~

~~f. The physician from the SENDING unit shall print out the Transfer Reconciliation Order form and place as the first sheet under the Physician Order tab section of the Patient's medical record. The physician may use this form as the actual order form or handwrite any changes on a pre-printed physician order form or the generic blank physician order form. Rewrite applicable orders~~

~~g.~~c. Discharge

i. All medications will be reviewed against HOME medications in Cerner.

1) Electronic Orders

~~a)~~ The physician will reconcile each medication on the active medication list and home list to either be continued or not continued upon discharge. New medications will be added as required.

~~b)~~a)

~~c)~~b) Prescriptions to be completed

i) ePrescribe – electronic prescription transmitted to the patient's pharmacy

ii) Printed on the unit and handed to the patient

iii) ~~Handwritten~~ on personal (physician's) prescription pad

2) Written Orders

~~a) Physician will print the Discharge Medication Reconciliation Form from Cerner for discharge, updates as appropriate for discharge, and signs. The Order sheet will be placed as the first sheet under the Physician Order tab section of the patient's medical record.~~

~~b)~~a) Physician handwrites prescriptions on personal (physician's) prescription pad.

~~c)~~b) ~~Nursing~~ Physician updates physician medication changes on the electronic Medication List through the Medication Reconciliation tool.

~~13.~~14. Daily progress notes must be documented by the attending member on all acute patients in the hospital.
   a. Progress notes for Behavioral Health unit patients, will be written six days per week by the attending member.
   b. All members of the medical staff will document progress notes in any of the following methods:
      i. Written on the progress notes form placed in the patient's active record;
      ii. Electronic note may be a Progress Note typed by the physician or a Progress Note generated using a voice recognition software application (e.g. Dragon)
         ~~1) Physicians who create an electronic progress note in Clinical Notes will need to document the following in the hardcopy Progress Notes, "Note recorded in EMR."~~
   c. All Progress Note entries shall be timed, dated, and electronically signed by the physician recording the note. Electronic notes shall be signed electronically.
      i. The electronic Progress Note shall not be printed, signed and placed in the hard copy chart (this is duplicate documentation that may require both documents to be maintained in the legal record (i.e. scan document as well as maintain electronic version).
   d. Progress Notes recorded by Residents and/or Physician Assistants are required to be co-signed by the attending physician member.
   e. Interdisciplinary Notes recorded by the other care providers are available in the Cerner system for review by the physician.
      i. These notes are recorded by non-physicians within the Power Note application in the Cerner system.
   f. Physician evaluation of Occupational Health patients (Work Partners) and Wound Care Center patients may result in an electronic note captured directly into the Cerner system.
      i. Voice Recognition/Dragon application may be utilized by practitioners in these areas to generate a note summarizing the patient's history, assessments, and treatments.
      ii. These notes will be authenticated by the examining physician and will be displayed as part of Clinical Notes.

~~14.~~15. Consent for Photography will be obtained from the patient when a patient will be photographed while receiving treatment at the Medical Center. The term "Photograph" includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

~~15.~~16. All surgical operations, invasive and diagnostic procedures (including blood transfusions) shall be performed with documented informed consent except in an emergency. The informed consent for hysterectomies and sterilization procedures must meet specific requirements as set forth in Title XXII.
   a. The informed consent documented will include the following:
      i. Discussion about potential benefits, risks, and side effects of the patient's proposed care, treatment, and services.
      ii. The likelihood of the patient achieving his or her goals
      iii. Any potential problems that might occur during recuperation

~~16.~~17. Physicians shall discuss a patient's Do Not Resuscitate (DNR) status with the patient and/or decision-maker prior to a surgery or procedure that requires anesthesia. The discussion shall include possible temporary suspension of the DNR status during the surgery or procedure. The DNR status shall be reevaluated immediately after the procedure. This discussion shall be documented in the medical record and an appropriate order entered/written.

~~17.~~18. A pre-sedation or pre-anesthesia assessment is performed for each patient before beginning moderate or deep sedation and before anesthesia induction within forty-eight (48) hours prior to surgery.

~~18.~~19. A post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia within forty-eight (48) hours after surgery for an inpatient.

~~19.~~20. Operative or other high risk procedure reports shall be dictated immediately after surgery and shall include:
   a. Pre-operative diagnosis
   b. Date of procedure
      i. If the procedure is canceled, the operative report should include the reason and time of the cancellation.
   c. Anesthesia type
   d. A detailed account of the findings;
   e. Technical procedure performed
   f. Estimated blood loss
   g. Specimen removed;
   h. Post-operative diagnosis;
   i. Name of the primary surgeon and any assistants.
   j. Complications
   k. Patient status

~~20.~~21. An Operative Note shall be documented immediately following surgery or other high-risk procedures. Use of the pre-printed Operative Note is necessary to document all required elements.
   a. Procedure performed
   b. Pre-Operative diagnosis
   c. Post-Operative diagnosis
   d. Patient status
   e. Estimated blood loss
   f. Name of primary surgeon and any assistants
   g. Anesthesia type
   h. Specimen collected
   i. Complications
   j. Findings

~~21.~~22. An intraoperative anesthesia record containing the following elements shall be completed by an anesthesiologist:
   a. Name and hospital ID number of the patient
   b. Name of anesthesiologist who administered the anesthesia
   c. Vital signs reflecting patient status just prior to induction
   d. Name, dosage, route, and time of administration of drugs and anesthesia agents
   e. Techniques used and patient position(s), including the insertion/use of any intravascular or airway devices
   f. Names and amounts of IV fluids, including blood or blood products
   g. Time-based documentation of vital signs as well as oxygenation and ventilation parameters, and
   h. Any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment.

~~22.~~23. The Operative Note shall be completed and signed by the surgeon prior to the patient being discharged or transferred from PACU.

~~23.~~24. All orders, including verbal orders, must be dated, timed, and authenticated.
   a. All orders shall be completed, legible, dated and signed within forty-eight (48) hours for medication orders and fourteen (14) days post-discharge for all other orders.

~~24.~~25. Medical Records/HIM will assign a deficiency to unsigned orders via the Inbox/Message Center.

~~25.~~26. It is acceptable for physicians involved in the care of the patient to sign orders given by other physicians unless they object to the order. A physician may proxy Message Center to another physician for coverage purposes.
   a. Verbal orders are to be used infrequently, only to meet th_e immediate care needs of the patient when it is impossible or impractical for the ordering practitioner to write/enter the order without delaying treatment. Every effort is to be made by the ordering physician to enter orders into Cerner or in writing ~~when he/she is present on the nursing unit~~.

b. All orders for treatment shall be entered~~/written~~. An order for treatment is considered ~~written~~ entered if dictated by a member or his designee to a registered nurse and signed by the attending member through the Message Center. When orders are dictated over the telephone, they shall be signed by the responsible physician within forty-eight (48) hours for medication orders and fourteen (14) days post-discharge for all other orders.

c. Physician orders for neonatal and pediatric populations will contain weight based dosing (e.g., mg/kg) along with the calculated dose and the patient's current weight with the exception of the following defined medication classes:
   i. Medications that are not determined by the patient's weight (e.g., iron sulfate).
   ii. Vaccines
   iii. Intravenous fluids
   iv. Medication doses that if weight based would equal or exceed normal adult doses.

~~26.~~27. When a patient is transferred from one level of care to another the physician is required to complete one of the following options:
   a. Electronic Orders
      i. Utilize the Merge View in Cerner to review and update all orders for the next level of care.
      ii. Complete the Transfer Medication Reconciliation function
   b. Written Orders
      i. Rewrite all orders. ~~OR document the following, "I have reviewed all orders, and they are appropriate for this patient at this level of care."~~
      ii. The physician is not required to rewrite orders when a patient is undergoing one of the following minor procedures and returns to the same level of care
         1) Heart Catheterization
         2) Interventional procedures including PICC line placement
         3) Endoscopy including bronchoscopies
         4) Inpatient dialysis
         5) Pain management
   ~~c. A registered nurse may write the order on paper or enter the order into Cerner with the comment that the communication was by verbal order. These orders as entered will be reviewed and signed by the ordering physician.~~

~~27.~~28. Consultations and recommendations shall include examination of the patient and a review of the patient's record by the consultant. The consultation shall be made a part of the patient's record. When operative procedures are involved, a consultation, except in an emergency, shall be recorded prior to the operation.

~~28.~~29. Current obstetrical records shall include complete prenatal records, including a copy of the actual lab reports. The prenatal record may be a legible permanent copy of the attending practitioner's office record transferred to the Medical Center before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

~~29.~~30. All patients evaluated by an Emergency Department physician are to have a documented report outlining the history of present illness, assessment, and treatment rendered.
   a. Records for patients evaluated by both a resident and an ED physician will include documentation by each of the evaluators. The attending ED physician is responsible for authenticating ED reports dictated by a resident.
   b. Records for patients evaluated by an ED Physician Assistant (PA) will include only documentation by the PA which will be authenticated/signed by both the PA and ED supervising physician.

~~30.~~31. All clinical entries in the patient's medical record shall be accurately dated and authenticated.

~~31.~~32. Discharge/Depart Process
   a. Electronic orders for discharge and follow-up care (including: activity, diet, equipment, follow-up, and medications) will be entered into the Depart Process application.
   b. Written orders for discharge and follow-up care (including: activity, diet, equipment, and follow-up) will be recorded on the Physician Order sheet.
      i. Nursing will enter into the Depart Process application

ii. Medication orders must be entered by the physician for Discharge Medication Reconciliation process (see section D.11.c.2)

~~32.~~33. A Discharge Summary shall be dictated at all deaths regardless of length-of-stay, and in addition on all patients hospitalized over forty-eight (48) hours, except for normal obstetrical deliveries, and normal newborn infants. A discharge summary must contain:

a. Discharge Diagnosis
b. Reason for hospitalization
c. Significant findings
d. Procedures performed and treatment given
e. Condition on discharge
f. Instructions given to the patient or patient representative
   i. Follow-up instructions
   ii. Diet instructions
g. Discharge medications
h. A written or dictated discharge note is acceptable for patient with a length-of-stay less than forty-eight (48) hours, normal obstetrical deliveries, and normal newborn infants.
   i. Requirements of the Note include:
      1) Discharge Diagnosis
      2) Follow-up instructions
      3) Diet Instructions
      4) Discharge Medications
i. Physicians having a Discharge Summary that requires dictation will be notified via the Message Center in Cerner. All physicians will be required to complete all pending dictations and/or signature within 14 days of discharge.

~~33.~~34. Physicians will be notified of outstanding charts requiring signature via their Message Center as well as via letter and call to their office.

a. Physicians will be suspended per Medical Staff Policy #8710-519 for Delinquent Medical Records and Medical Staff Bylaws Section 6.4-4(a).

~~34.~~35. Late Entry

a. Documentation shall be recorded timely within the patient's medical record. When this is not possible a late entry will be made with the following required elements documented:
   i. The date and time of the observation
   ii. A note clearly identifying the documentation as "Late Entry"
b. It is not permitted to have entries "backdated" or "predated".
c. The chart shall be completed within fourteen (14) days of discharge; it is expected no Late Entries will appear after this time period.

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 activities approved by the Chief Nurse Executive which are likewise ~~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.

D. **Approval of Exceptions.** The Chief Nursing Executive may approve written requests submitted by employees and groups supported, sponsored by or affiliated with the District for permission to conduct activities within the scope of paragraph C.1, above, such as bake sales, handicraft fairs and similar charitable or non-commercial scale activities, limited in time and location which are otherwise consistent with this policy and the terms and conditions applicable to the use of Assembly Rooms, Classrooms and Conference Rooms per Board Policy #14-043.

Reviewed by the Gov/Leg Committee: 9/1/15
Approved by the Board of Directors: 9/24/2015
Reviewed by the Gov/Leg Committee: 11/1/2015
Approved by the Board of Directors:

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY # 15-045

POLICY TITLE: Philanthropic Naming Policy

On occasion, Tri-City Healthcare District (District), working with the Tri-City Hospital Foundation (Foundation) seeks to recognize the philanthropic contributions of individuals or organizations by the naming of buildings, portions of buildings, rooms, fixed furniture, units, service lines, medical equipment, and other services or facilities, collectively referred to hereafter as "Property."

Philanthropic contributions shall mean a contribution to the District from a third party ("Donor") for which there is no reciprocal commercial and/or marketing benefit expected or required from the District. This policy establishes a uniform and consistent procedure to gain District approval and to record these namings for all District Property, on and off campus. When the District is involved in a capital campaign, the District Board of Directors ("Board"), with input from the Foundation, may create donation levels for Property. Board approval is required before the naming of any District Property either as authority is delegated under this policy or by specific Board action.

I. INTENT

A. The primary intent of the Property naming process is to allow the District to recognize the importance of a Donor's contribution to the District.

B. As a general rule, a building name holds more importance or represents greater District recognition than the naming of a portion of the building, such as a unit, floor, wing, service line, or a single room.

II. POLICIES

A. Selection of Names for New Buildings

1. As a general rule, a Donor must contribute a substantial share of the cost of construction of a building to be granted naming rights. Exceptions to this Policy are allowed only when specifically approved by the Board. Naming rights shall be reflected in a deed of gift or other written instrument reflecting any gift conditions accepted or imposed by the District. Gifts of real property require approval of a certificate of acceptance by the Board prior to recordation. In the absence of a written instrument, a naming gift shall be considered to be unrestricted.

B. Namings Other Than Buildings

1. From time to time portions of buildings, rooms, fixed furniture, units, service lines, medical equipment, and other Property, may be named in honor of a Donor who has contributed significantly to a project or goal of the District. Space on the District campus is a District resource and may be reallocated from time to time to best meet the needs of the District. The naming deed of gift or other instrument should be worded to allow the reallocation of movable Property as appropriate. All naming rights shall include a specific term, which shall not be longer than the useful life of the Property as determined by the District. In the absence of a written instrument, a naming gift shall be considered to be unrestricted.

C. Modification, Renovation, or Relocation of Property and Names

1. As modifications are made to Property over time, situations may occur where it is in the best interest of the District to relocate, modify, or reallocate named District Property. In the event modifications to named Property are required or recommended, the Foundation and District will be involved in early planning. This is to insure that the original purposes of the naming and the Donor's wishes, as may be reflected in the deed of gift or other instrument, are preserved as appropriate. These occurrences underscore the importance of obtaining District recognition of all naming. Any such modification or reallocation will be reviewed by the Chief Development Officer and the District CEO with respect to the conditions, if, any, to the original naming.

D. Sign Design Guidelines

1. All interior and exterior signage on campus will be representative and complementary when viewed with existing signage.

2. All District Property signage will follow the campus guidelines and design intent.

E. Plaques Commemorating Namings

1. The text of all plaques will be submitted to the Chief Development Officer for review and approval in consultation with the District CEO. Plaques on rocks, posts or trees are not permitted.

F. Ownership of Gifted or Purchased Items

1. All named Property shall be property of the District

III. AUTHORITY

A. All recommendations and requests for approval of building naming items will be presented to the Board or CEO for approval. District CEO, in consultation with the Chief Development Officer, may accept gifts in conjunction with approval of naming of other Property.

B. Review and Approval of Naming

1. The Chief Development Officer will review and advise District administration and the Board of any concerns raised by any proposed naming. No employee or agent may commit the District to acceptance of any naming gift prior to formal acceptance by the Board or District CEO, as appropriate. Requests for naming of specific Property must be submitted as outlined in this document for review and approval by the Board or District CEO. The Board or District CEO, as appropriate, may refuse any gift, including any in kind donation, if it is deemed to not be in the best interests of the District or inconsistent with this policy.

C. Equipment and Other Property Naming

1. The District CEO may approve, after the review of the Chief Development Officer, the naming of equipment and other Property, excluding buildings, in accordance with this policy without prior submission to the Board.

D. Duration of Naming

1. If during the useful life of a building, the building is transferred or conveyed from the District, closed, deconstructed, destroyed or severely damaged, significantly renovated, upgraded, or modified; relocated, or replaced, then the naming rights will terminate. In such event, however, the Donor, if available, and in consultation with and as mutually agreed by the Board, will have the right of first refusal on an equivalent or replacement building for an additional agreed upon donation amount.

2. In the event that a Donor is no longer living or unwilling/unable to participate in naming of the equivalent or replacement building, the Donor's legacy (prior) naming will be recognized in a prominent location in the form of a plaque or other suitable display method that honors the Donor and his/her donation.

3. Other Property naming will end upon the disposal, termination, or end of useful life of said named Property.

IV. OTHER NAMING RIGHTS

A. The District Board may add to or adopt additional naming rights policies for corporate sponsorships and service honors.

Reviewed by the Gov/Leg Committee:
Approved by the Board of Directors:

Tri-City Medical Center
Audit, Compliance & Ethics Committee
November 19, 2015
Assembly Room 3
8:30 a.m-10:30 a. m.

Members Present:	Director Ramona Finnila (Chair); Director Larry W. Schallock; Director Laura Mitchell; Jack Cumming, Community Member; Barton Sharp, Community Member; Kathryn Fitzwilliam, Community Member; Leslie Schwartz, Community Member
Non-Voting Members:	Steve Dietlin (CFO); Tim Moran (CEO); Kapua Conley, COO; Cheryle Bernard-Shaw, CCO
Others Present:	Diane Racicot, General Counsel; Teri Donnellan, Executive Assistant; Kathy Topp, Director of Education and Clinical Informatics; Colleen Thompson, Director of Medical Records, HIM and Privacy Officer
Absent:	Dr. Frank Corona, Medical Staff Member

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to Order	The meeting was called to order at 8:30 a.m. in Assembly Room 3 at Tri-City Medical Center by Chairperson Finnila.		
2. Approval of Agenda	**It was moved by Mr. Jack Cumming and seconded by Mr. Leslie Schwartz to approve the agenda as presented. The motion passed unanimously.**	**Agenda approved.**	Ms. Donnellan
3. Comments by members of the public and committee members on any item of interest to the public before Committee's consideration of the item	There were no public comments.		
4. Ratification of minutes – October 15, 2015	**It was moved by Ms. Kathleen Fitzwilliam and seconded by Director Mitchell to approve the minutes of the October 15, 2015 meeting as presented. The motion passed unanimously.**	**Minutes ratified**	Ms. Donnellan
5. New Business			
A) Review and discussion of Administrative Policies &			

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
Procedures 1. 8610-502 – Employee Response to Government Investigation	Committee members had several concerns with some of the language in the policy and it was recommended that the content of the policy as well as the title be discussed further with the Chief Compliance Officer and General Counsel. Director Schallock also requested that the name of the Audit Committee be revised in all policies presented today to accurately reflect the name of the committee - Audit, Compliance & Ethics Committee in the header of the document.	**Policy 8610-502 Employee Response to Government Investigation to be brought back to the committee for review; item to be placed on the next agenda.**	Ms. Donnellan
2. 8610-527 – Facility Directory & Visiting Guidelines for Clergy	Ms. Colleen Thompson explained policy 8610-527 – Facility Directory & Visiting Guidelines for Clergy is a type of privacy policy for visiting celery. Mr. Kapua Conley explained the process for clergy visits and the fact that patients may opt in or out of a visit by their respective clergy. General Counsel Ms. Diane Racicot also noted the policy was written to comply with HIPAA. It was noted the committee's name should be amended in the header as previously discussed as well as insertion of the word "information" in section B. 2. to read in part "…identifiable health **information** transmitted…". **It was moved by Director Mitchell to recommend approval of Policy 8610-527 – Facility Director & Visiting Guidelines for Clergy as presented and amended. Director Schallock seconded the motion. The motion passed unanimously.**	**Recommendation to be sent to the Board of Directors to approve Policy 8610-527 –Facility Director & Visiting Guidelines for Clergy as presented; item to appear on Board agenda and included in agenda packet.**	Ms. Donnellan

3. 8750-532 – Compliance Program Generally; Introduction	Ms. Bernard—Shaw explained Policy 8750-532 – Compliance Program Generally; Introduction is a broad overview and is not intended to be exhaustive. It was suggested that the Volunteers be included and reflected in the policy. It was noted the committee's name should be amended in the header as previously discussed **It was moved by Mr. Leslie Schwartz to recommend approval of Policy 8750-532 – Compliance Program Generally; Introduction as presented and amended. Director Schallock seconded the motion. The motion passed unanimously.**	**Recommendation to be sent to the Board of Directors to approve Policy 8750-532 – Compliance Program Generally; as presented and amended; item to appear on Board agenda and included in agenda packet.**	Ms. Donnellan
4. 8750-538 – Hiring and Employment; Screening Prospective Employees/Covered Contractors	The committee reviewed Policy 8750-538 – Hiring and Employment; Screening Prospective Employees/Covered Contractors. The committee had several suggestions: ➢ Reference the legality to work in the U.S. ➢ Amend title to include the word "eligibility". ➢ Strike section C. 1 c. due to redundancy of section C. 1. b. General Counsel Ms. Racicot explained this policy is focused on the exclusion issue. She explained there are other things performed as part of the hiring process (criminal background checks, etc.) however those items are outlined in a separate Human Resource policy. *Director James Dagostino joined the meeting at 9:09 a.m.* It was noted the committee's name should be amended in the header as previously discussed. **It was moved by Director Schallock to recommend approval of Policy 8750-538 – Hiring and Employment; Screening Prospective Employees/Covered Contractors as presented and amended. Mr. Leslie Schwartz**	**Recommendation to be sent to the Board of Directors to approve Policy 8750-538 – Hiring and**	Ms. Donnellan

	seconded the motion. The motion passed unanimously. *Ms. Kathy Topp left the meeting at 9:17 a.m. due to the Disaster Drill currently in progress.*	**Employment; Screening Prospective Employees/Covered Contractors as presented and amended; item to appear on Board agenda and included in agenda packet.**	
5. 8750-544 – Hiring and Employment; Duty to Report Suspected Misconduct/Potential Compliance Irregularity	The committee reviewed Policy 8750-544 – Hiring and Employment; Duty to Report Suspected Misconduct/Potential Compliance Irregularity. Ms. Bernard-Shaw stated in New Employee Orientation she discusses the importance of reporting misconduct or irregularities. It was noted the committee's name should be amended in the header as previously discussed. **It was moved by Director Mitchell to recommend approval of Policy 8750-544– Hiring and Employment; Duty to Report Suspected Misconduct/Potential Compliance Irregularity as presented and amended. Mr. Cumming seconded the motion. The motion passed unanimously.**	**Recommendation to be sent to the Board of Directors to approve Policy 8750-544 – Hiring and Employment; Duty to Report Suspected Misconduct/Potential Compliance Irregularity as presented and amended; item to appear on Board agenda and included in agenda packet.**	Ms. Donnellan
6. 8750-545 – Education & Training – Introduction & General Policies	The committee reviewed Policy 8650-545 – Education & Training – Introduction & General Policies. Extensive discussion was held regarding whether the volunteers are required to participate in compliance training. Mr. Cumming stated the area of volunteers is an area of increasing vulnerability and it is important to ensure the hospital's interests are fully protected. General Counsel stated she believes there is currently a process in place that covers the volunteers. It was suggested that the policy be amended to specifically list and include the volunteers. It was noted the committee's name should be amended in the header as previously discussed. It was recommended the policy be reviewed further and brought back to the next meeting.	**Policy 8710-545 Education & Training – Introduction & General Policies to be brought back to the**	Ms. Donnellan

		committee for review; item to be placed on the next agenda.	
7. 8750-547 – Education & Training – General Annual Compliance Training Program	A revised copy of Policy #8750-547 – Education & Training – General Annual Compliance Training Program was distributed for the committee's review. For consistency it was suggested the word "District" be revised to **TCHD**. One additional formatting change was suggested to section E. 1. q. It was noted the committee's name should be amended in the header as previously discussed. *Mr. Cumming briefly left the meeting at 9:20 a.m.* *Director Mitchell briefly left the meeting at 9:25 a.m.* **It was moved by Director Schallock to recommend approval of Policy 8750-547–Education & Training – General Annual Compliance Training Program as presented and amended. Ms. Kathryn Fitzwilliam seconded the motion. The motion passed with Mr. Cumming and Director Mitchell absent for the vote.** *Ms. Colleen Thompson left the meeting at 9:30 a.m.*	**Recommendation to be sent to the Board of Directors to approve Policy 8750-547– Education & Training – General Annual Compliance Training Program as presented and amended; item to appear on Board agenda and included in agenda packet.**	Ms. Donnellan
B) Review and discussion of Organizational Compliance Committee Charter	Ms. Cheryle Bernard-Shaw presented the proposed Organizational Compliance Committee Charter. Chairperson Finnila clarified this Charter is the staff's internal compliance committee charter not the Board's Audit, Compliance & Ethics Committee Charter. Ms. Bernard-Shaw explained the organizational Compliance Committee has been re-established. She reviewed the membership of the Committee as well as its purpose and role. *Director Mitchell rejoined the meeting at* 9:31 a.m.		

	Mr. Jack Cumming rejoined the meeting at 9:32 a.m. Ms. Bernard-Shaw further explained that much of the work is done by smaller ad hoc groups rather than the full committee. Discussion was held regarding the level of reporting back to the Audit, Compliance & Ethics Committee. It was suggested Ms. Bernard-Shaw present a quarterly overview to the committee which reflects a summary of high level issues and steps taken to remedy those issues. **It was moved by Director Schallock to recommend approval of the Organizational Compliance Committee Charter. Mr. Leslie Schwarz seconded the motion. The motion passed unanimously**.	**Recommendation to be sent to the Board of Directors to approve the Organizational Compliance Committee Charter as presented; item to appear on Board agenda and included in agenda packet.**	Ms. Donnellan
C) Review of FY2016 1st Quarter Financial Statement Results	Mr. Steve Dietlin presented the quarterly financial update which focused on areas of importance to the Audit Committee. He reported the Fiscal YTD (through September, 2015) results as follows: • Net Operating Revenue – $83,908 • Operating Expense – $83,421 • EROE - $1,656 • EBITDA – $5,220 Other Key Indicators for the current year included the following: • Average Daily Census - 189 • Adjusted Patient Days – 28,275 • Surgery Cases – 1,690 • Deliveries – 681 • ED Visits – 17,006 • Net Patient Accounts Receivable – $41.1 million • Days in Net Account Receivable – 46.0	**Information only.**	

	Mr. Dietlin also presented graphs which reflected Net Days in Patient Accounts Receivable, Average Daily Census excluding Newborns, Adjusted Patient Days, Emergency Department Visits, EROE and EBITDA. Mr. Cumming commented the trend for Net Days in Patient Accounts Receivable is a tribute to Mr. Dietlin's leadership. In response to a question related to the decline in deliveries, Mr. Dietlin stated a recruitment effort is underway to bring in new Obstetricians and we hope that recruitment will bring a positive impact and perhaps enhance the payor mix. Discussion was held regarding ICD 10 implementation. Mr. Dietlin stated thus far we have not seen an increase in the denial rate and do not anticipate a decrease in revenue however there has been a slow down in the coding process and getting claims out of the door, thus a delay in payments.		
D) Consider cancellation of December 17, 2015 Audit, Compliance & Ethics Committee Meeting	Director Finnila suggested the committee cancel the December 17, 2015 Audit Compliance & Ethics Committee meeting due to the holidays.	**December 17, 2015 Committee Meeting cancelled.**	Ms. Donnellan
6. Old Business A) Discussion of FY2016 Financial Statement Auditor	Mr. Dietlin reported at last month's meeting the committee discussed options relative to the appointment of an auditor for the FY2016 Financial Statements. Mr. Dietlin stated per the committee's recommendation he has inquired as to whether Moss Adams is open to a rotation of partner based on best practice. Mr. Dietlin stated Moss Adams has indicated that they are open to a partner change and expect to bring a proposal to the committee for consideration in January, along with CVs of two of the most appropriate partners.	**FY2-16 Financial Statement Auditor proposal to be placed on the committee's January agenda.**	Ms. Donnellan
B) Review and discussion of amendments to Administrative Policy & Procedure: 1. 8610-525 – Use and Disclosure of Protected Health Information	Chairperson Finnila noted this agenda item was deferred to the January meeting.	**Policy 8610-525 – Use and Disclosure of Protected**	Ms. Donnellan

(PHI) for Fundraising		**Health Information (PHI) for Fundraising to be placed on the January agenda.**	
7. Oral Announcement of Items to be Discussed during Closed Session (Government Code Section 54957.7)	Chairperson Finnila made an oral announcement of the items listed on the agenda to be discussed during closed session which included approval of closed session minutes and three matters of potential litigation.		
8. Motion to go Into closed session	**It was moved by Director Mitchell and seconded by Director Schallock to go into closed session at 10:00 a.m. The motion passed unanimously.**		
9. Open Session	The committee returned to open session at 10:19 a.m. with attendance as listed above.		
10. Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)	Chairperson Finnila reported no action was taken in closed session.		
11. Date of Next Meeting	Chairperson Finnila stated the Committee's next meeting will be held on January 21, 2016.	**The committee's next meeting is scheduled for January 21, 2016.**	
12. Committee Communications	Committee Communications will be a standing agenda item to allow committee members an opportunity to comment on items not listed on the agenda.	**Committee communications will be placed as a standing agenda item.**	Ms. Donnellan
13. Adjournment	Chairperson Finnila adjourned the meeting at 10:20 a.m.		

AUDIT, COMPLIANCE AND ETHICS COMMITTEE
November 19, 2015

Administrative Policies & Procedures			
1. Employee Response to Government Investigation	8610-502	3 year review, revised	Pulled for further review
2. Facility Directory & Visiting Guidelines for Clergy	8610-527	3 year review, revised	Forward to BOD for approval with revisions
3. Compliance Program Generally, Introduction	8610-532	Revised	Forward to BOD for approval with revisions
4. Hiring and Employment; Screening Prospective Employees/Covered Contractors	8610-538	3 year review, revised	Forward to BOD for approval with revisions
5. Hiring and Employment; Duty to Report Suspected Misconduct/Potential Compliance Irregularity	8610-544	3 year review, revised	Forward to BOD for approval
6. Education & Training – Introduction & General Policies	8610-545	3 year review, revised	Pulled for further review
7. Education & Training – General Annual Compliance Training Program	8610-547	3 year review, revised	Forward to BOD for approval with revisions

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 4/03 **SUBJECT:** Facility Directory & Visiting Guidelines for Clergy

REVISION DATE: 1/06; 01/09; 03/11 **POLICY NUMBER:** 8610-527

Administrative Policies & Procedures Committee Approval:	**~~02/11~~10/15**
~~**Executive Council Approval:**~~	~~**02/11**~~
Audit, Compliance and Ethics Committee Approval Date(s):	**11/15**
~~**Professional Affairs Committee Approval:**~~	~~**03/11**~~
Board of Directors Approval:	**03/11**

A. **PURPOSE:**

1. To establish policy for **the Use and** ~~d~~**D**isclos**ure**~~ing~~ **of** Protected Health Information (PHI) to the clergy and to define guidelines for visiting clergy.

B. **DEFINITIONS:**

1. **Disclosure: the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.**
2. **Protected Health Information (PHI): individually identifiable health information transmitted or maintained in paper or electronic form that is created or received by Tri-City Healthcare District (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.**
3. **Research: a systematic investigation including research development, testing and evaluation designed to develop or contribute to generalizable knowledge.**
4. **Use: the sharing, application, utilization, examination or analysis of PHI within TCHD.**

C. **POLICY:**

1. **TCHD may Use and Disclose patient directory information to clergy where patients have been informed of such Use and Disclosure and have not objected or restricted such Use and Disclosure.**

D. **PROCEDURES:**

1. Disclosure of PHI
   a. In accordance with Health Insurance Portability and Account**ability**~~ing~~ Act (HIPAA), clergy, including Eucharistic Ministers, ~~will~~ **may** have access to a subset of PHI for all patients who have not opted out of the facility directory **for purposes of hospital visits.**.
   b. Clergy will be able to checkout from the ~~**Admitting/**~~ **EDRegistration (Sat/Sun) and the Information Desk (Monday thru Friday)** ~~Information Desk~~ a list of patients **(who have not objected or restricted Disclosure to clergy)** from the facility directory only for their specific religious affiliation if they have a badge. A ~~Tri-City Healthcare District~~**TCHD** badge will be required for all clergy requesting a list of patients.
   c. **The facility directory may include the following limited information:**
      i. **The patient's name**
      ii. **Location in the hospital**

iii. **General health conditions (that does not communicate specific medical information about the patient) and**
iv. **Religious affiliation**

d. **Registrars in the Admitting/Registration department** ~~Auxiliary at the Information Desk~~ will print, on request, the list of patients for the clergyperson's religious affiliation **for the Information Desk.** ~~only and complete the attached log~~

~~d.~~**e.** **ED Registration will generate the listing on weekends at 7am which will be available to be checked out.**~~.~~

f. When the clergy person is finished with the list, they must return it to the **Information Desk (Mon thru Fri) and ED Registration (Sat/Sun) where it will be logged in.**

~~e.~~**i.** **The patient listing** ~~**Admitting/Registration department** Information Desk to~~ **will** be ~~logged as returned and~~ disposed of in the confidential bin. In no cases is the list to leave **TCHD premises**~~the medical center~~.

~~f.~~**g.** The Director of the Chaplains or his/her designee will have access to all patients in the facility directory.

~~g.~~**h.** The Director of the Chaplains will **review the daily logs for confirmation that all have been received and will follow-up on any non-compliance with TCMC procedures.** ~~keep all~~ Clergy Logs **will be maintained** for a period of one **week** ~~year~~.

2. Guidelines for visiting clergy
   a. Community clergy and religious lay visitors are guided by the same policy as all visitors.
   b. It is expected that both clergy and lay visitors confine their visits in their official capacity to the members of their own congregation or group.
   c. The Hospital assists patients to observe the rites and practices of their religious groups in order to receive spiritual support and enhance their basic well-being.
      i. Rites and sacraments, such as baptism, communion, confession and the sacrament of the sick, should be given only at the patient's or the family's expressed wish, and should be administered by the patient's clergy in accordance with the patient's denomination or affiliation.
      ii. Staff in their various departments cooperate with patients who wish to participate in religious rites and observances, with the exception of anything in the attending physician's or nurse's view, would be detrimental to the patient.
      iii. Patients and those who administer such rites and sacraments are expected to cooperate with staff by coordinating their ministry with the other demands of the patient's treatment.

E. **FORM REFERENCED WHICH CAN BE LOCATED ON THE INTRANET:**
1. Clergy Log

F. **REFERENCES:**
1. ~~Federal Register~~ **42 CFR** section 164.510 (a) (1)

Date:_____

Tri-City Medical Center

Clergy Log

Name of Clergy	Religious Affiliation	Time list logged out	Time list returned

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: 5/12 **SUBJECT: Compliance Program Overview**

REVISION DATE: 12/12 **POLICY NUMBER:** 8750-532

Department Approval:	**~~3/15~~10/15**
Administrative Policies and Procedure Committee Approval:	**10/15**
Audit, Compliance and Ethics Committee Approval:	**~~4/15~~11/15**
Board of Directors Approval:	**4/15**

A. **PURPOSE:**

1. ~~This policy~~To provides an overview of Tri-City Healthcare District's (TCHD) Healthcare Compliance Program (Compliance Program) and the scope and objectives of the Compliance Program. As set forth below, the Compliance Program is comprised of TCHD's Code of Conduct, General Compliance Policies ("General Policies"), and Specific Compliance Policies (Specific Policies). The General and Specific Policies are referred to collectively as the "Policies").

B. **INTRODUCTION:**

1. TCHD owns and operates Tri-City Medical Center, a licensed 397-bed, general acute care hospital organized under the California Health & Safety Code § 32000, et. seq., which is governed by a publicly elected Board of Directors (the "Board"), that represents the residents of Carlsbad, Oceanside and Vista. As set forth in the Code of Conduct, TCHD's mission is to advance the health and wellness of those TCHD serves. An integral component of this mission is TCHD's unequivocal commitment to operating in compliance with applicable federal and state laws and regulations and to demonstrate good corporate citizenship. Both to reflect and achieve this commitment, TCHD has developed and implemented a formal Compliance Program, as described in this Policy.

C. **POLICIES:**

1. TCHD's Compliance Program supplements laws, regulations and other governmental rules. As a general matter, laws, regulations, and other governmental rules control the standards set forth in the Compliance Program unless the Compliance Program imposes stricter requirements than these authorities.
2. TCHD's Code of Conduct provides ethical and compliance guidance on a broad range of conduct. TCHD's Compliance Policies provide more detailed guidance regarding ethical and appropriate conduct, and are intended to be consistent with the general principles established in the Code of Conduct.

D. **SCOPE:**

1. Unless otherwise limited, the Compliance Program applies to:
   a. All members of the TCHD's Board of Directors and members of TCHD's committees;
   b. All employees, including officers and managers; ~~and~~
   c. All members of TCHD's Medical Staff and TCHD's allied health professionals, and their respective agents, including independent contractors who or which provide health care or related services in any of TCHD's facilities, including facilities that are owned and/or operated through joint ventures or under arrangements, for such time periods in which they furnish patient care or other related services at TCHD and/or with respect to the delivery of patient care or related services to TCHD or any of its patients;
   d. **All vendors;**
   e. **All volunteers**

E. **OBJECTIVES:**

1. The primary objective of TCHD's Compliance Program is to promote ethical and lawful conduct and to ensure compliance with both the letter and the spirit of applicable healthcare laws and regulations. TCHD's Compliance Program is modeled after the voluntary "Compliance Program Guidance for Hospitals," initially published by the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) in February 1998, and supplemented in the "OIG Supplemental Compliance Program Guidance for Hospitals" published in January 2005.
2. TCHD's Compliance Program includes the seven elements identified by the OIG as fundamental to an effective compliance program:
   a. Implement written policies and standards of conduct;
   b. Designate a Compliance Officer and establish an Internal Compliance Committee;
   c. Conduct effective training and education regarding policies, procedures and practices;
   d. Develop effective lines of communication regarding compliance concerns;
   e. Enforce policies and standards through well-publicized disciplinary guidelines;
   f. Conduct internal monitoring and audits; and
   g. Respond promptly to detected compliance irregularities and implementing appropriate corrective action.
3. A second, but equally important, objective is to ensure maintenance and enforcement of high standards of individual and organizational ethical and legal business practices throughout TCHD. This facilitates TCHD's ability to carry out its health care mission in a manner consistent with its values, principles and mission.

F. **COMPLIANCE PROGRAM COMPONENTS:**

1. **CODE OF CONDUCT:** TCHD has adopted a written Code of Conduct to govern TCHD's interactions including patients, their families, and providers of care, vendors, federal, state and local regulators, payors and the public in general. The Code of Conduct is a critical part of and is incorporated by reference into the Compliance Program.
2. **POLICIES:**
   a. TCHD has General and Specific Compliance Program policies. General policies address the fundamental requirements of an effective Compliance Program. Specific policies provide more detailed guidance on compliance with applicable federal and state laws and regulations.
   b. General policies include the following:
      i. Compliance Program Overview;
      ii. Compliance Officer;
      iii. Hiring and Employment;
      iv. Education and Training;
      v. Monitoring Compliance/Auditing and Reporting;
      vi. Communicating and Reporting Compliance Concerns;
      vii. Responding to Compliance Issues; and
      viii. Development, Revision and Approval of Standards of Conduct and Policies.
   c. Specific policies include, but are not limited to the following:
      i. Physician Arrangements;
      ii. Conflicts of Interest;
      iii. Document Retention; and
      iv. Gifts and Other Non-Monetary Compensation.
3. **RESOLUTION OF CONFLICTS**:
   a. Some of the policies that make up TCHD's Compliance Program summarize various government laws, regulations and guidelines. Such policies should not be read or used as substitutes for the actual laws or regulations to which they relate. In other words, TCHD's policies may supplement, and clarify, applicable laws and regulations.
   b. In the event of an inconsistency between any policy in the Compliance Program and applicable laws or regulations, you are to (1) follow the applicable law or regulation unless

TCHD's policy imposes stricter requirements and (2) report the inconsistency to the Compliance Officer.

c. If you are unsure as to the appropriate standard, do not guess. Ask a supervisor or the Compliance Officer.

G. **REFERENCES:**

1. **Compliance Program Guidance for Hospitals, published by U.S. Department of Health and Human Services, Office of Inspector General, February 1998.**
2. **Office of Inspector General Supplemental Compliance Program Guidance for Hospitals, January 2005.**

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: 05/12

SUBJECT: **Hiring and Employment; Screening for Eligibility of Prospective Employees/Covered Contractors**

REVISION DATE(S):

POLICY NUMBER: 8750-538

Department Approval Date(s):	**10/15**
Administrative Policies and Procedures Approval Date(s):	**10/15**
Audit, Compliance and Ethics Committee Approval Date(s):	**11/15**
Board of Directors Approval Date(s):	**05/12**

A. **PURPOSE:**

1. ~~This Policy~~**To** provide~~s~~ a statement of Tri-City Healthcare District's **(TCHD)** policy regarding screening prospective employees and Covered Contractors.

B. **SCREENING PROSPECTIVE EMPLOYEES/COVERED CONTRACTORS:**

1. Before hiring an individual as an employee or engaging a Covered Contractor (as defined in 8750-537):
   a. TCHD shall conduct a reference check of the individual/Covered Contractor.
   b. TCHD shall conduct a criminal background check of the individual/Covered Contractor.
   c. TCHD shall determine whether (1) the individual's/Covered Contractor's duties and obligations require a professional license, registration, or certification and if so, (2) whether such license, registration or certification is current and (3) whether any Adverse Action has been taken.
   d. TCHD shall verify the education or other credentials of the individual/Covered Contractor, as appropriate.
   e. TCHD shall screen the individual/Covered Contractor against the:
      i. **Office of Inspector General List of Excluded Individual/Entities** (OIG LEIE), and
      ii. **United States General Services Administration Excluded Parties List System** (GSA ~~EPLS~~**SAM)**
   f. TCHD shall require the individual/Covered Contractor to certify in writing that the individual/Covered Contractor:
      i. Has not been charged with or convicted of committing any criminal offense;
      ii. Does not have any charges pending for violating any criminal law;
      iii. Is not and has not been, at any time, debarred, excluded or otherwise been deemed ineligible for participation in Federal health care programs;
      iv. Has not received notice of debarment or exclusion or notice of an intention to debar or exclude;
      v. Is not the subject of or otherwise part of any ongoing federal or state investigation;
      vi. Possesses a current professional license, registration, or certification, as applicable, and is in good standing with, and has had no Adverse Action (as defined in **Administrative Policy** 8750-537**, Hiring and Employment Definitions)** taken by, any and all authorities granting such license, registration or certification as applicable; and
      vii. Has earned the degrees or other academic credentials, as represented to TCHD.

2. In the event that the individual/Covered Contractor cannot provide the certification set forth in Section ~~II.F~~**B.1** above, the individual/Covered Contractor shall provide complete and accurate information with respect to the matters at issue.

C. **HIRING:**

1. TCHD shall not hire an individual, or engage Covered Contractor if it knows that the employee/Covered Contractor:
   a. Has been convicted of, or charged with a criminal offense that has a bearing on the: ~~(a) trustworthiness of the individual/Covered Contractor, or (b) ability of the individual/Covered Contractor to perform relevant job responsibilities.~~
      i. **trustworthiness of the individual/Covered Contractor, or**
      ii. **ability of the individual/Covered Contractor to perform relevant job responsibilities.**
   b. Examples of criminal offenses that may meet this standard include, but are not limited to, homicide, kidnapping, false imprisonment, indecency, sexual assault, aggravated assault, child endangerment, aiding suicide, arson, robbery, fraud, and forgery.
   c. Has been convicted of committing a health care fraud-related criminal offense.
   d. Is currently debarred, excluded or otherwise ineligible for participation in Federal health care programs.
   e. Does not have a current professional license, registration or certification as applicable, and/or is not in good standing with, and/or has had Adverse Action taken by, the relevant state authorities that grant such license, registration or certification.
   f. Has not earned the degrees or other academic credentials relevant to the position.

D. **DOCUMENTATION:**

1. TCHD shall document compliance with 8750-538. For employees, such documentation shall be maintained in the employee's personnel file consistent with TCHD's document retention practices. For Covered Contractors, such documentation shall be maintained in the relevant Covered Contractor file consistent with TCHD's document retention practices.

E. **REFERENCES:**

1. **Administrative Policy 8750-537, Hiring and Employment: Definitions**
2. **Administrative Policy 8610-478, Authorization to Hire New Employees and Engage Consultants**

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: 05/12

SUBJECT: **Hiring and Employment; Duty to Report Suspected Misconduct/Potential Compliance Irregularity**

REVISION DATE(S): 12/12

POLICY NUMBER: 8750-544

Department Approval Date(s):	**10/15**
Administrative Policies and Procedures Approval Date(s):	**10/15**
Audit, Compliance and Ethics Committee Approval Date(s):	**11/15**
Board of Directors Approval Date(s):	**12/12**

A. **PURPOSE:**

1. ~~This policy~~**To** provide~~s (1)~~ a statement of the District's policy regarding the duty to report suspected misconduct or potential compliance irregularities.

B. **DUTY TO REPORT:**

1. Each District employee is required, as a condition of employment, to report suspected misconduct, including, but not limited to, any practice that the employee believes violates or may violate the District's Compliance Program or applicable laws, regulations, or other governmental rules.
2. The procedures for reporting suspected misconduct or potential compliance irregularities are set forth in **Administrative Policy** 8750-556, **Communicating and Reporting Compliance Concerns; Reporting of Suspected Misconduct/Potential Irregularities** and **Administrative Policy** 8750-557, **Communicating and Reporting Compliance Concerns; Confidential Reporting Line (Values Line)**. Note that suspected misconduct may be reported (free of charge) any day, any time, through the District's Confidential Reporting Line (Values Line) at 1-800-273-8452, or online at www.tricitymed.alertline.com. Note further that the District is committed to ensuring that there will be no retaliation or retribution against any employee for performing his or her duty to report pursuant to 8750-544 in good faith.
3. The procedures for responding to such reports are set forth in 8750-558 through 8750-561.
4. The procedures for determining the appropriate corrective action and/or discipline for employees who violate applicable laws, regulations, other governmental rules, or the District's Compliance Program or supervisors who fail to detect or report **such**~~suck~~ violations, are set forth in 8750-562.

C. **DOCUMENTATION:**

1. The documentation requirements for misconduct reports are set forth in 8750-556.

D. **REFERENCES:**

1. **Administrative Policy 8750-556, Communicating and Reporting Compliance Concerns; Reporting of Suspected Misconduct/Potential Irregularities**
2. **Administrative Policy 8750-557, Communicating and Reporting Compliance Concerns; Confidential Reporting Line (Values Line)**
3. **Administrative Policy 8750-558, Responding to Compliance Issues; Introduction; General Policies**
4. **Administrative Policy 8750-559, Responding to Compliance Issues; Introduction; Reports**

of Suspected Misconduct; Confidentiality

5. **Administrative Policy 8750-560, Responding to Compliance Issues; Reports of Suspected Misconduct; Non-Retaliation**
6. **Administrative Policy 8750-561, Responding to Compliance Issues; Reports of Suspected Misconduct; Investigation**
7. **Administrative Policy 8750-562, Responding to Compliance Issues; Remedial Action**

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: 05/12

SUBJECT: Education and Training; General Annual Compliance Training Program

REVISION DATE(S):

POLICY NUMBER: 8750-547

Department Approval Date(s):	**10/15**
Administrative Policies and Procedures Approval Date(s):	**10/15**
Audit, Compliance and Ethics Committee Approval Date(s):	**11/15**
Board of Directors Approval Date(s):	**05/12**

A. **PURPOSE:**

1. ~~Policy 8750-547 provides (1)~~ **To provide** a statement of ~~the District's~~**Tri-City Healthcare District's (TCHD)** policies regarding the general annual education and training program for all employees, Covered Contractors and Directors ("General Compliance Training Program").

B. **SCHEDULE:**

1. ~~The District~~**TCHD** shall provide a General Compliance Training Program to all employees and Members of the Board of Directors annually.
2. New employees and Covered Contractors shall be trained pursuant to the General Compliance Training Program within 30 days of their date of hire or contract.

C. **PARTICIPATION:**

1. All Members of the Board of Directors, employees, and Covered Contractors shall participate in the ~~District's~~ **TCHD's** General Compliance Training Program. For employees, such participation shall be a condition of employment.
2. Participation shall be documented, and, for employees, will be a critical employee performance evaluation factor.
3. Failure to participate will be considered a violation of the Compliance Program and will result in corrective and/or disciplinary action, as appropriate. The procedures for imposing corrective and/or disciplinary action are set forth in 8750-562 – **Responding to Compliance Issues; Remedial Action**.
4. The Chief Compliance Officer shall determine whether any Covered Contractor does not have to participate in the General Compliance Training Program

D. **DELIVERY:**

1. The General Compliance Training Program may be presented in any manner the Chief Compliance Officer determines to be effective. This may include, for example, in-person training, video conference training, computerized training or telephone conference training.

E. **CONTENT DEVELOPMENT, IMPLEMENTATION AND REVIEW:**

1. The Chief Compliance Officer, with the assistance of the **Organizational** Compliance Committee and/or legal counsel (as necessary), shall be responsible for developing, implementing, regularly reviewing (at least annually), and updating the General Compliance Training Program. The General Compliance Training Program shall cover at least the following topics.
   a. An overview of ~~the District's~~**TCHD's** Compliance Program (with a focus on any modifications or additions since the previous General Compliance Training Program).

b. ~~The District's~~**TCHD's** strong and continuing commitment to compliance with all applicable laws and regulations (with a focus on new legal regulatory developments).
c. A discussion of the then current Compliance Program Code of Conduct and Policies, the requirement that they be followed, and the consequences if they are not.
d. The importance of asking questions and seeking the guidance of the Chief Compliance Officer when in doubt about the propriety of a particular practice.
e. The duty to report any suspected misconduct or practice or activity by a ~~District~~ **TCHD** director, employee, or Covered Contractor that the employee believes violates or may violate any laws, regulations, or ~~the District's~~**TCHD's** Compliance Program Code of Conduct or Policies.
f. The methods that can be used to communicate reports of any suspected misconduct or practice that the employee believes violates or may violate any laws, regulations, or Compliance Program Code of Conduct or Policies.
g. ~~The District's~~**TCHD's** policy of striving to protect the identity of employees who report a practice that the employee believes violates or may violate any laws, regulations, or Compliance Program Code of Conduct or Policies, as set forth in 8750-559 – **Responding to Compliance Issues – Introduction Reports of Suspected Misconduct; Confidentiality**.
h. ~~The District's~~**TCHD's** policy of non-retaliation and non-retribution with respect to an employee who, in good faith, reports a practice that the employee believes violates or may violate any laws, regulations, or Compliance Program Code of Conduct or Policies (where the employee was not involved in the practice at issue), as set forth in 8750-560 – **Responding to Compliance Issues; Introduction; Reports of Suspected Misconduct; Non-Retaliation**.
i. An overview of government and private payer reimbursement.
j. General prohibitions on paying or accepting kickbacks, gifts, or other things of value in exchange for referrals.
k. The referral and billing prohibitions of the Stark Law.
l. The duty to return and report overpayments.
m. Proper documentation and the integrity of medical records.
n. Proper authorization to provide inpatient services.
o. Patient rights and education.
p. Medicare conditions of participation.
q. **Deficit Reduction Act of 2005 and/or State Federal False Claims Act.**

F. **DOCUMENTATION:**

1. ~~The District~~**TCHD** shall maintain, consistent with its document retention policies the following in the Compliance Program files:
   a. All materials used in connection with the General Compliance Training Program (e.g., handouts, presentation outlines and videotapes); and
   b. Sign-in sheets, attendance charts and/or any other documents used to reflect and confirm participation in the General Compliance Training Program.

G. **REFERENCES:**

1. **Administrative Policy 8750-559 - Responding to Compliance Issues – Introduction Reports of Suspected Misconduct; Confidentiality**
2. **Administrative Policy 8750-560 - Responding to Compliance Issues; Introduction; Reports of Suspected Misconduct; Non-Retaliation**
3. **Administrative Policy 8750-562 - Responding to Compliance Issues; Remedial Action.**
4. **Deficit Reduction Act of 2005; State Federal False Claims Act**

TCHD COMPLIANCE DEPARTMENT

TRI-CITY HEALTHCARE DISTRICT

Organizational Compliance Committee Charter

Purpose and Role

The Organizational Compliance Committee (the "Committee") provides oversight and guidance to the Tri-City Healthcare District and assists the Chief Compliance Officer in the implementation and operation of the Compliance Program. The Committee shall serve as a working sub-committee of the Tri-City Healthcare District ("TCHD") Executive Compliance Committee (the "ECC"). In its role, the Committee shall, with the Chief Compliance Officer,

- take actions necessary to facilitate the development, implementation, and operation of an effective compliance program, consistent with TCHD standards, and federal, state, and local regulations;
- implement standards and processes at the direction of the ECC to further operations of a consistent Compliance Program throughout TCHD;
- promote an organizational culture within TCHD that encourages law abiding and ethical conduct; and
- provide feedback to the ECC about the operation of the Compliance Program.

Membership

Membership on the Committee shall be appointed from time to time by the Chief Compliance Officer and shall include at a minimum the following individuals:

- Chief Compliance Officer (Chair)
- Sr. Director, Revenue / Integrity
- Sr. Director, Clinical Risk Management, Patient Safety & QIPI
- Sr. Human Resources Workforce Specialist
- Privacy Officer
- Physician Leader
- Director, Education & Clinical Informatics & Staffing
- Director, Medical Records
- Legal Counsel
- Sr. Director, Clinical Efficiency & Alternative Care
- Sr. VP of IT
- Sr. Director, Ancillary Services
- Director of Supply Chain Management
- Patient Safety Officer
- Director, Regulatory Compliance, Clinical Quality & Infection Control
- Director, Home Health
- Ad hoc Guests

Committee Members are appointed to bring representative perspectives to the Compliance Program planning processes and also to facilitate implementation and communication within their respective areas of responsibility. All Members of the Committee are voting Members for the purpose of any actions taken by the Committee. The Chief Compliance Officer shall serve

as chair of the Committee, and shall be responsible for establishing agendas for committee meetings.

Meetings

The Committee shall meet four times per year, or more frequently at the request of the Chief Compliance Officer. Discussions and actions taken by the Committee shall be reflected in recorded minutes which shall be maintained by the Chief Compliance Officer and reported to the ECC. Attendance by Members and staff of the Committee shall be recorded in the minutes. The presence of sixty percent (60%) of the Committee Members shall constitute a quorum for purposes of taking action. Membership of the Committee shall not be substituted.

Responsibilities

- Supports a culture of compliance throughout the organization
- Promotes an environment that encourages reporting of compliance concerns and does not tolerate retaliatory behavior
- Provides advice and guidance to the Chief Compliance Officer on the implementation and operation of the Compliance Program
- Evaluates compliance processes to assure that they are properly designed and implemented to facilitate effective integration with existing operations
- Oversees completion of the annual TCHD Compliance Program Plan, monitors progress, and provides support as needed to facilitate completion of activities outlined on the workplan
- Allocates resources, when necessary, to mitigate activities determined to be a high compliance risk
- Participates in compliance risk assessment activities and provides input into prioritization of issues identified
- Reviews training program content and completion statistics
- Receives and reviews results of compliance auditing and monitoring activities
- Receives and reviews a summary report of confidential reporting mechanism activities throughout the organization
- Assists the Chief Compliance Officer in assuring that necessary procedures are in place to facilitate adherence to legal and regulatory requirements as outlined in new and revised compliance policies and procedures
- Reviews reports of the overall effectiveness of the Compliance Program and makes recommendations to the ECC for improvements to the Compliance Program
- Advises the ECC on new and emerging compliance risks
- Ensures that Members maintain accountability for compliance activities within their areas of responsibility, and support the Chief Compliance Officer in the implementation and operation of the compliance program
- Incorporate systems and processes to promote effective clinical compliance

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

October 29, 2015 – 1:30 o'clock p.m.
Classroom 6 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at Tri-City Medical Center, 4002 Vista Way, Oceanside, California at 1:30 p.m. on October 29, 2015.

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

Director James Dagostino, DPT, PT
Director Ramona Finnila
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry Schallock

Also present were:

Greg Moser, General Legal Counsel
Tim Moran, Chief Executive Officer
Kapua Conley, Chief Operating Officer
Steve Dietlin, Chief Financial Officer
Cheryle Bernard-Shaw, Chief Compliance Officer
Dr. Gene Ma, Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1. The Board Chairman, Director Schallock, called the meeting to order at 1:30 p.m. in Classroom 6 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.

2. Approval of Agenda

   Mr. Tim Moran, CEO requested agenda item 17 a. Consideration to approve Primary Care Provider (PCP) Agreement be pulled from the agenda pending review of additional information.

   Chairman Schallock requested agenda item 20 (1) F. 1) c. Division of General & Vascular Surgery Rules & Regulations be pulled for discussion.

   It was moved by Director Dagostino to approve the agenda as amended. Director Nygaard seconded the motion. The motion passed unanimously (7-0).

3. Public Comments – Announcement

Chairman Schallock read the Public Comments section listed on the October 29, 2015 Regular Board of Directors Meeting Agenda.

There were no public comments.

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

Chairman Schallock deferred this item to the Board's General Counsel. General Counsel, Mr. Greg Moser made an oral announcement of the items listed on the October 29, 2015 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Labor Negotiators; one Report Involving Trade Secrets; Conference with Legal Counsel regarding two matters of Potential Litigation; Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees; Conference with Legal Counsel regarding two matters of Existing Litigation, Public Employee Performance Evaluation of the General Counsel; one Conference with Real Property Negotiators regarding property at 4120 Waring Road and Approval of Closed Session Minutes.

5. Motion to go into Closed Session

It was moved by Director Dagostino and seconded by Director Kellett to go into closed session. The motion passed unanimously (7-0).

6. The Board adjourned to Closed Session at 1:35 p.m.

8. At 3:40 p.m. in Assembly Rooms 1, 2 and 3, Chairman Schallock announced that the Board was back in Open Session.

The following Board members were present:

Director James Dagostino, DPT, PT
Director Ramona Finnila
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Greg, General Legal Counsel
Tim Moran, Chief Executive Officer
Kapua Conley, Chief Operations Officer
Steve Dietlin, Chief Financial Officer
Sharon Schultz, RN, Chief Nurse Executive
Esther Beverly, VP, Human Resources
Cheryle Bernard-Shaw, Chief Compliance Officer
Dr. Gene Ma, Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

9. Chairman Schallock stated no action was taken in closed session, however the Board will be returning to closed session at the conclusion of this meeting to conduct unfinished business.

10. Director Kellett led the Pledge of Allegiance.

Chairman Schallock noted the following items were pulled from the agenda:

- 17 a. Consideration to approve Primary Care Provider (PCP) Agreement
- 20(4) F. 1) c. Rules & Regulations – Division of General & Vascular Surgery (for discussion)

11. Chairman Schallock read the Public Comments section of the Agenda, noting members of the public may speak immediately following Agenda Item Number 24. Chairman Schallock asked that speakers be concise and adhere to the three-minute rule.

12. Special Recognitions:

(1) James C. Esch, M.D.
(2) Terry A. Haas, M.D.
(3) Jeffrey O. Leach, M.D.
(4) Jon A. LeLevier, M.D.
(5) Martin M. Nielsen, M.D.

Chairman Schallock stated we would like to honor five of our physicians who have either just retired or are planning to retire. Chairman Schallock stated these five physicians have nearly 200 years of medical service among them and we wanted to recognize their years of service to Tri-City Medical Center, to their patients and to the community they serve.

Chairman Schallock began by recognizing Dr. James Esch, an orthopedic surgeon and a 45 year member of our Medical Staff who is well recognized within the orthopedic surgical field.

Secondly, Chairman Schallock recognized Dr. Terry Haas, an internist and primary care physician who has been a member of the Medical Staff for 40 years and has been extremely active in Medical Staff and Board committees.

Next, Chairman Schallock recognized Dr. Jeffrey Leach, an internist and family practice physician who has been on the TCHD Medical Staff since 1978 and has also been involved in multiple committees over the years.

Chairman Schallock also recognized Dr. Jon LeLevier, a family practice physician who has been on staff since 1980 and who has also been involved in multiple Medical Staff committees.

Lastly, Chairman Schallock recognized Dr. Martin Nielsen, a Pulmonologist who has been on staff since 1978 and served on multiple Medical Staff and hospital committees over the years.

9. Chairman Schallock stated no action was taken in closed session, however the Board will be returning to closed session at the conclusion of this meeting to conduct unfinished business.

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Chairman Schallock stated we would like to honor five of our physicians who have either just retired or are planning to retire. Chairman Schallock stated these five physicians have nearly 200 years of medical service among them and we wanted to recognize their years of service to Tri-City Medical Center, to their patients and to the community they serve.

Chairman Schallock began by recognizing Dr. James Esch, an orthopedic surgeon and a 45 year member of our Medical Staff and is well recognized within the orthopedic surgical field.

Secondly, Chairman Schallock recognized Dr. Terry Haas, an internist and primary care physician who has been a member of the Medical Staff for 40 years and has been extremely active in Medical Staff and Board committees.

Next, Chairman Schallock recognized Dr. Jeffrey Leach, an internist and family practice physician who has been on the TCHD Medical Staff since 1978 and has also been involved in multiple committees over the years.

Chairman Schallock also recognized Dr. Jon LeLevier, a family practice physician who has been on staff since 1980 and who has also been involved in multiple Medical Staff committees.

Lastly, Chairman Schallock recognized Dr. Martin Nielsen, a Pulmonologist who has been on staff since 1978 and served on multiple Medical Staff and hospital committees over the years.

Chairman Schallock presented each of the five physicians with a plaque in appreciation for their dedication and years of service on the TCHD Medical Staff. Chairman Schallock stated that all five physicians have provided such great service to the people in the community and will be sorely missed.

Dr. Gene Ma, Chief of Staff stated he has had the pleasure of working with each of these physicians for the past 15-16 years and the impression that these physicians have left on their patients cannot be replaced. On behalf of the Medical Staff, Dr. Ma extended his appreciation for all they have given to Tri-City.

Director Reno stated these five physicians are Tri-City and San Diego County's finest and we have been extremely fortunate to have had these physicians in our community and at our hospital.

Director Dagostino stated he has had the good fortune to work with these fine physicians and they are the gems of our community.

Director Kellett stated he personally joined the Medical Staff in 1973 and these physicians and the Tri-City Medical Staff in general confirmed for him that he made the right decision to practice here as he observed the quality exhibited by our physicians and it was clear that the community was very well cared for.

No action was taken.

13. Introduction of Xiangli Li, M.D. – North County Internal Medicine Group

Mr. Wayne Knight, Senior Vice President stated last May the Board approved the recruitment of Dr. Xiangli Li and he is honored to introduce her today. Mr. Knight briefly summarized Dr. Li's education and training and invited Dr. Jeffrey Leach to comment as well.

Dr. Jeffrey Leach stated Dr. Li is extremely well educated and he feels very fortunate to have recruited her. Dr. Leach stated he is confident Dr. Li will take good care of our patients.

Chairman Schallock invited Dr. Li to introduce herself. Dr. Li expressed her appreciation for the opportunity to serve the community and join the Tri-City Medical Staff. She stated she is looking forward to serving our community for many years to come.

No action taken.

14. Report from TCHD Foundation – Glen Newhart, Chief Development Officer

Mr. Glen Newhart reported we have completed a sample Labor & Delivery room as part of the major foundation project. Mr. Newhart presented a "before and after" remodel slide. He explained the room was designed as a relaxing and soothing environment and all labor and delivery rooms will be renovated in a similar fashion.

Mr. Newhart also presented a "before and after" remodel slide of the private NICU suite. He explained the rooms will be much quieter and allow the mother to bond with the baby and there will be 13 private NICU suites renovated in a similar fashion. Mr.

Newhart further explained that the Foundation will allow the donors to select photos and personalize the rooms with pictures, etc.

Directors were impressed with the look of the new rooms and pleased that we are on the cutting edge of technology.

Mr. Newhart stated next year is the 30th anniversary of the NICU and a reunion is scheduled where we will be able to share these new rooms with the community.

Lastly, Mr. Newhart stated the Baile de Esperanza (also known as the Diamond Ball) is scheduled for Saturday, November 7th. He noted this is the 35th anniversary of the Baile and the Foundation is honoring the first event by reverting back to the original name of the event - Baile de Esperanza (Dance of Hope) which is fitting in light of the fact that proceeds are being used for the NICU and Labor & Delivery remodel.

No action was taken.

15. Report from Chief Executive Officer

Mr. Tim Moran, Chief Executive Officer expressed his appreciation to the Board for authorizing the NICU and Labor & Delivery remodel several months ago and stated it will make an incredible difference for our patients. He also thanked Mr. Newhart, the Foundation and the Corporate Council for their strong leadership on this endeavor.

Mr. Moran stated that just as the Labor & Delivery and NICU remodel is intended to help provide a place that will respect the patient's dignity and privacy, our Campus Development Plan will be developed similarly. He stated we have had initial meetings with the architect and in the coming months we will hear some ideas to shape up our campus, improve our Emergency Room and provide for a longer term future.

Mr. Moran explained there are two organizations that are Gold Standard when you operate a hospital and those are the Joint Commission and the Leap Frog organizations. Mr. Moran stated he is extremely happy to share that we were recently advised by the Leap Frog group for the fifth straight year we have an A rating for patient safety and quality, one of only five hospitals in San Diego County.

Secondly, Mr. Moran stated we recently spent an entire week with the Joint Commission and they commented that they learned some things from our organization that they will share with other organizations around the United States. Mr. Moran invited Ms. Sharon Schultz, CNE to elaborate on these two achievements.

Ms. Sharon Schultz reported the Joint Commission is looking for high reliability in the organization where you sustain your practices and processes at a very high level over a long period of time. She explained that one of the elements they really looked at was our quality improvement for what we sustained. Ms. Schultz stated two areas which we are extremely proud of is our central line infection rates where we have had some areas that haven't had those infections in many years, and the second is our Rapid Response Team which is comprised of ICU nurses and the Respiratory Therapist Team. Ms. Schultz explained that not only does the Rapid Response Team go to patients when they are called but also proactively look at patient's lab work and testing that has come back and see what can be done do to prevent something from happening to that patient that day. Ms. Schultz stated we provide a safe passage

through Tri-City Medical Center and we hope our patients and community will see that we are a quality, patient centric organization.

Ms. Schultz echoed Mr. Moran's sentiments in recognizing our staff and physicians. She stated this was one of the best surveys we have had and the role they provide in providing our patient's with safe passage is commendable. In closing, Ms. Schultz commented on the Leap Frog A safety rating.

Directors individually recognized employees and the Medical Staff for their hard work and working so diligently and loyally to bring to this hospital an "A" rating and excellent quality care.

Mr. Moran also expressed his appreciation to Dr. Ma for his hard work with the Medical Staff.

Mr. Moran recognized Mr. Chris Miechowski and the Engineering staff for the excellent job they do in keeping an aging facility such as ours operational. Mr. Moran stated we received an excellent set of findings from the surveyor in our Environment of Care area.

Mr. Moran expressed his appreciation to the Board for their direction in moving forward with affiliation with the UC San Diego Health System. He stated that he was gratified that it was a unanimous decision and is pleased with the response we have had from the community on that decision. Mr. Moran stated he will provide periodic updates to the Board in a similar fashion as the Strategic Plan so that we can get a glimpse of the items we are working on and the progress that is being made.

Mr. Moran reported we recently had our Employee Awards Dinner and there was a family feeling from those who have been on staff a long period of time. Mr. Moran shared some clips of the employee comments shared at the Awards Dinner.

Mr. Moran acknowledged the Procopio law firm as a major sponsor at the Baile de Esperanza and expressed his appreciation to Mr. Moser and his team for their loyal support.

Lastly, Mr. Moran commented that our second Annual Report to the community will be out soon. He stated the report will reflect some of the direction we are taking, how many lives we are impacting and what we are doing on the Board's commitment in keeping Tri-City independent and strong.

No action was taken.

16. Report from Chief Financial Officer

Mr. Steve Dietlin reported on the two months of FY 2016 ended September 30, 2015 as follows:

- Net Operating Revenue – $83,908
- Operating Expense – $83,421
- EROE - $1,656
- EBITDA – $5,220

Other Key Indicators for the current year driving those results included the following:

- Average Daily Census – 189
- Adjusted Patient Days – 28,275
- Surgery Cases – 1,690
- Deliveries 681
- ED visits – 17,006

Mr. Dietlin also reported on the current month as follows:

- Operating Revenue - $27,666
- Operating Expense - $27,900
- EBITDA - $1,357
- EROE - $182

Mr. Dietlin reported on the following indicators for FY16 Avg:

- Net Patient Accounts Receivable - $41.1
- Days in Net Accounts Receivable - 46.0

Mr. Dietlin also presented graphs which reflected trends in Net Days in Patient Accounts Receivable, Average Daily Census excluding Newborns, Adjusted Patient Days, and Emergency Department Visits.

Mr. Dietlin stated that he expects Days in Net Accounts Receivable to increase on a temporary basis due to the implementation of ICD 10, however he is pleased to report the District is submitting clean claims and the denial rate has not increased.

Director Finnila commended Mr. Dietlin on the tracking of financials and moving the District forward in a positive direction.

No action was taken.

17. New Business

a. Consideration to approve Primary Care Provider (PCP) Agreement

Per discussion at the beginning of today's meeting, consideration of this agenda item is deferred pending additional information.

b. Consideration of appointment of Chief Executive Officer and Chief Operating Officer as managers for Tri-City Real Estate Holding & Management Company, LLC

It was moved by Director Dagostino that the TCHD Board of Directors: (1) appoint the Chief Executive Officer of TCHD (Tim Moran) and the Chief Operating Officer of TCHD (Kapua Conley) to serve as managers of the Company, and (2) ratify the appointment of the Chief Financial Officer of TCHD (Steve Dietlin) to serve as manager of the Company. Director Finnila seconded the motion.

Mr. Wayne Knight explained this item is being considered today to update the Officers in the Tri-City Real Estate Holding & Management Company, LLC. He explained this is simply a "housekeeping" item due to a change in staff.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

18. Old Business – None

19. Chief of Staff

a. Consideration of October 2015 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on October 26, 2015.

Dr. Ma stated the credentials are being brought forward today as listed for consideration.

It was moved by Director Kellett to approve the October 2015 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on October 26, 2015. Director Finnila seconded the motion.

Director Dagostino stated the credentials report is excellent and he is impressed with our physician screening process in that it brings the quality of physicians to us that we witnessed earlier this afternoon.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

b. Consideration of October 2015 Recredentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on October 26, 2015.

It was moved by Director Finnila to approve the October 2015 Recredentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on October 26, 2015. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard Reno and Schallock**

NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

20. Consent Calendar

Chairman Schallock noted agenda item 20 (1) F. 1) c. Division of General & Vascular Surgery Rules & Regulations was pulled for discussion previously.

It was moved by Director Finnila to approve the Consent Agenda. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

It was moved by Director Reno to pull items 20 (1). D. Finance, Operations & Planning Committee, E. Professional Affairs Committee and G. Audit, Compliance & Ethics Committee Director Kellett seconded the motion

The vote on the main motion minus the items pulled was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

21. Discussion of items pulled from Consent Agenda

Director Reno who pulled item 20 D. (1) Finance, Operations & Planning Committee stated the minutes reflect we have a new Medical Director of the Surgical Service Department. She suggested a report be given at next month's meeting to perhaps introduce and discuss the role of the Medical Director so that the community is informed.

It was moved by Director Kellett to approve item 20 D. (1) Finance, Operations & Planning Committee. Director Kellett seconded the motion.

The vote on the main motion minus the items pulled was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

Director Reno also commented on the Finance Operations & Planning Committee Work Plan and explained it was set up as an oversight of projects and she does not want to see the Work Plan abolished.

Director Reno who pulled pulled 21 (1) E. Professional Affairs Committee requested clarification on the deletion of the Emergency Operations Manual. Ms. Sharon Schultz explained the policies contained in the Emergency Operations Manual are being combined with the HICS Emergency Plan and the policies are simply moved from one area to another. Ms. Schultz stated if any Board member is interested in reviewing the HICS Emergency Plan manual it can be made available in the Administrative offices.

It was moved by Director Dagostino to approve the Professional Affairs Committee policies. Director Nygaard seconded the motion.

The vote on the main motion minus the items pulled was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

Mr. Moser explained item 20 (1) F. 1) c. Division of General & Vascular Surgery Rules & Regulations was pulled to recommend a change that is consistent with the other Rules & Regulations that the Governance Committee has previously approved. Mr. Moser suggested the language read as follows: "By virtue of appointment to the Medical Staff ***and as approved by the Board*** all physicians are authorized to order diagnostic and therapeutic tests…". Mr. Moser stated this language makes it consistent with the intent of the Medical Staff and Dr. Ma is in agreement with this language.

It was moved by Director Dagostino to approve the Division of General & Vascular Surgery Rules & Regulations. Director Kellett seconded the motion

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

It was moved by Director Dagostino to approve the amendment to the Division of General & Vascular Surgery Rules & Regulations as described. Director Kellett seconded the motion.

The vote on the amendment was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

Director Reno who pulled item 20 (1) G. the Audit, Compliance & Ethics Committee requested clarification of the discussion related to the selection of an Auditor for FY 2016. Chairman Schallock clarified the intent is to interview the new potential partner and then it will come to the Board.

Director Finnila requested that Mr. Dietlin, CFO provide an overview of the process that the Audit Committee went through to arrive at that decision.

Mr. Dietlin explained that the committee had extensive discussion and direction from the committee was to negotiate with Moss Adams for an additional one-year and based on best practice request a partner change in that negotiation. Mr. Dietlin explained that when you are with a firm for an extended period of time, it is best practice to rotate partners and get a fresh set of eyes. He reiterated Chairman Schallock's comments that the direction of the committee was to seek a one year extension with Moss Adams with a partner rotation and if at that time the Committee would recommend whether to go with Moss Adams or go out for an RFP. Director Reno asked additional questions that were answered by Mr. Dietlin and Chairman Schallock. Mr. Dietlin reiterated it is best practice to rotate partners and there is no dissatisfaction with the current partner that we are aware of.

It was moved by Director Reno to approve item 20 (1) G. Audit, Compliance & Ethics Committee. Director Dagostino seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

22. Reports (Discussion by exception only)

23. Legislative Update

Chairman Schallock reported congress is in session and the house has passed a budget to take it up to 2017. He stated the American Hospital Association has not been pleased with some of the changes in the budget related to health care and reimbursement. Chairman Schallock also commented that sequestration has been added on for another year and there is no cost of living increase to Medicare B which would raise the healthcare component significantly for some individuals.

24. Comments by members of the Public

Chairman Schallock recognized Ms. Karen Unger, Employee Staffing Resource Representative and SEIU/UHW member. Ms. Unger commented that quality patient care and safety should be the top priority of Tri-City Medical Center.

Chairman Schallock recognized Ms. Rena Morraco. Ms. Morraco commented on our Neonatal and Labor & Delivery renovation and the positive impact the renovation will have with our patients.

Ms. Morraco also commented on rumors of jobs being outsourced. She urged the District to use utilize their dollars effectively and wisely and keep jobs here.

Chairman Schallock recognized Mr. Victor Roy. Mr. Roy expressed his appreciation for helping reposition the state of the art exercise equipment in Club 55 previously located in the Nifty after Fifty locations.

Secondly, Mr. Roy stated he has had three very positive personal experiences of healthcare here at Tri-City and is a Champion for Tri-City.

Lastly, Mr. Roy stated he is an activist in the community and invited the public to attend the City of Oceanside's Parks & Recreation Fall Festival Chili Cook Off on November 7th with live music and entertainment.

Chairman Schallock recognized Ms. Kimberly Stone however she passed on speaking today.

25. Additional Comments by Chief Executive Officer

Mr. Moran did not have any additional comments.

26. Board Communications

Director Dagostino stated the Joint Commission had very positive comments about our employees and facility during their recent visit and he was fortunate to have been able to hear the comments first-hand. He expressed his appreciation to all for a job well done.

Director Finnila stated this Board puts patient care as their number one priority which is demonstrated by our recent Leap Frog A safety rating and other recognitions that we have received in various areas.

Director Kellett commended the physicians and staff on our excellent Joint Commission survey. He also commented that across the board both retired honorees and employees have one common thread – they like being here.

Lastly Director Kellett stated he is pleased with the Board's decision to affiliate with UCSD.

Director Reno stated we have seen significant changes this past year including the loss of five of our outstanding physicians who were recognized today.

Secondly, Director Reno commented on the exciting technological advances we have seen coming forward in the NICU and Labor & Delivery remodel.

Director Reno stated the greatest change is our recent collaboration with UCSD. She stated that after much deliberation the right choice was made and the community will benefit from this collaboration.

Lastly, Director Reno expressed her appreciation to all for an excellent Joint Commission survey.

Director Mitchell expressed her appreciation to staff and physicians for a job well done both with the Joint Commission and our A rating in Leap Frog.

Director Mitchell also congratulated Drs. Esch, Haas, Leach, LeLevia and Nielsen on their retirement.

Director Nygaard expressed her appreciation to everyone for working together to strengthen the Tri-City family.

27. Report from Chairperson

Chairman Schallock stated he has heard many favorable comments regarding the recent UCSD Affiliation from both the community and staff and it is gratifying to have had that feedback.

Chairman Schallock encouraged everyone to come out for the Oceanside Turkey Trot on Thanksgiving morning.

Chairman Schallock stated both he and Director Reno recently attended an "Old Timers" luncheon in which three of our retired nurses attended who are in their 90's. He stated it was a very touching event.

Lastly, Chairman Schallock wished everyone a happy Thanksgiving.

28. Oral Announcement of Items to be Discussion in Closed Session

Chairman Schallock reported the Board would be returning to Closed Session to complete unfinished closed session business.

29. Motion to return to Closed Session.

Chairman Schallock adjourned the meeting to closed session at 5:09 p.m.

30. Open Session

At 6:30 p.m. Chairman Schallock reported the Board was back in open session. All Board members were present.

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

Chairperson Schallock reported no action was taken in closed session.

32. There being no further business Chairman Schallock adjourned the meeting at 6:30 p.m.

_____
Larry Schallock, Chairman

ATTEST:

_____
Ramona Finnila, Secretary

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

November 5, 2015 – 10:00 o'clock a.m.
Assembly Rooms 2&3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 10:00 a.m. on November 5, 2015.

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

Director Jim Dagostino, DPT, PT
Director Ramona Finnila
Director Cyril F. Kellett, MD
Director Laura Mitchell
Director Larry Schallock

Absent were Directors Nygaard and Reno

Also present were:

Greta Procter, General Legal Counsel
Tim Moran, Chief Executive Officer
Kapua Conley, Chief Operating Officer
Steve Dietlin, Chief Financial Officer
Sharon Schultz, Chief Nurse Executive
Esther Beverly, VP/Human Resources
David Bennett, Chief Marketing Officer
Wayne Knight, SVP
Glen Newhart, Chief Development Officer
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Schallock, called the meeting to order at 10:00 a.m. in Assembly Rooms 2&3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Schallock led the Pledge of Allegiance.

2. Approval of agenda.

   It was moved by Director Dagostino to approve the agenda as presented. Director Finnila seconded the motion. The motion passed unanimously (5-0-2) with Directors Nygaard and Reno absent.

3. Public Comments – Announcement

   Chairman Schallock read the Public Comments section listed on the Board Agenda. There were no public comments.

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

   Chairman Schallock deferred this item to the Board's General Counsel. General Counsel, Ms. Greta Procter, made an oral announcement of items listed on the

November 5, 2015 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees and two Reports Involving Trade Secrets with disclosure dates of November 5, 2015 and "various".

5. Motion to go into Closed Session

It was moved by Director Dagostino and seconded by Director Finnila to go into Closed Session. The motion passed unanimously 5-0-2) with Directors Nygaard and Reno absent.

6. Chairman Schallock adjourned the meeting to Closed Session at 10:05 a.m.

7. The Board returned to Open Session at 2:21 p.m. with attendance as listed above.

8. Open Session

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

Chairman Schallock reported no action had been taken in closed session.

10. Consideration to approve Primary Care Provider (PCP) Agreement

It was moved by Director Dagostino that the TCHD Board of Directors recommend approval of the following subject to final legal and compliance review:

Formation, ownership, and management by TCHD of primary care physicians clinic (PCP Clinic) to be operated in Vista, California, for a period of five years, based on financial and other terms as described in the Oct 20, 2015 PowerPoint Presentation including:

1. **Execution of a Professional Services Agreement with Clancy Medical Group, Inc., for a period of five years;**

2. **Entering into an operating lease for equipment and furniture for the five -year period;**

3. **Funding a capital expenditure not to exceed $327,290 for architectural design, entitlements and permits, construction of tenant improvements and start-up for operation of the PCP Clinic; and**

4. **Leasing 3,140 square feet at 2375 South Melrose, Vista, CA; and Execution and delivery of all agreements and documents necessary or advisable to consummate the foregoing transactions.**

Director Finnila seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Mitchell, Kellett and Schallock**
NOES:	**Directors:**	**None**

ABSTAIN: Directors: None
ABSENT: Directors: Nygaard, Reno

9. There being no further business, Chairman Schallock adjourned the meeting at 2:24 p.m.

_____
Larry W. Schallock
Chairman

ATTEST:

_____
Ramona Finnila
Secretary

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

November 12, 2015 10:00 o'clock a.m.
Oceanside Room– Veterans Association of North County
1617 Mission Avenue, Oceanside, CA 92058

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 1617 Mission Avenue at 10:00 a.m. on November 12, 2015.

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

Director Jim Dagostino, DPT, PT
Director Ramona Finnila
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie Reno
Director Larry Schallock

Also present were:

Tim Moran, Chief Executive Officer
Steve Dietlin, Chief Financial Officer
Kapua Conley, Chief Operations Officer
Esther Beverly, VP/Human Resources
David Bennett, Chief Marketing Officer
Wayne Knight, Senior Vice President
Glen Newhart, Chief Development Officer
Gene Ma, M.D., Chief of Staff
Jim Rice, PhD, Board Facilitator
Kathy Hall
Greg Moser, General Legal Counsel
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Schallock, called the meeting to order at 10:00 a.m. in the Oceanside Room at the Veterans Association of North County with attendance as listed above. Chairman Schallock led the Pledge of Allegiance.

2. Approval of Agenda

   It was moved by Director Dagostino to approve the agenda as presented. Director Nygaard seconded the motion. The vote on the motion passed unanimously (7-0).

3. Public Comments – Announcement

   Chairman Schallock read the Public Comments section listed on the Board Agenda. There were no public comments.

4. Open Session

New Business

(a) Consideration to waive Board Policy 14-006 – Board of Director Meeting Minutes, Section #3

Chairman Schallock explained per Board Policy 14-006, "all Open Sessions of Board of Directors meetings shall be audio or video taped". Board Facilitator, Dr. Jim Rice had suggested Board members may be more forthcoming in their discussions if the work session were not taped. Chairman Schallock clarified the agenda item pertains strictly to the taping of today's Special Meeting.

It was moved by Director Finnila to waive Board Policy 14-006 Board of Director Meeting Minutes, Section #3. Director Dagostino seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

(b) Board of Directors Public Workshop for the purpose of review and discussion of:

1) Review Board Self Assessment
2) Enhance our Collaboration with Stakeholders
3) Define Governance Enhancement Plan for 2016-2020

Chairman Schallock introduced and welcomed Dr. Jim Rice, Board Facilitator and his associate Ms. Kathy Hall.

Dr. Rice provided a brief summary of his background, noting he facilitated a Workshop with the Board previously in 2005. He explained that attendees received a binder that contained the following information:

- Board Policy 14-006
- Board Self Assessment Results
- Self Assessment Comparison Graphs
- Governance Time Map

Dr. Rice gave a brief description of the materials. He explained the Board Self Assessment Results is a compilation of Board member responses to a survey that was provided by ACHD and was tabulated by an independent party, The Walker Company.

Dr. Rice explained the Self Assessment Comparison Graphs compares TCHD with 11 other California District Hospitals.

Dr. Rice stated the Governance Time Map was developed to provide an estimate of time effectiveness.

Dr. Rice began his presentation with a Power Point that discussed the following:

- Essential Practices and the Board's Duty of Care, Duty of Loyalty and Duty of Obedience

- Three Mode of Governance including Fiduciary, Strategic and Generative

Throughout Dr. Rice's presentation, attendees discussed the Board's highest priority and key issues for next year, the Board's most significant strengths as well as their most significant weaknesses

Dr. Rice also provided an overview of the six areas of focus for today's meeting which included the following:

- Explore Board Strategies to Enhance Performance:
  Review Mission and Vision

  1. Enhancing Community Relations Throughout District
  2. Enhancing Relations with Physician Colleagues
  3. Enhancing our Reliance on Committees/Groups
  4. Enhancing Financial Vitality
  5. Enhancing Quality & Service Excellence
  6. Enhancing Quality of Meetings

- Conclusions and 999 Action Plan
- Concluding Remarks

The attendees spent considerable time participating in table exercises to discuss the six areas of focus mentioned above. Following the meeting Dr. Rice will provide a document which will accompany today's minutes that captures observations and strategies that surfaced from the discussions including actions for the next nine (9) days, next nine (9) weeks and next nine 9) months (999 Action Plan).

In closing, attendees gave their impression of today's workshop and all were positive and appreciative of the time and effort put forth. Dr. Rice encouraged the Board to further explore ideas and issues raised today and consider reconvening in 6-9 months.

Dr. Rice and Ms. Hall exited the meeting at 4:18 p.m.

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

   Chairman Schallock deferred this item to the Board's General Counsel. General Counsel, Mr. Moser made an oral announcement of the item listed on the November 12, 2015 Special Board of Directors Meeting Agenda to be discussed during the morning session of Closed Session which included Conference with Labor Negotiators.

6. Motion to go into Closed Session

   It was moved by Director Dagostino and seconded by Director Finnila to go into Closed Session. The motion passed unanimously (7-0).

7. The Board adjourned to Closed Session at 4:25 p.m.

9. The Board returned to open session at 4:35 p.m. with all Board members present.

10. Open Session

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

Chairman Schallock reported no action had been taken in closed session.

12. There being no further business, Chairman Schallock adjourned the meeting at 4:36 p.m.

_____
Larry W. Schallock
Chairman

ATTEST:

_____
Ramona Finnila
Secretary

2015

Tri-City Healthcare District

GOVERNANCE ENHANCEMENT PLAN 2015-2016

GOVERNANCE ENHANCEMENT 2015-2016

NOVEMBER 12, 2015

Preface:

The Board and Leadership of the Tri-City Healthcare District invested substantial time In November 2015 to assess the structure, systems and performance of their governance work. This investment was motivated by a shared recognition that the health services and economic dimensions of the Healthcare District are essential to the future health and well being of the communities and people living and working within the District.

This document seeks to capture observations and strategies that surfaced from the recent Board Self-Assessment and related Retreat. It is anticipated that these ideas should be considered draft and subject to the review and refinement by Tri-City Executive and Board Leadership, working in partnership with the Governance Committee over the next two weeks. Final action could be considered at the December Board meeting.

This year's review was facilitated by James Rice and Kathy Hall of Gallagher Integrated. http://www.integratedhealthcarestrategies.com/

Introduction:

Strong board effectiveness helps create the conditions in which those who deliver and manage health services can successfully meet the strategic mission, goals, plans and budgets of the enterprise. This document is divided into three sections to help support the Board's journey to enhanced governance effectiveness in 2016 and beyond.

- Section 1: 999 Action Plan
- Section 2: Activities to Earn "All Seven Greens"
- Section 3: Strategic moves to enhance performance of the Tri-City Healthcare District Board:

The recent results of the Board Self-Assessment are attached for reference.

Section 1: 999 Action Plan

Participants were invited at the close of the retreat to share their insights into a short list of actions that could enhance the governance effectiveness and impact of the Tri-City Healthcare District Board. The actions are grouped into those for the next 9 days, the next 9 weeks and the next 9 months.

The ideas are shared here in random order for further discussion and refinement by Board Leadership with support from the Executive Team.

Actions for the Next 9 Days:

- Send summary of the retreat to all participants before he next board meeting
- Update our mission, vision and values.
- Ask results of retreat to be reviewed and refined by the Governance committee and Tri-City Leadership
- Commit now for action at December Board meeting to enhance our board work beginning in January 2016
- Ask Governance Committee to review and refine all committee charges
- Explore how need for culture change can be assessed and improved among our medical staff and employee colleagues
- Ask for proposed process and timeline for our board discussions with UCSD
- Others?

Actions for the Next 9 Weeks:

- Ask for progress reports on implementing the ideas from this retreat.
- Organize significant process for board to work with management and medical staff to engage with community leaders for a new strategic planning process
- Ask board, medical staff and executives to review health needs of The District and anchor the discussions with UCSD within these needs.
- Explore media relations plan that enables board and executive leaders to speak publically about UCSD's value to people we exist to serve.
- Study how the board can begin to use modern web based portals and tablets given to all board members with training to support our decision making like The BoardEffect type mentioned in Dr. Rice's presentation, see: http://www.boardeffect.com/
- Ask staff to share recent insights from marketing studies on how we can build market share
- Define our many stakeholder groups and how we can strengthen our relationships with them all
- Provide board leadership to encourage enhanced payer contracts driven by our plans and market studies

- Develop a schedule for monthly board updates on our strategic planning process and relations with UCSD
- Explore how we can define themed meetings for 2016 that allow us to weave in education and thoughtful reflection about our work and performance... not just always the same agenda structure
- Settle MOB issues
- Consider forming a "Technology Assessment and Planning Task Force" as part of our enhanced strategic planning process.
- Others?

Actions for the Next 9 Months:

- Conduct another board self-assessment process next year that shows we are making good progress to achieve the actions we defined (see below) for "All Seven Greens"
- Celebrate substantial progress and results from the UCSD Affiliation
- Implement activities that help develop "Patient Centric Culture." This work must ensure everyone, including, employees and board members. Board members will be role models. A culture of caring and tolerance(tolerance for mistakes so we are continually improving), while continuing to drive service excellence and quality
- Implement initiatives to enhance market share
- Assess vertical integration strategies
- Establish clear and assertive plan for funding for 2030—seismic plan as well as campus redevelopment
- Meet with HUD on financing some key elements our plans
- Others?

Section 2: Activities to Earn All Seven Greens:

What can our Management and Board do to have "All Seven Greens" on the Strategic Direction questions in the next Board Self-assessment? (in random order)

1. Identify practical ways to improve our communications with management, medical staff and community leaders so we are proud of our board work and plans.
2. Commit ourselves to minimize time on minutia in our meetings in favor of the strategic issues, the work and investments that are essential for meeting the health needs of the people we exist to serve.
3. Find new time to communicate, learn from, and collaborate with management outside of routine board meetings to improve coordination and cooperation
4. Openly talk about the scores in this assessment that are low and work together to improve them
5. Support more positive cooperation with medical staff and managers in the new discussions with UCSD
6. We need to minimize bi-directional talking with each other and encourage joint discussion among board, managers, physicians and staff on strategic issue of patient centered care.
7. Make sure that all of our meetings provide an opportunity for each board member's ideas and questions to be heard and addressed
8. Experiment with our board meeting calendar and agenda. Find new ideas beyond consent agenda to all us more relaxed time on strategic issues and opportunities.
9. Make sure we define time to review our "progress to plan" in most of our meetings
10. Continue to explore sue of reports card, balanced score card or dashboards that tell us at a glance how we are performing as an organization in quality, finance, market position, morale of workers etc.
11. Improve the way we prepare for meetings and the quality of information we have for our strategic discussions in meetings
12. Not enough to have a great plan that has our fingerprints, we need to see the progress of meeting plan at each meeting, and with time for questions.
13. Others?

Section 3: Strategic moves to enhance performance of the Tri-City Healthcare District Board:

Small groups of board, managers and physician leaders were invited to discuss ways to address six important challenges defined in the self-assessment:

- **Enhancing Community Relations Throughout The District**
- **Enhancing Relations with Physician Colleagues**
- **Enhancing Reliance on Committees/Groups**
- **Enhancing Financial Vitality**
- **Enhancing Quality and Service Excellence**
- **Enhancing Quality of Meetings**

A summary of their suggestions are captured here for further refinement

1. Enhancing Community Relations Throughout The District

- Restart community breakfasts for better communication among the three cities
- Discover how to use technology wiser to communicate more consistently and timely among our many stakeholders
- Conduct an updated community needs assessment; share results and planned actions with the community
- Schedule regular meetings with the city councils and supervisors
- Communicate and educate the public on HCAHP scores
- Others?

2. Enhancing Relations with Physician Colleagues

- Conduct planning meetings with the medical staff and the board at least twice a year
- Create better ways to communicate with the physicians to keep them informed and to show them we value their hard work and professionalism to serve our patients and communities
- Improve use of electronic medical/health record portals for physicians to make it easier for them to obtain medical chart information outside of the hospital
- Senior team should develop expanded plans to communicate regularly with individual physician groups on professional and business affairs, as well as social opportunities
- Others?

3. Enhancing Our Reliance on Committees/Groups

- Conduct a careful review of the charges, composition, and work plans for each committee. We are spending too much time and not yielding enough substantial results for time invested.

- Consider the possibility of combining the Professional Affairs Committee with the Governance Committee to reduce time spent on approving policies; Mr. Moser to provide clarity on policies that require board approval
- Place medical issues/contracts with another committee to balance the time and workload of each committee
- Reduce or eliminate committee functions that are of a redundant nature
- Remove perfunctory things on committee's list to increase the reporting and discussion of the pertinent board issues
- Others?

4. Enhancing Financial Vitality

- Continue to strive to provide high quality and low cost services so we can earn market share gains
- Continue to grow revenue base by carefully leveraging the new UCSD affiliation
- Explore and educate board members on new financial models, e.g. value based purchasing, grow key areas, etc.
- Maintain strong cash position to provide greater potential of access to capital
- Further develop our primary care clinic strategies in partnership with our physician colleagues
- Remain flexible in our response to market needs
- In first quarter 2016, add education on healthcare financing 101; record session and offer this to the public
- Others?

5. Enhancing Quality and Service Excellence

- Create a highly engaged culture of "patient's first "with input/involvement from the medical staff, board, employees and senior team; each group must understand how their daily job achieves the strategic initiatives
- Determine how the board will show support/involvement in the culture improvement at all levels of our organization
- Train staff to improve patient/customer service with information from groups like Studer
- Others?

6. Enhancing Quality of Meetings

- Create a calendar of education themes for an entire year
- Board Chair to prepare a summary of the meeting to be sent to board members after the meeting; consider communication options of text or video for board and other stakeholders
- Schedule a dedicated block of time for board meeting each month regarding strategic or emergent issues that occur to ensure immediate action/change as necessary; cancel the meeting if no issues arise
- Revisit the membership of each committee to better manage the work load and results
- Others?

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

November 17, 2015 – 4:00 o'clock p.m.
Assembly Room 2– Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 4:00 p.m. on November 17, 2015.

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

Director James J. Dagostino, DPT, PT
Director Ramona Finnila
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Tim Moran, Chief Executive Officer
Kapua Conley, Chief Operations Officer
Steve Dietlin, Chief Finance Officer
Sharon Schultz, Chief Nurse Executive
David Bennett, Chief Marketing Officer
Wayne Knight, SVP, Medical Affairs
Diane Racicot, General Legal Counsel
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Schallock, called the meeting to order at 4:00 p.m. in Assembly Room 2 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Schallock led the Pledge of Allegiance.

2. Approval of Agenda

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

3. Public Comments – Announcement

   Chairman Schallock read the Public Comments section listed on the Board Agenda. There were no public comments.

4. Open Session

5. Board of Directors Public Workshop for the purpose of conducting Compliance Training

Chief Compliance Officer, Ms. Cheryle Bernard-Shaw provided a 60 minute educational session for Board members and senior management on practical guidance for healthcare governing boards on compliance oversight.

Ms. Bernard-Shaw reviewed the following:

- Critical Elements of Effective Oversight
- Expectations for Board Oversight of Compliance Program Functions
- Board Resources
- Compliance Program Design

Ms. Bernard-Shaw's presentation addressed the following:

- Roles of and relationships between the organization's audit, compliance and legal departments;
- Mechanism and process for issue-reporting within the organization;
- Approach to identifying regulatory risks; and
- Methods of encouraging enterprise-wide accountability for achievement of compliance goals and objectives.

With regard to internal audit functions, Ms. Bernard-Shaw stated she would be bringing an individual on board to fulfill this function.

Ms. Bernard-Shaw explained she will be developing a scorecard, a mechanism to report to the Board which will provide a barometer of how the organization is doing. The scorecard may include reporting on internal and external investigations, serious issues raised in internal and external audits, hotline activity, all allegations of material fraud, senior management misconduct, exceptions to the organizations Code of Conduct and any significant regulatory changes. It was suggested that the Strategic Plan Dashboard format be utilized for this purpose.

Ms. Bernard-Shaw also described the processes in place that include the implementation of an Organizational Compliance Committee comprised of Directors and key staff and the Executive Compliance Committee comprised of senior leadership. She provided a synopsis of the tasks of each committee.

With regard to our physicians, Ms. Bernard-Shaw stated the same laws apply to the physicians that practice at the hospital, however they should have own compliance program and their role in compliance should be specified. Ms. Bernard-Shaw stated she is opening up avenues of education for our physicians and will be meeting with the Chief of Staff in this regard.

Discussion was held regarding the Board's role in oversight of the Foundation. Ms. Bernard-Shaw explained that the Foundation is an independent entity however we do have a Business Associate Agreement with the Foundation. She clarified that we do not handle the contracting with the Foundation's vendors.

With regard to our satellite locations, Ms. Bernard-Shaw stated all staff regardless of location will be offered the same training opportunities and may be required to participate in some annual training.

In conclusion, Ms. Bernard-Shaw stated she is confident we have many good processes in place and is pleased that the Board in their attendance today is making efforts to increase its knowledge of relevant and emerging regulatory risks, is recognizing their role and function of the organization's compliance program in the face of those risks and understand the flow and

elevation of reporting of potential issues and problems to senior management. She noted the importance of encouraging compliance accountability across the organization.

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

Chairman Schallock deferred this item to the Board's General Counsel. General Counsel, Ms. Racicot, made an oral announcement of item listed on the November 17, 2015 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees.

7. Motion to go into Closed Session

It was moved by Director Dagostino and seconded by Director Kellett to go into Closed Session. The motion passed unanimously (7-0).

Chairman Schallock adjourned the meeting to Closed Session at 5:05 p.m.

9. The Board returned to Open Session at 5:35 p.m. with attendance as listed above.

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

Chairman Schallock reported no action had been taken in closed session.

12. There being no further business, Chairman Schallock adjourned the meeting at 5:36 p.m.

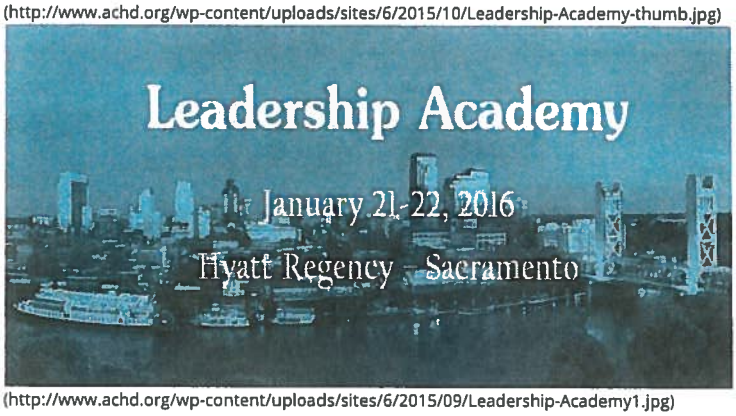
_____
Larry W. Schallock
Chairman

ATTEST:

_____
Ramona Finnila
Secretary

2016 Leadership Academy

(http://www.achd.org/wp-content/uploads/sites/6/2015/10/Leadership-Academy-thumb.jpg)



(http://www.achd.org/wp-content/uploads/sites/6/2015/09/Leadership-Academy1.jpg)

The Leadership Academy is designed to provide new and veteran trustees and administrators with the knowledge and skills necessary to effectively govern a Healthcare District. Healthcare District Executives, Clerks and Secretaries to the Board are encouraged to take advantage of this educational opportunity.

Click here (https://www.regonline.com/builder/site/?eventid=1760463) to register for the Leadership Academy.

Event Schedule

Day 1: Thursday, January 21, 2016

7:30 am – 8:45 am	*Breakfast*
9:00 am – 9:45 am	David McGhee, Chief Executive Officer, ACHD ***Welcome*** Ken Cohen, Executive Director, ACHD ***Overview of ACHD, Advocacy and Outreach***
9:45 am – 10:00 am	*Break*
10:00 am- 12:00 pm	Larry Walker, President, The Walker Company ***The Essentials of Good Governance*** Learning Outcome: An understanding of the key behaviors required of Trustees to assure Governing Board effectiveness.
12:00 pm – 1:15 pm	*Lunch Speaker* Mark Finucane, Managing Director, Alvarez & Marsal ***Strategic Challenges and Solutions for Healthcare Districts*** Learning Outcome: An understanding of the role of strategic planning in understanding and preparing responses to the ever changing landscape of health care.
1:30 pm - 2:45 pm	Gary Winuk, Counsel, Murphy Austin Attorneys ***FPPC- The Agency's Role In California Government*** Learning Outcome: An understanding of the regulatory duties of the Fair Political Practices Commission in overseeing California's governmental process.
2:45 pm – 3:00 pm	*Break*

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RECENT NEWS

- Stymied health plan tax back on agenda (http://www.achd.org/2015/12/01/stymied-health-plan-tax-back-on-agenda/)
- 'Right-To-Die' Law Highlights Need for Palliative Care in California (http://www.achd.org/2015/12/01/right-to-die-law-highlights-need-for-palliative-care-in-california/)
- Spike in Medi-Cal Enrollment Adds Pressure to 'Doctor Deserts' (http://www.achd.org/2015/11/24/spike-in-medi-cal-enrollment-adds-pressure-to-doctor-deserts/)
- Beach Cities Health District Named to Modern Healthcare's 100 Best Places to Work List for Fourth Year (http://www.achd.org/2015/11/06/beach-cities-health-district-named-to-modern-healthcares-100-best-places-to-work-list-for-fourth-year/)
- Medi-Cal 2020: New Waiver in Sight, But Long-Term Vision Needed (http://www.achd.org/2015/11/04/medi-cal-2020-new-waiver-in-sight-but-long-term-vision-needed/)

3:00 pm – 4:30 pm	Martha Knutson, ESQ., Attorney at Law, Knutson Law Firm ***The Brown Act and Fair Political Practices Commission: Rules of Engagement*** Learning Outcome: An understanding of the Brown Act, specifically methods of compliance and the implications of non-compliance.
5:30 pm	*Chair's Reception and Dinner* Samuel 'Mike' McCreary, PhD, Chair, ACHD Board of Directors

Day 2: Friday, January 22, 2016

7:30 am – 8:30 am	*Breakfast*
8:45 am – 10:00 am	Martha Knutson, ESQ., Attorney at Law, Knutson Law Firm ***The Brown Act and Fair Political Practices Commission: Rules of Engagement (continued)*** Learning Outcome: An understanding of the Brown Act, specifically methods of compliance and the implications of non-compliance.
10:00 am – 10:15 am	*Break*
10:15 am – 11:30 am	Rich Gianello, CEO, HFS Consultants ***Public Entity Accounting: Understanding District Financial Statements*** Learning Outcome: An understanding of District financial statements, the key metrics associated with strong financial performance and questions to ask when there is variance from financial plans.
11:30 am	*Closing Remarks* David McGhee, Chief Executive Officer, ACHD
12:00 pm	*Lunch*

Event Questions:

Sheila Johnston (mailto:Sheila.Johnston@achd.org), Member Services Specialist, 916.266.5208

Registration Questions:

Sean McDonald (mailto:registration@achd.org), Event Coordinator, 916.266.5240

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2016 Legislative Day

(http://www.achd.org/wp-content/uploads/sites/6/2015/09/Leg-Day.jpg)

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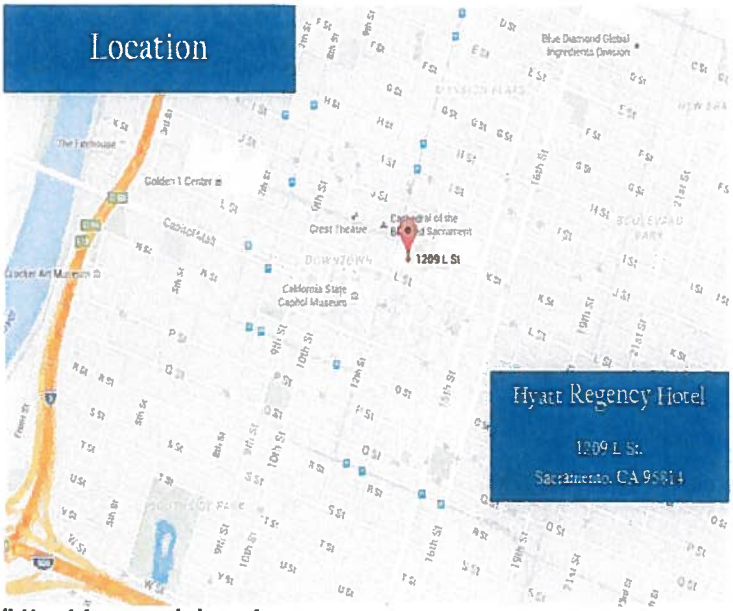
The Legislative Day program is tailored to connect Healthcare District Trustees and Administrators with Legislative Representatives at the State Capitol. The program will provide detailed information regarding the most pressing legislative issues, while creating opportunities for Trustees and Administrators to foster relationships with state lawmakers.

Click here (https://www.regonline.com/builder/site/?eventid=1762238) to register for Legislative Day.



(http://www.achd.org/wp-content/uploads/sites/6/2015/09/Sac-Event-Map.jpg)

Event Questions:

Sheila Johnston (mailto:Sheila.Johnston@achd.org), Member Services Specialist, 916.266.5208

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- Tri-City Medical Center and UC San Diego Health Enter into Exclusive Affiliation (http://www.achd.org/2015/10/15/tri-city-medical-center-and-uc-san-diego-health-enter-into-exclusive-affiliation/)
- ACHD Needs Your Feedback! (http://www.achd.org/2015/10/13/achd-needs-your-feedback/)
- Closing a Hospital, and Fearing for the Future (http://www.achd.org/2015/10/09/closing-a-hospital-and-fearing-for-the-future/)

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Our vision is of a society of healthy communities where all individuals reach their highest potential for health

American Hospital Association

Future AHA Annual Meeting Dates

2016 - Sunday, May 1 - Wednesday, May 4

2017 - Sunday, May 7 - Wednesday, May 10

2018 - Sunday, May 6 - Wednesday, May 9

The AHA Annual Meetings above will be held in Washington, DC at the Washington Hilton Hotel.

View highlights from the 2015 AHA Annual Meeting.

2016 Annual Meeting

(http://www.achd.org/wp-content/uploads/sites/6/2015/09/Annual-Meeting.jpg)

(http://www.achd.org/wp-content/uploads/sites/6/2015/09/Annual-Meeting-thumb.jpg)

As the state of health care continues to evolve and the pace of change continues to increase, we wonder…how will our important member Districts evolve to meet the challenges ahead and continue to serve their communities? ACHD's Annual Meeting will provide opportunities to hear different perspectives on a wide verity of topics, ranging from effective governance to improving the health status of residents of your community, while providing opportunities share your experiences and views with your Healthcare District colleagues.
(http://www.achd.org/wp-content/uploads/sites/6/2015/09/Annual-Meeting.jpg)

Click here (https://www.regonline.com/builder/site/?eventid=1762253) to register for Annual Meeting.

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RECENT NEWS

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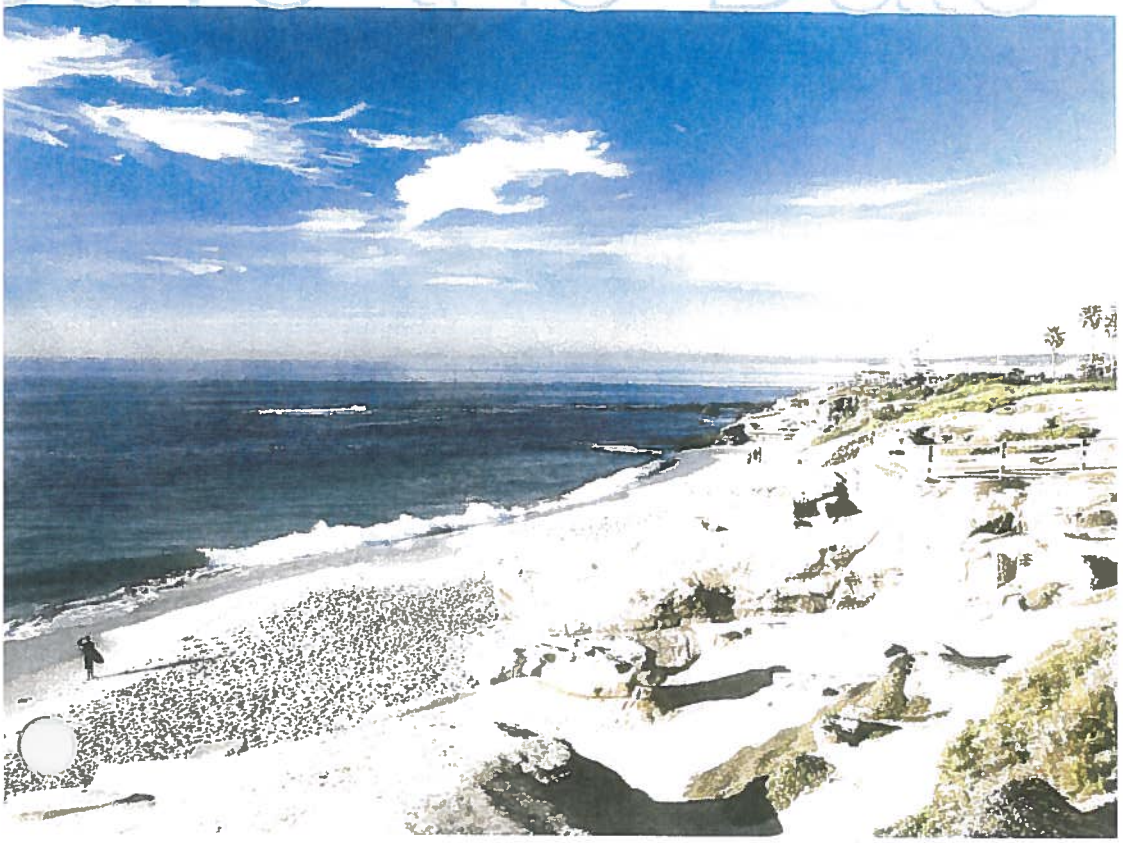

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onfirmed and invited speakers for
ext year's event include:

llan Frankel, MD – Allan applies his clinical xperience as an anesthesiologist and his nowledge of patient safety and reliability science help health care organizations and clinicians eliver safe and reliable care to achieve optimal utcomes.

cott Griffith, MS – Scott brings world-class ollaborative skills and practices from his work ith high-consequence industries to guide ospitals in organizing to achieve reliability.

Amy Edmondson, PhD – Amy is a Harvard Business School professor and is widely known for her work around leadership influences on learning, collaboration, and innovation in teams and organizations. She brings research to practice in learning from failure to create innovation and resilience.

Daniel L. Gross, DNSc, RN – As executive vice president, Dan and the Sharp HRO leadership team share their blueprint and lessons learned on the journey to performing as a High Reliability Organization.

Johan Otter, DPT – Johan shares his first-hand knowledge of the importance of physical endurance and mental toughness to survive a grizzly bear attack. These are the attributes of individual and organizational resilience. Working at Scripps Health, he is an expert in workforce health and safety, a precondition to patient safety.

Duane Dauner – As CEO of CHA, Duane discusses the future of California hospital performance in reliable and high quality care and the role of public reporting.

Atul Gawande, MD, MPH (Invited) – Su writer, and public health researcher, Atul compassionate view of palliative and end care and aging in America.

Mark R. Chassin, MD, FACP, MPP, MI President and CEO of The Joint Commis provides a broad view of performance as advances from quality and safety to the r of high reliability.

Kenneth Sands, MD, MPH (Invited) – K chief quality officer at Beth Israel Deacon Medical Center engaged in a multi-site in humanize intensive care, focusing on dig respect for people.

Plus, additional sessions on: pediatri quality, transparency in public reporting, learned from the CHPSO database and n

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PROPOSED
TCHD BOARD OF DIRECTORS
MEETING SCHEDULE
CALENDAR YEAR 2016

Regular Board of Directors Meetings – Open Session to begin at 3:30 p.m. Closed Session to begin at 1:30 p.m. and again immediately following Open Session, if needed

- January 28, 2016 (Last Thursday)
- February 25, 2016 (Last Thursday)
- March 31, 2016 (Last Thursday)
- April 28, 2016 (Last Thursday)
- May 26, 2016 (Last Thursday)
- June 30, 2016 (Last Thursday)
- July 28, 2016 (Last Thursday)
- August 25, 2016 (Last Thursday)
- September 29, 2016 (Last Thursday)

No Meeting in October due to November 8th Election

- November 10, 2016 (First Thursday following the election)
- December 8, 2016 (Second Thursday in December)

Special Board of Directors Meeting – January, 2016 Date TBD
Strategic Plan/Mission, Grant Guidelines, Vision & Values

Special Board of Directors Meeting – February, 2016 DATE TBD
Strategic Planning Workshop

Special Board of Directors Meeting – May, 2016 Date TBD
Closed Session to review biennial quality reports

Special Board of Directors Meetings – June 9, 2016 – 6:00 p.m.
Budget Workshop

Special Board of Directors Meeting – October, 2016 Date TBD
Closed Session to review biennial quality reports

2016 Dates to Note

- ACHD Leadership Academy – January 21-22, 2016, Sacramento, CA
- CHA Legislative Day – March 16, 2016, Sacramento, CA
- ACHD Legislative Day – April 4-5, 2016, Sacramento, CA
- AHA Annual Meeting – May 1-4, 2016, Washington, D.C.
- ACHD Annual Meeting – May 3-5, 2016, Monterey, CA
- 24th Annual Leadership Summit – July 17-19, 2016, San Diego, CA
- Hospital Quality Institute Conference – November 2-4, 2016, San Diego, CA

Proposed: Board of Directors: December 10, 2015

TCHD BOARD OF DIRECTORS
BOARD COMMITTEE MEETING CALENDAR YEAR 2016

Governance & Legislative Committee	Human Resources Committee	Employee Fiduciary Subcommittee	*Professional Affairs Committee	*CHAC	Finance Operations& Planning	Audit, Compliance & Ethics
1st Tues of Each Month	2nd Tues of Each Month	Qtrly. 2nd Tues of Month	2nd Thursday of Each Month	3rd Thursday of Each Month	4th Tuesday of Each Month	3rd Thursday of Each Month
12:30 p.m.	12:30 p.m.	11:00 a.m.	12:00 p.m.	12:30 p.m.	12:30 p.m.	8:30 a.m.

NOTE: Committees may not meet every month depending on agenda items

***NOTE: Professional Affairs Committee has been moved to the Second Thursday of Each Month**
CHAC has been moved to the Third Thursday of Each month

Proposed: Committee Schedule: December 10, 2015

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TCHD BOARD OF DIRECTORS
MEETING ROTATION CALENDAR YEAR 2016
(Individual Board members will rotate attendance at MEC, Auxiliary and Foundation Board Meetings)

Month	MEC—Meets 4th Monday of Month at 6:00 pm (except as noted)	*Foundation Board—Meets 3rd Wednesday @ Noon (does NOT meet every month)	Auxiliary BOD Meets 3rd Wed. from 9-11 a.m. (attendance welcome anytime during that time period)
January	Dagostino – January 25	Dagostino – January 20	Dagostino – January 20
February	Reno – February 22	Reno – February 17	Reno – February 17
March	Schallock – March 28	Schallock – March 16	Schallock – March 16
April	Finnila – April 25	Finnila – April 20	Finnila – April 20
May	Kellett – May 16*	Kellett – May 18	Kellett – May 18
June	Mitchell – June 27	Mitchell – June 15	Mitchell – June 15
July	Nygaard– July 25	Nygaard– July 20	Nygaard– July 20
August	Dagostino – August 22	Dagostino – August 17	Dagostino – August 17
September	Reno – September 26	Reno – September 21	Reno – September 21
October	Schallock – October 24	Schallock – October 19	Schallock – October 19
November	Finnila – November 28	Finnila – November 16	Finnila – November 16
December	Cancelled	Kellett – December 21	Kellett – December 21

NOTE: The Foundation and Auxiliary Board may not meet every month

***MEC moved to May 18th due to Memorial Day Holiday**

Proposed: Board of Directors: December 10, 2015

Stakeholder Experience

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Employee Satisfaction

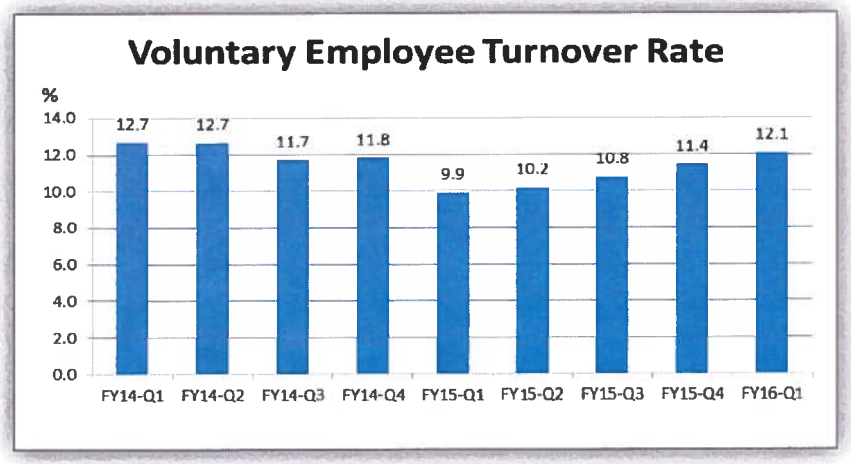
Partnership™
"Satisfaction + Engagement"
Mean = 66.1 (-1.0)
Percentile = 28th (from 13th)

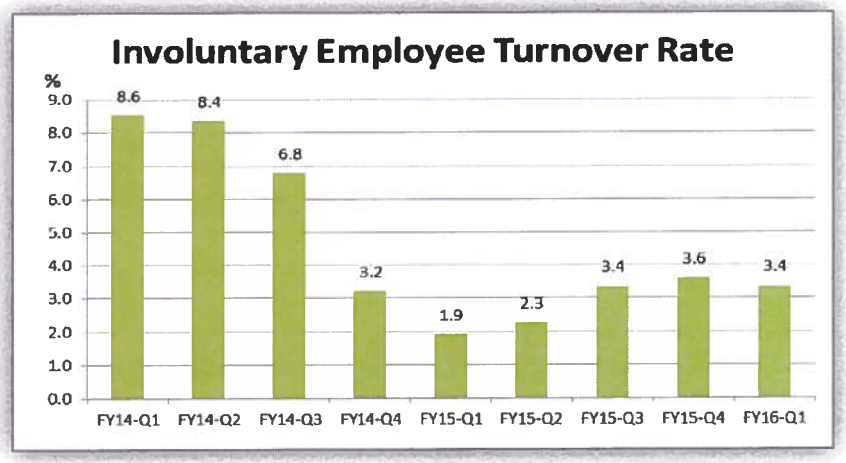
Satisfaction
"what do I get?"
Mean = 61.9 (-1.2)
Percentile = 27th (from 13th)

Engagement
"what do I give?"
Mean = 71.8 (-0.5)
Percentile = 31st (from 12th)

National 90th Mean Scores

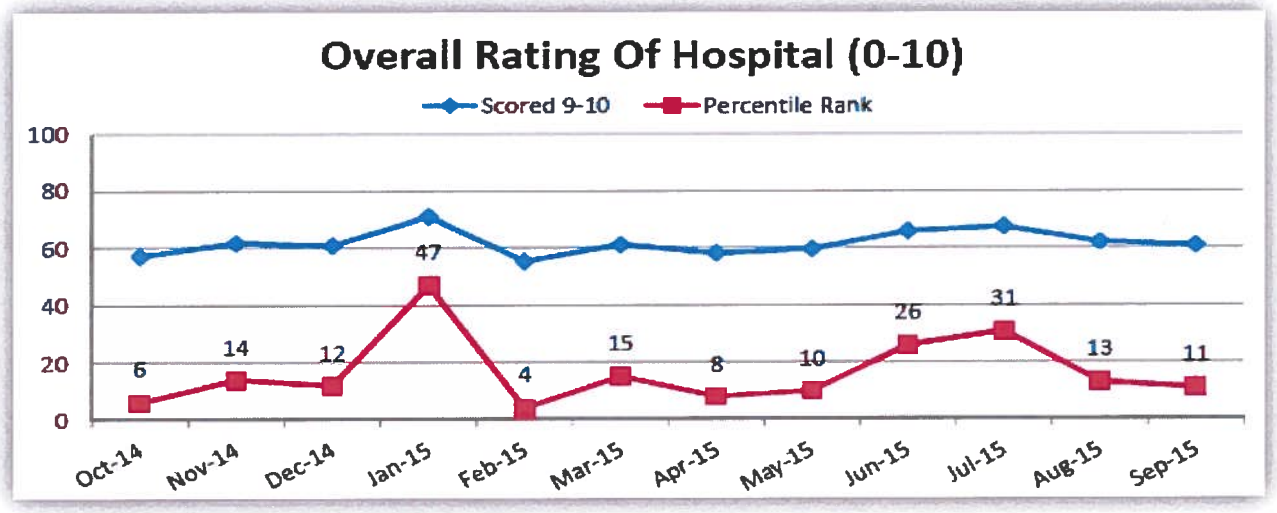
Partnership:	79.9
Satisfaction:	77.1
Engagement:	83.6





HCAHPS (Top Box Score)

Hospital Consumer Assessment of Healthcare Providers & Systems

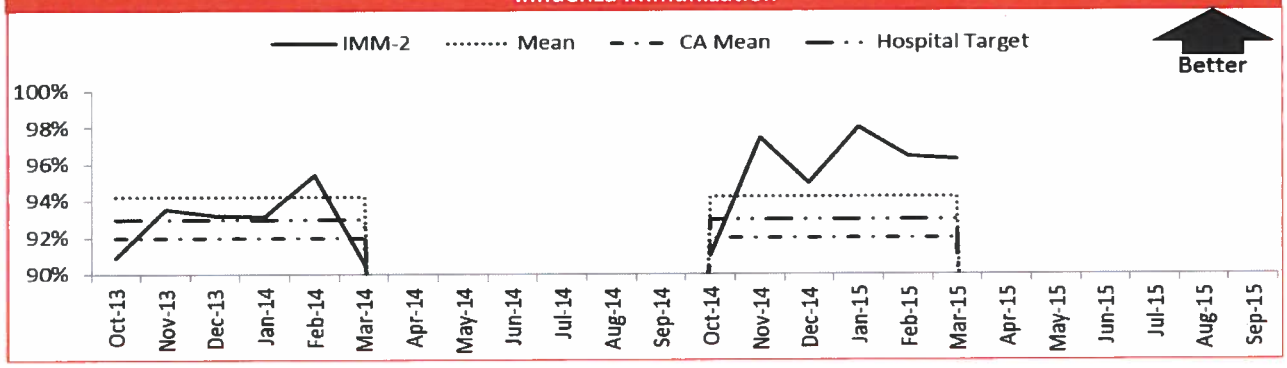


Quality Outcomes

Process of Care Measures (Core Measures)

Centers for Medicare & Medicaid (CMS)

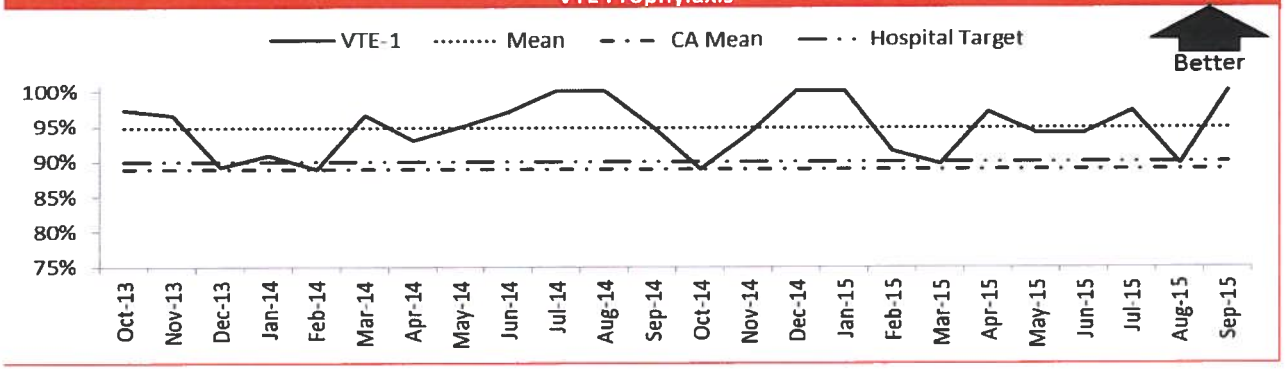
Influenza Immunization



Action Plan

Continue to monitor

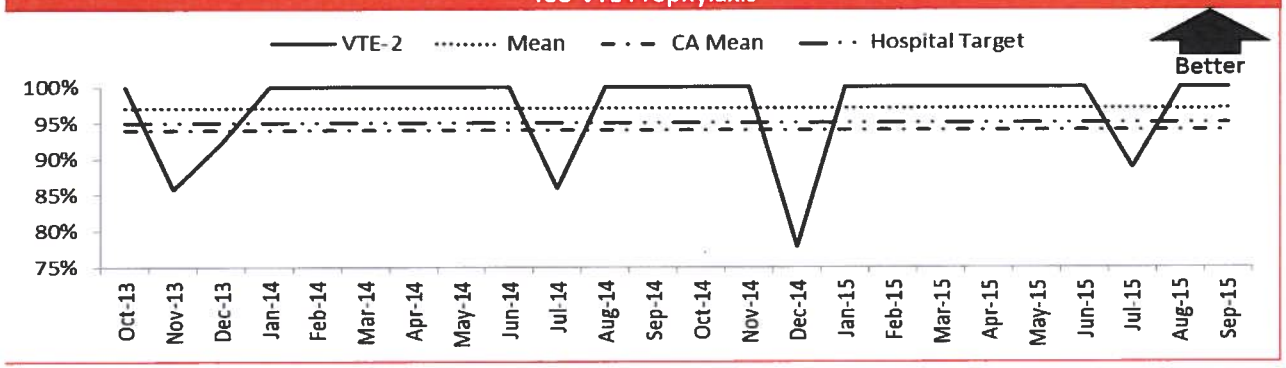
VTE Prophylaxis



Action Plan

Continue to monitor

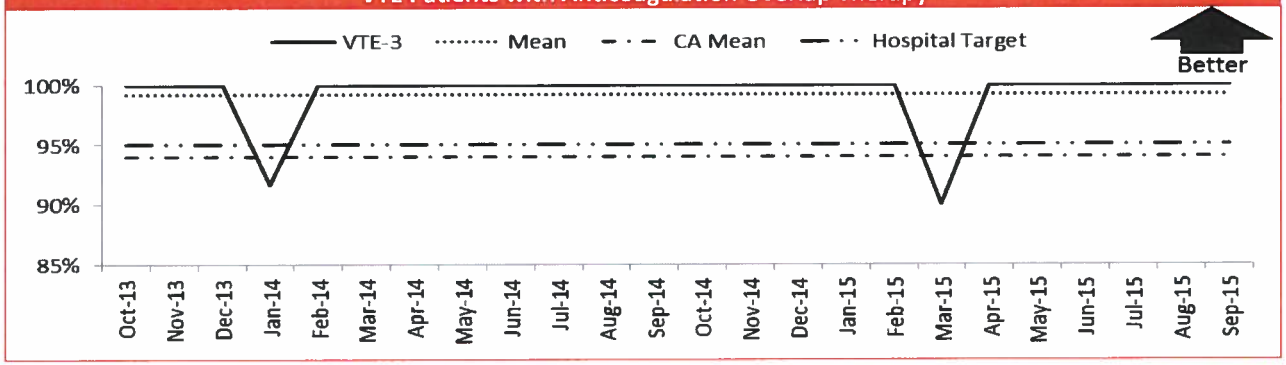
ICU VTE Prophylaxis



Action Plan

Continue to monitor

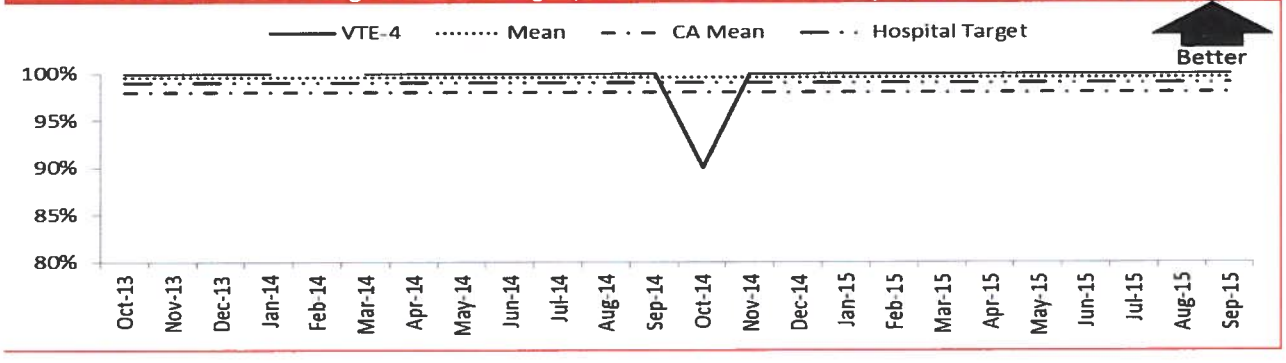
VTE Patients with Anticoagulation Overlap Therapy



Action Plan

Continue to monitor

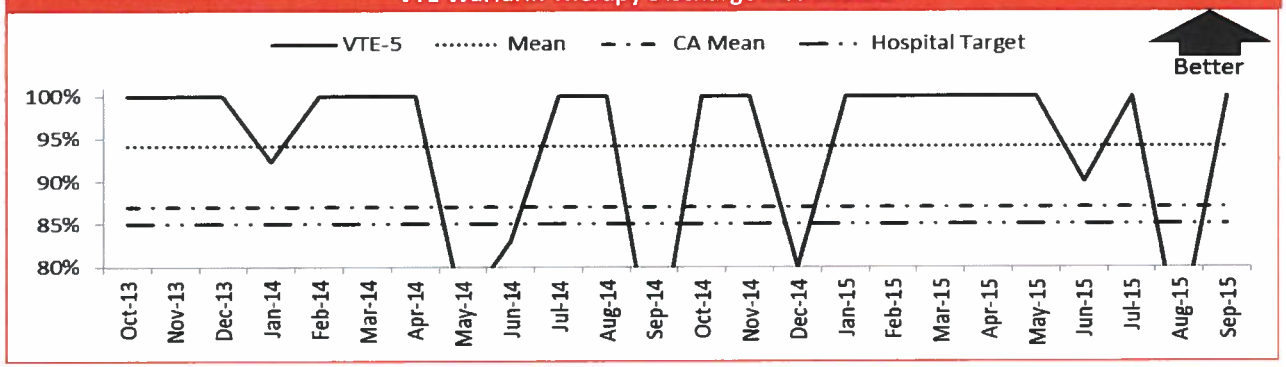
VTE Patients Receiving UFH with Dosages / Platelet Count Monitoring by Protocol or Nomogram



Action Plan

Continue to monitor

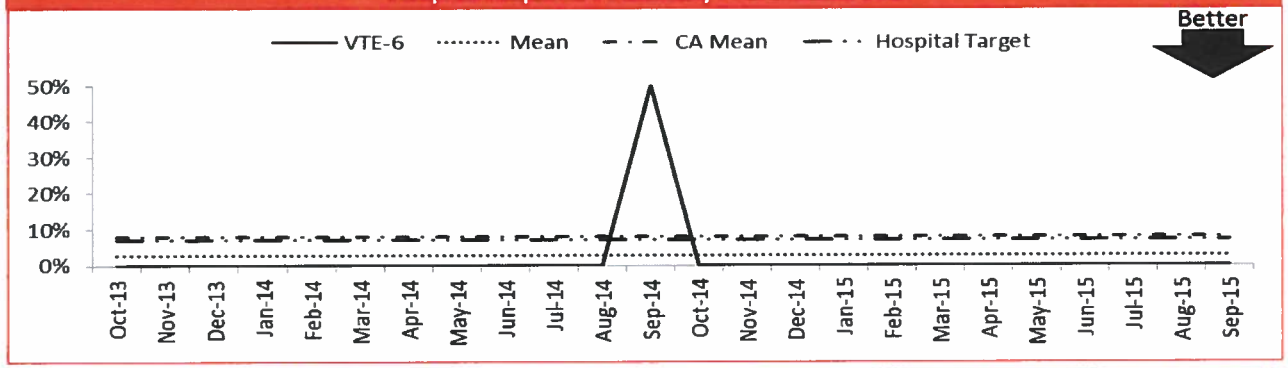
VTE Warfarin Therapy Discharge Instructions



Action Plan

Continue to monitor

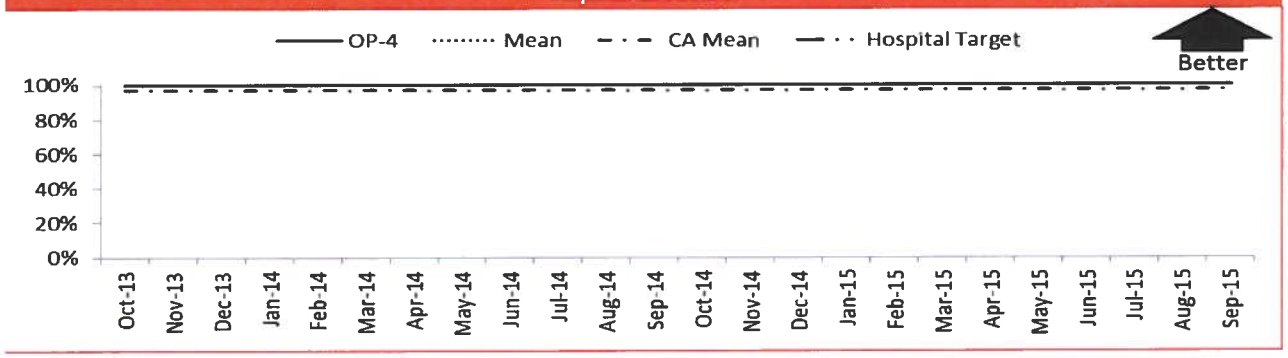
Hospital Acquired Potentially Preventable VTE



Action Plan

Continue to monitor

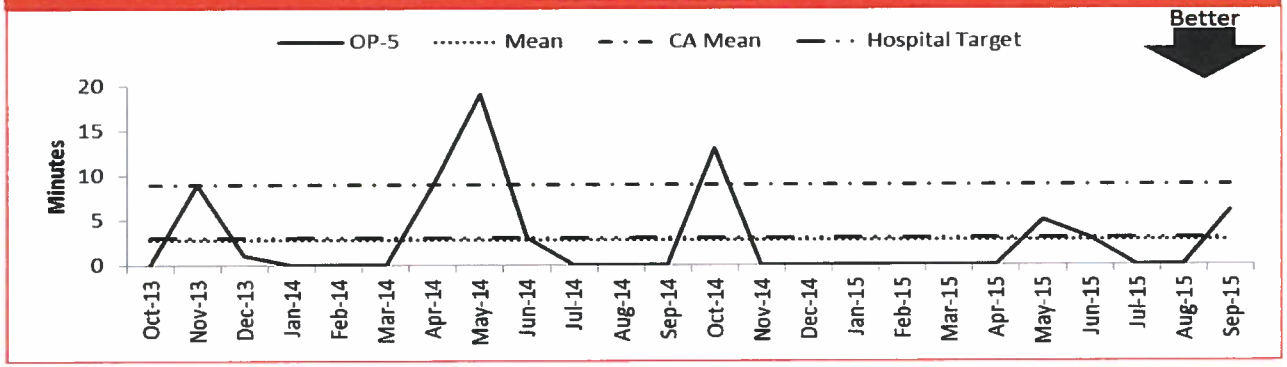
Aspirin at Arrival



Action Plan

Continue to monitor

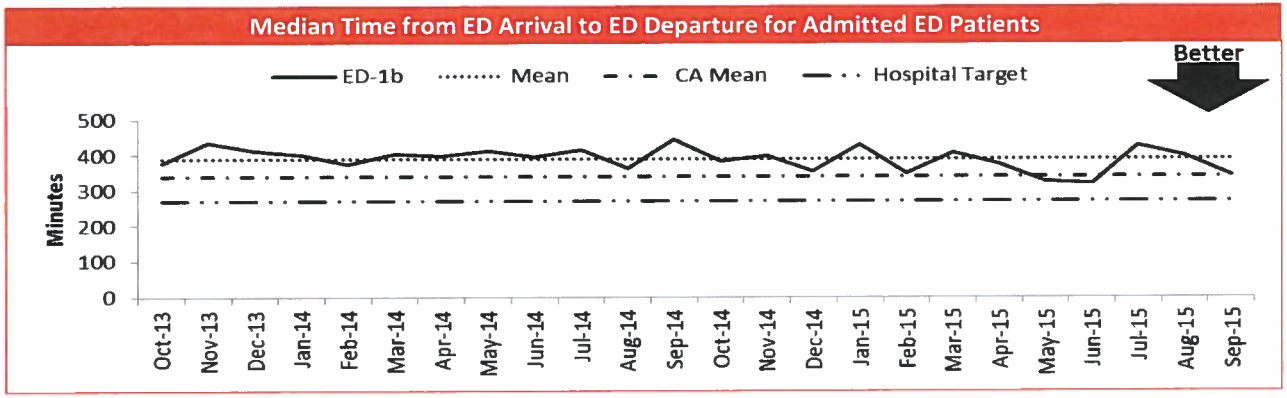
Median Time to ECG



Action Plan

Continue to monitor

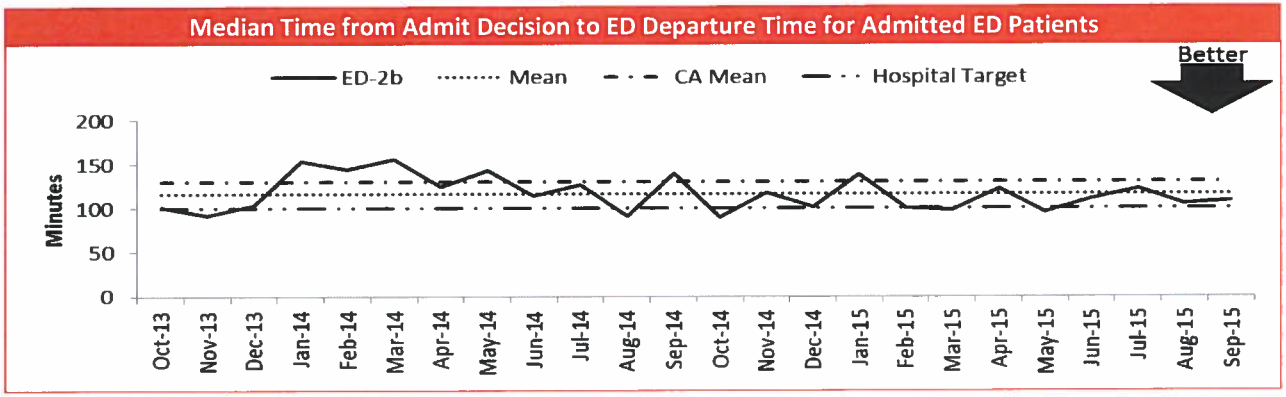
Median Time from ED Arrival to ED Departure for Admitted ED Patients



Action Plan

Continue to monitor

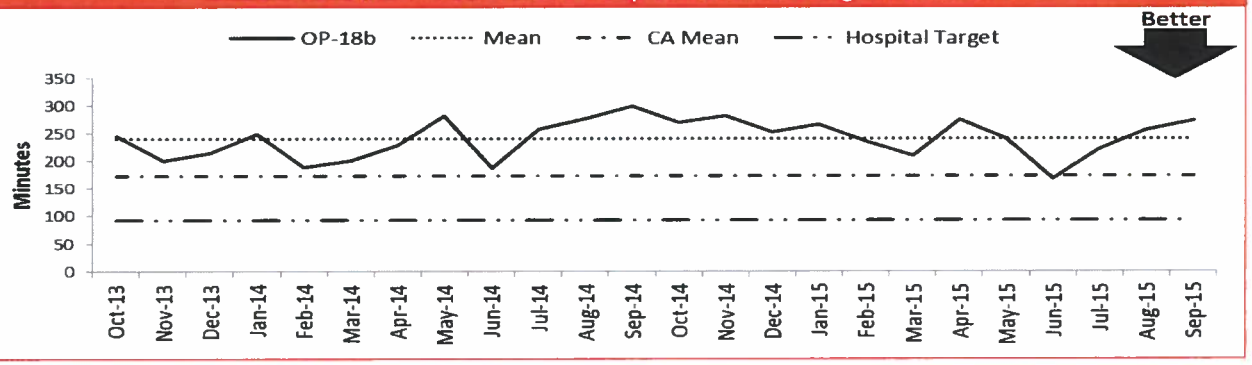
Median Time from Admit Decision to ED Departure Time for Admitted ED Patients



Action Plan

Continue to monitor

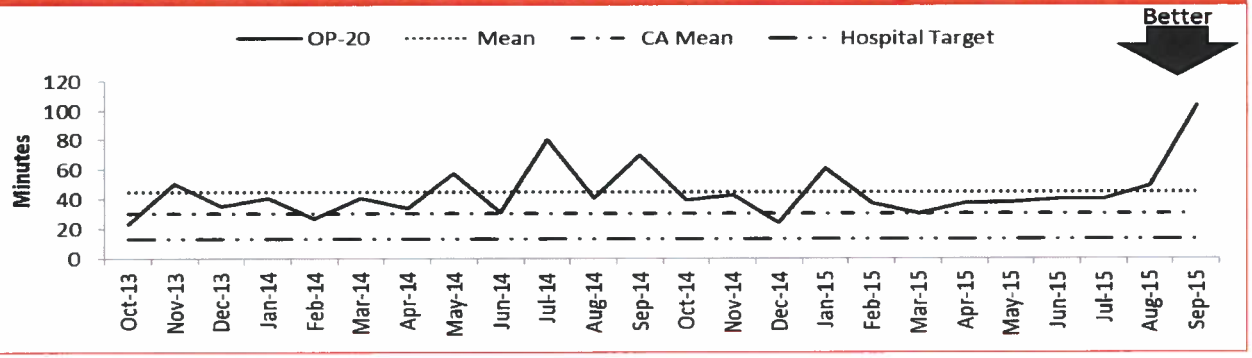
Median Time from ED Arrival to ED Departure for Discharged ED Patients



Action Plan

Continue to monitor

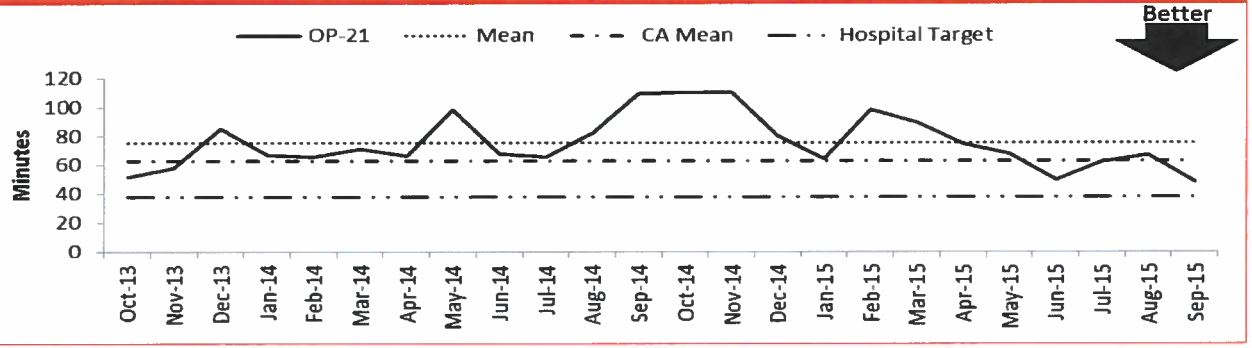
Median Time from ED Arrival to Provider Contact for ED Discharged Patients



Action Plan

Continue to monitor

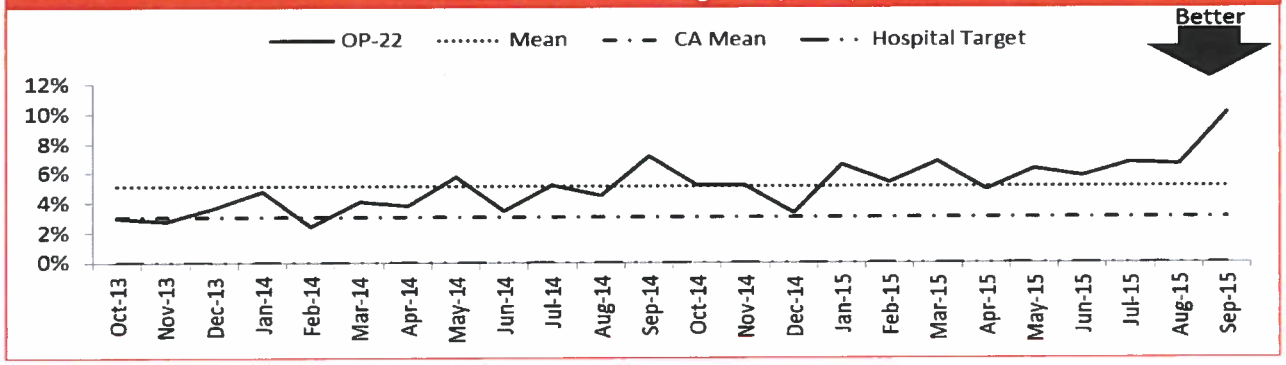
Median Time to Pain Management for Long Bone Fracture



Action Plan

Continue to monitor

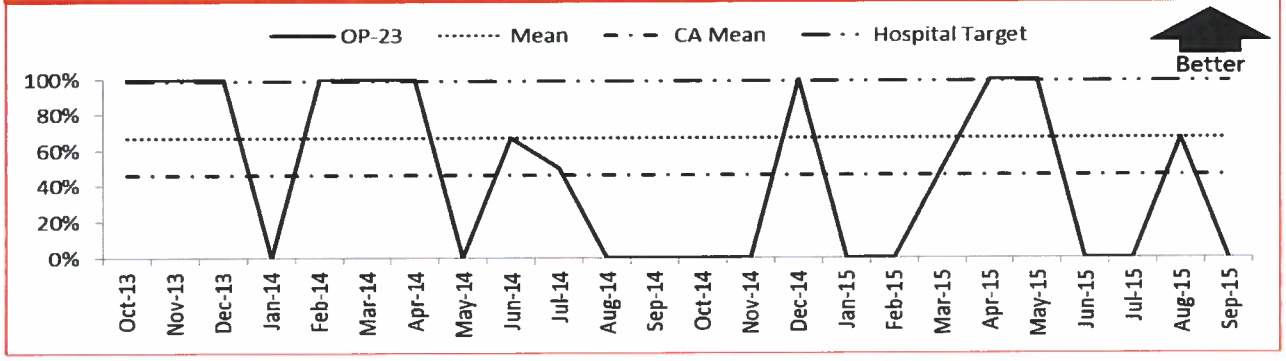
Patient Left Before Being Seen (LWOT)



Action Plan

Continue to monitor

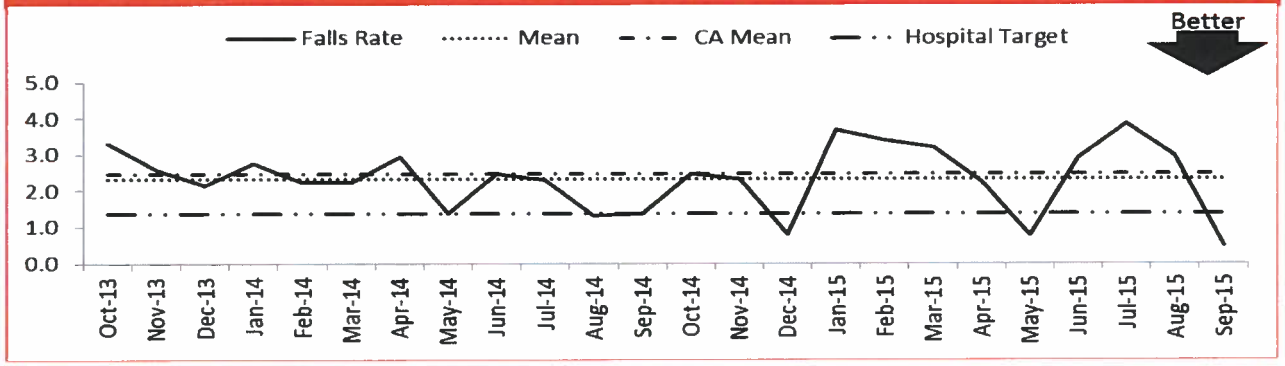
Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival



Action Plan

Continue to monitor

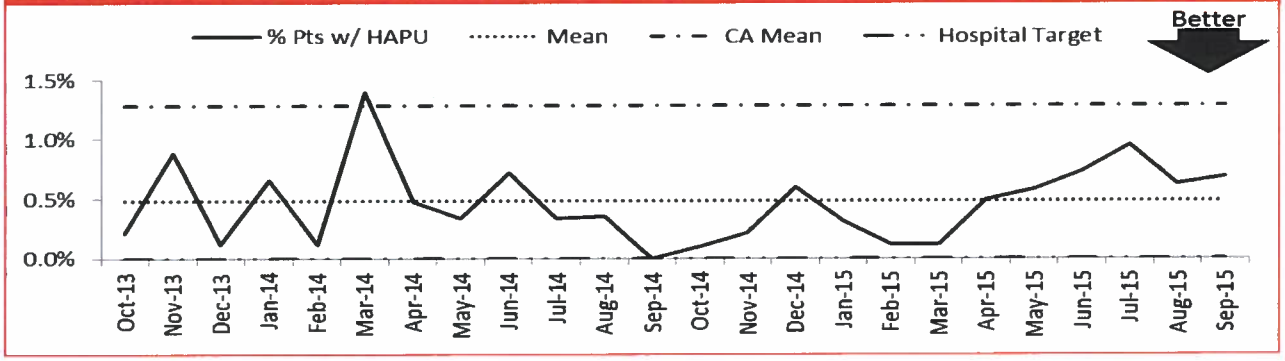
Hospital Wide Falls Rate Per 1000 Pt Days



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

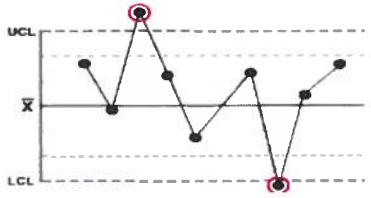
Legend

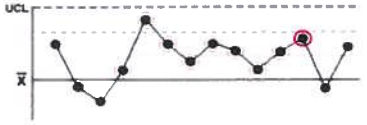
- Hospital Mean
- Hospital Rate
- Hospital UCL
- CA Mean

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	Jun	C/M YTD Avg	Goal Range
FY16	46.7	45.7	45.7	45.3									45.8	48-52
FY15	46.3	48.8	48.5	48.9	49.0	48.9	51.0	50.6	50.6	51.0	49.9	46.4	48.1	48-52

TCMC Days in Accounts Payable (A/P)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY16	83.6	85.8	92.1	88.7									87.5	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	83.7	78.6	75-100

TCHD EROE $ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY16	$862	$612	$182	($189)									$1,467	$507
FY15	$368	($348)	$112	$568	$556	$632	$198	$370	$292	$343	$1,814	($471)	$700	

TCHD EROE % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY16	3.03%	2.20%	0.66%	-0.68%									1.31%	0.45%
FY15	1.33%	-1.32%	0.41%	1.93%	1.99%	2.20%	0.70%	1.42%	1.02%	1.22%	6.04%	-1.61%	0.63%	

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	Jun	C/M YTD	C/M YTD Budget
FY16	$2,046	$1,817	$1,357	$1,011									$6,231	$5,817
FY15	$1,761	$988	$1,456	$1,888	$1,896	$1,983	$1,498	$1,652	$1,591	$1,620	$3,136	$724	$6,093	

TCHD EBITDA % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY16	7.20%	6.53%	4.90%	3.65%									5.58%	5.16%
FY15	6.38%	3.75%	5.37%	6.42%	6.77%	6.91%	5.34%	6.34%	5.58%	5.76%	10.44%	2.48%	5.51%	

TCMC Paid FTE (Full-Time Equivalent) per Adjusted Occupied Bed

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY16	6.13	6.05	5.91	5.98									6.02	6.06
FY15	5.93	5.89	6.01	6.09	6.39	6.28	5.89	5.69	6.18	6.17	5.89	6.26	5.98	

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	TTM Jun	Covenant	
FY16	1.88	1.96	2.15	2.05									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	1.81	1.10	

TCHD Liquidity $ in Millions (Cash + Available Revolving Line of Credit)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
FY16	$30.7	$33.4	$36.1	$35.7									
FY15	$27.7	$21.4	$19.9	$18.8	$18.9	$22.2	$19.9	$16.4	$13.4	$17.8	$26.4	$35.3	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Volume

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	49	28	30	30									137
FY15	35	32	46	48	35	33	39	35	31	35	37	27	433

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	20	19	15	23									77
FY15	14	9	22	24	18	21	19	13	21	19	19	20	219

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	9	10	8	8									35
FY15	6	10	9	8	12	11	9	7	16	14	6	7	115

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	16	19	13	4									52
FY15	10	7	10	12	13	7	11	8	9	21	11	15	134

Performance compared to prior year: Better | Same | Worse

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	40	36	37	44									157
FY15	45	51	32	43	49	27	33	43	37	39	40	41	480

Inpatient Behavioral Health - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	19.9	19.6	17.6	18.0									18.8
FY15	23.3	26.5	27.1	21.2	22.8	19.1	18.3	17.5	19.6	16.9	17.5	17.9	20.7

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	7.1	4.9	5.6	6.9									6.1
FY15	5.2	3.5	4.3	5.0	4.3	7.2	7.0	6.0	6.5	5.1	5.9	5.1	5.4

Neonatal Intensive Care Unit (NICU) - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	13.3	11.1	14.3	15.1									13.5
FY15	13.2	18.2	19.7	18.1	15.6	16.4	18.3	21.5	14.3	13.9	11.7	13.5	16.2

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	183.9	183.4	199.7	187.7									188.6
FY15	190.8	195.0	195.1	195.6	189.2	187.9	203.3	199.8	188.0	186.3	181.5	179.7	191.0

Performance compared to prior year: Better | Same | Worse

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	215	214	252	227									908
FY15	246	263	244	233	194	233	199	159	208	186	218	198	2581

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	16	9	19	12									56
FY15	16	19	12	19	17	11	15	8	12	22	23	21	195

Outpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	7	3	7	4									21
FY15	4	6	2	1	4	8	1	15	4	3	5	1	54

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	7	14	4	6									31
FY15	10	9	10	10	12	12	12	5	12	10	6	13	121

TCMC Adjusted Factor (Total Revenue/IP Revenue)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY16	1.65	1.63	1.60	1.62									1.62
FY15	1.64	1.63	1.58	1.58	1.56	1.58	1.58	1.63	1.62	1.63	1.65	1.66	1.61

Performance compared to prior year: Better | Same | Worse

Building Operating Leases
Month Ending October 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)	$ 4,880.00	05/01/13	04/30/16	**Vacant Building** 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)	$ 9,400.74	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)	$ 24,931.00	10/01/12	10/01/22	**Chemotherapy/Infusion Oncology Office** 3617 Vista Way, Bldg.5 Oceanside, Ca 92056	7086
[illegible]eway/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	**Vacant Building** 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		$ 8,218.54	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		$ 12,923.17	01/01/12	12/31/16	**Vacant Bank Building Property** 4000 Vista Way Oceanside, Ca 92056	8462 Until operational
Total				**$ 336,639.20**				

(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 10/31/15

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6150	PCCN EXAM	82315	155.00	82518	MICHELLE MUSICH
6171	CA-NV AMER CORRECTIONAL HEALTH SRCS	102315	225.00	82523	LORI ROACH
6385	IOBNN CERTIFICATION	100515	325.00	82528	BRENDA BENEDETTI
6440	PPS BOOT CAMP	80315	745.70	29226	CHRISTINE GERVASI
6440	PPS COORD BOOT	80315	875.70	29226	CHRISTINE GERVASI
7400	ANESTHESIA TECH	60515	275.00	82524	LYN MONTEGOMERY
7400	NCC CREDENTIALING	100215	325.00	81135	KRISTEN BAUMBACH
7400	RNC CERTICATION	101315	325.00	82314	JACQUELYN COBBS
7400	RNC OB EXAM	92315	325.00	82517	KELLY GAVAGHAN
7570	ACLS CERTIFICATION	101415	210.00	82535	RICHARD HARM
8340	SERVICE SAFE TRAINING AND TEST	92915	308.00	77940	ERIC CLEMENS
8510	AMERICAN PAYROLL SEMINAR	102215	491.92	46503	ANH NGUYEN
8620	GOVERNANCE FORUM	108152EXP	603.18	78591	LARRY W. SCHALLOCK
8631	FOUNDATION BOARD RETREAT & STAFF CONFERENCE	429153	1,237.24	79486	TCHF BOARD & STAFF
8700	ROI SEMINAR	100715	160.00	15106	MELISSA SANCHEZ
8700	ROI SEMINAR	1007152	160.00	15106	LEILANI SAGALE
8730	ANNUAL BH SYMPOSIUM	101215	404.77	82530	JOY MELHADO
8730	BH SYMPOSIUM	101215	695.00	14365	CAROLA HAUER
8730	BH SYMPOSIUM	10122015	695.00	14365	JOY MELHADO
8740	CCRN RENEWAL	92415	120.00	80613	JILLIAN WILLIAMS
8740	PALS RENEWAL COURSE	91715	160.00	81220	TRACI ALIIPULE
8740	RADIATION PROTE	100715	167.90	79610	CLAUDIA RODRIGUEZ
8740	MEDICAL SURGICAL	101515	200.00	66786	BRENDA L. TAVARES-HAM
8740	CARDIOVASCULAR	101515	200.00	77616	ELEANOR SANTIAGO
8740	VERMONT OXFORD	101515	200.00	79048	JACLYN KEEGAN
8740	NEONATAL NURSES	100115	200.00	81651	KAREN SULLIVAN
8740	BSN	91715	2,500.00	81413	EMILY GREENE
8758	AADE DIABETES CONFERENCE	101215	418.93	80490	APRIL LOMBARDO
8790	BOOK- UNDERSTANDING DRUG ISSUES	5134358	114.72	77130	DAVID EMMETT

**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.

Seminar Evaluation

Seminar Title: Basic Compliance Academy
Location: The Cosmopolitan
Las Vegas, NV
Dates: 19 October to 22 October 2015

1. **Identify reason for attending seminar:**
   I attended this conference to learn about health care compliance and my responsibilities as both a healthcare district board member and a healthcare provider.

2. **List three major topics of the seminar. Rate them as to your evaluation of priorities. Provide a brief explanation of key information covered under each topic.**

   a. HIPAA: Amplified my existing knowledge of HIPAA, especially what is and isn't a covered entity.
   b. Board responsibilities and accountability for compliance, especially since the OIG is tightening its focus to include boards
   c. Coding and Billing: A total complete mystery to me before this. Now I have a firmer understanding of how important documentation not only to document care provided but provide the correct information for correct coding and billing.

3. **What was the most important topic covered in the seminar?**
   For me, it was the importance of healthcare boards as compliance champions.

4. **Who was/were the main speaker/s and their topics?**
   Debbie Troklus, a founding member of the Healthcare Compliance Association, spoke on *Policies, Procedures and Infrastructure* while Lynda Hilliard, spoke about *Corporate Responsibility: Role of Boards of Director.* There were also speakers on HIPAA, coding and billing, and the breadth of compliance issues, e.g. FAA compliance for helicopter landing areas.

5. Evaluate the seminar as a whole.

The conference was well organized and a thorough introduction to health care compliance.

Laura Mitchell, RN, Bsn, C-HC

Board Leadership:
A Driver of Health Care Quality

The Developing Requirements and How to Meet Them

The purpose of this brief is to provide an overview of the evolving role and expectations for hospital Boards in achieving higher levels of clinical quality and patient safety.

Situation

It is well established that hospital governing Boards have responsibility for the quality of care provided in their institutions.[1] Historically, how Boards fulfilled this responsibility has been open to interpretation and varying practices. In recent years, the changing social, political and economic environment has led to a new era of publicly reported comparative quality measures, transparency, and new reimbursement models that reward performance. The role of hospital Boards in assuring quality of care in this context is more focused that ever before.[2] A challenge in meeting these evolving expectations was framed in a recent study that raised questions about whether hospital Boards are sufficiently educated about and engaged in oversight of quality.[3] Hospital Boards that have met this challenge, however, demonstrate great positive impact on institutional and patient outcomes.

Background

Momentous events occurred during the course of the last decade that are an impetus for today's heightened expectation that hospital Boards exercise active oversight of the quality of care delivered by their organizations. First, the Institute of Medicine (IOM) published two seminal reports, *To Error is Human*[4] and *Crossing the Quality Chasm*[5], in 2001 and 2002, respectively. These reports documented the serious and pervasive nature of the nation's overall quality problem, finding nearly 100,000 deaths per year from medical errors, as well as systemic failure to provide evidence-based care nearly half of the time. Second, concurrent with the release of the IOM reports, the for-profit business sector experienced a series of ruinous accounting fraud scandals leading to the bankruptcies of Enron and WorldCom, and the related demise of Arthur Anderson. Additionally, the notorious $1.3 billion bankruptcy of the Allegheny Health, Education and Research Foundation reverberated with many of the issues

Key Points

- Engaged Boards improve quality outcomes
- The nation has a serious quality and patient safety problem
- There are new expectations for governance oversight of quality
- Quality is at the center of healthcare reform
- Best practices for Boards are available

demonstrated by the infamous commercial failures, but within non-profit healthcare. These examples mark unconscionable lapses in corporate integrity and governance oversight leading to an increased scrutiny of Boards and higher standards of accountability. In 2002, Congress responded by passing the Sarbanes-Oxley legislation which introduced major changes to the regulation of corporate governance and public finance.[6] While charitable organizations are largely not covered by its provisions, the law has affected and strengthened Board practices in not-for-profit organizations. Some predict, however, that a direct ". . . Sarbanes-Oxley for quality is around the corner."[7] Third, while many aspects of the US healthcare system are exceptionally advanced, the care provided is too often unsafe and inefficient. Exacerbating the patient safety issues are federal forecasts that predict US healthcare spending will exceed $4.1 billion by 2016, representing 20% of the gross national product.[8] In response to the demand for better quality, patient safety, and cost efficiency, policy leaders and patient organizations have called governing Boards to enhance their oversight function on quality of care. In March 2010 Congress passed the Patient Protection and Affordable Care Act[9] which addressed multiple changes to the current healthcare delivery system. Payors are moving into value-based purchasing models using financial incentives targeted at providers, consumers, or both, linked to measures of health care quality and efficiency.

These events usher in a new era of accountability for health system Boards. The change is welcomed as evidence shows that highly engaged Boards focused on quality of care can impact outcomes in very positive ways.

Assessment

Boards face important new issues related to how quality of care affects matters of reimbursement and payment, efficiency, cost controls, and collaboration between organizational providers and individual and group practitioners. "These new issues are so critical to the operation of health care organizations that they require attention and oversight, as a matter of fiduciary obligation, by the governing Board."[10]

Historically, Boards delegated to medical staff and management the operational responsibility for safe care. Hospital Boards are beginning to realize that they can no longer regard the quality and safety of care in the hospital as the sole responsibility of the doctors, nurses and executives. Even though most hospital Board members are not clinically trained, they are nevertheless ultimately responsible for everything that goes on in the hospital, including the quality of clinical care.[11] Training in quality principles and methods, as well as attuned organizational structures and processes are critical to enable Board effectiveness.

Recent studies show that the majority of hospital Boards are not prepared to meet the new level of expectations and accountabilities for quality of care. In a national survey of Board chairs, a study conducted by researchers at the Harvard School of Public Health found that fewer than half of the Boards rated quality of care as one of their top two priorities. Few reported receiving training in quality. Moreover, using publically reported quality data, the researchers assessed Board engagement relative to high-performing and low-performing hospitals. They identified large differences in Board activities and engagement between high-performing and low performing hospitals. Highly engaged and trained Boards who exercised active oversight of quality realized significantly higher quality performance.[12]

Recommendations

Many excellent resources are available to suggest potential strategies to support Boards in meeting their oversight of quality.[13] Most of these resources share common themes in their recommendations. A succinct statement of recommended Board activities was advanced in a recent study by researchers at the Johns Hopkins Quality and Safety Research Group.[14] The recommendations include:

1. Boards should have a separate quality and patient safety committee that meets regularly and reports to the full Board. Evidence suggests Boards with such a committee spend more time on improvement activities, and their hospitals may have better outcomes.

2. Boards should ensure the existence and annual review of a written quality improvement and patient safety plan that reflects systems thinking, contains valid empirical measures of performance, and is consistent with national, regional, and institutional quality and safety goals.

3. Boards should have an auditing mechanism for quality and safety data, just as they do for financial data. While data quality control principles apply to clinical research and apply to financial data through generally accepted accounting principles, data quality in measuring quality and patient safety has received little to no attention in most health-care organizations.

4. Boards should routinely hear stories of harm that occurred at the hospital, putting a face on the problem of quality and patient safety. Stories may be case reviews presented by staff or interactions with patients or families who suffered harm.

5. In conjunction with the CEO and medical staff leaders, boards should identify specific, measurable, valid quality indicators consistent with strategic goals and hospital services, and review performance against the indicators no less than quarterly. Such review should include:

    a. Regular quantitative measurement against benchmarks;
    b. Reported compliance with rigorous data quality standards;
    c. Performance transparency;
        i. Weekly or monthly reports of harm;
        ii. Sentinel event and claims review for quality and safety problems;
    d. Methods for active intervention to improve care;
        i. Survey of quality and safety culture;
        ii. Use of survey results to shape improvement efforts;
        iii. Routine mechanism to tap the wisdom of bedside caregivers.

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[1] Lister E, Cameron DL. The role of the Board in assuming quality and driving major change initatives – part 1: maintaining organizational integrity. *Group Practice Journal*. 2001;50:13-20.

[2] Miller TE, Gutmann VL, "Changing expectations for Board oversight of healthcare quality: the emerging paradigm," *J Health Life Sci Law 2009 Jul;2(4):31, 33-77.*

[3] Jha, A and Epstein, A, "Hospital Governance and the Quality of Care," *Health Affairs 29 (1):182-187.*

[4] To Err is Human: Building a Safer Health System (2000), Institute of Medicine

[5] In Crossing the Quality Chasm: A New Health System for the 21st Century (2001), the Institute of Medicine (IOM) identifies six aims of the healthcare quality system: that it should be safe, effective, efficient, timely, patient centered, and equitable.

[6] Sarbanes-Oxley Act of 2002, PL 107-204, 116 Stat 745

[7] Nash DB, Medical Executive Post, March 9, 2008. See also, Royo MB, Nash DB. 2008. "Sarbanes-Oxley and Not-for-Profit Hospitals: Current Issues and Future Prospects," *American Journal of Medical Quality*, 23(1):70-72

[8] Poisal JA, et al, "Health Spending Projections Through 2016: Modest Changes Obsure Part D's Impact," Health Affairs 26 (2):w242-w253 (2007)

[9] Patient Protection and Affordable Care Act, PL 111- 148

[10] Callendar et al, Corporate Responsibility and Health Care Quality: A Resource for Health for Health Care Boards of Directors, American Health Lawyers Association, 2007

[11] National Quality Forum, Hospital Governing Boards and Quality of Care: A Call to Responsibility, 2004

[12] Jha, A and Epstein, A, "Hospital Governance and the Quality of Care," *Health Affairs 29 (1):182-187.*

See also, Carlow DR, "Can Healthcare Boards Really Make a Difference in Quality and Safety?" Law & Governance, 13(8) 2010;

Jaing JH, "Enhancing Board Oversight on Quality of Hospital Care: An Agency Theory Perspective," AHRQ, 2011

[13] See:
Governance Certification for Tennessee Hospital Trustees and Boards, Tennessee Hospital Association, 2006;
Competency-Based Governance Enters the Health Care Boardroom, The American Hospital Association's Center for Healthcare Governance, 2010;
Hospital Governing Boards and Quality of Care: A Call to Responsibility, National Quality Forum, 2004;
Great Boards: Promoting Excellence in Health Care Governance, The American Hospital Association;
Reinertsen, JL, Hospital Boards and Clinical Quality: A Practical Guide, Ontario Hospital Association, 2007;
Conway J, Getting Boards on Board: Engaging Governing Boards in Quality and Safety, The Joint Commission Journal on Quality and Patient Safety, Volume 34 Number 8, April 2008

[14] Goeschel CA, Wachter RM, Pronovost PJ, "Responsibility for Quality Improvement and Patient Safety: Hospital Board and Medical Staff Leadership Challenges," Chest 2010;138;171-178

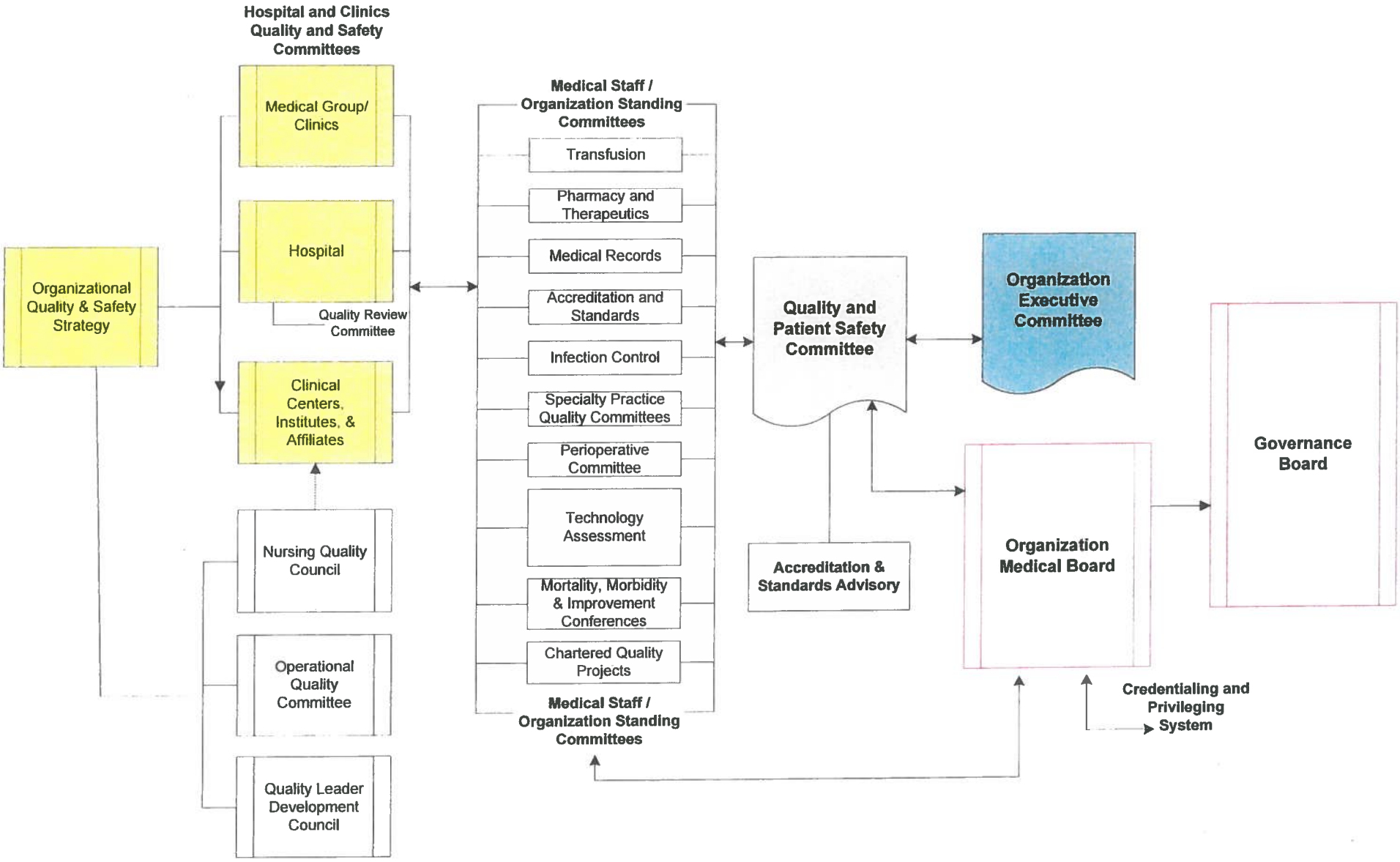
Governance Oversight of Quality

Key Questions for Boards

1. Is there a systemic view for strategy, e.g. planning process and strategic plan?
2. Are there measures that answer whether or not strategy is advancing, i.e.: Is care getting better or worse?
3. How were the measures selected? What are the criteria?
4. Are there contexted measures and metrics? For example:
   - upper/lower control limits if appropriate
   - target
   - actual absolute numbers, not percentages; or both
   - comparison to history and targets
5. Is there a coordinated process? Is there conformance and predictability in presentations, data displays, etc.?
6. Is the focus on the core product(s) of clinical care, such as core measures, eliminating harm, other specific and relevant topics?
7. Can all staff leaders answer the following questions?
   - how does "this" compare to past?
   - how does "this" compare to best-of-class?
   - what are we doing to improve and close the performance gap?
   - what can we predict from what we know?
   - what might be unintended consequences of our improvement efforts?
8. What is the relevance to the front line caregivers and providers? Where is street level example that ties "front office to front line?"

Hospital Quality Institute
Leadership in quality and patient safety

Example
Quality & Safety Accountability & Reporting Flows



Courtesy of Hospital Quality Institute, www.hqinstitute.org