SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS MEETING
465 West Putnam Avenue, Porterville, CA – Board Room

AGENDA
November 26, 2024

OPEN SESSION (5:00 PM)

The Board of Directors will call the meeting to order at 5:00 P.M. at which time the Board of Directors will undertake procedural items on the agenda. At 5:05 P.M. the Board will move to Closed Session regarding the items listed under Closed Session. The public meeting will reconvene in person at 5:30 P.M. In person attendance by the public during the open session(s) of this meeting is allowed in accordance with the Ralph M. Brown Act, Government Code Sections 54950 et seq.

Call to Order

I. Approval of Agendas
Recommended Action: Approve/Disapprove the Agenda as Presented/Amended

The Board Chairman may limit each presentation so that the matter may be concluded in the time allotted. Upon request of any Board member to extend the time for a matter, either a Board vote will be taken as to whether to extend the time allotted or the chair may extend the time on his own motion without a vote.

II. Adjourn Open Session and go into Closed Session

CLOSED SESSION (5:01 PM)

As provided in the Ralph M. Brown Act, Government Code Sections 54950 et seq., the Board of Directors may meet in closed session with members of the staff, district employees and its attorneys. These sessions are not open to the public and may not be attended by members of the public. The matters the Board will meet on in closed session are identified on the agenda or are those matters appropriately identified in open session as requiring immediate attention and arising after the posting of the agenda. Any public reports of action taken in the closed session will be made in accordance with Gov. Code Section 54957.1

III. Closed Session Business

A. Pursuant to Evidence Code Sections 1156 and 1157.7; Health and Safety Code Section 32106(b): Chief of Staff Report

B. Pursuant to Evidence Code Sections 1156 and 1157.7; Health and Safety Code Section 32106(b):

1. Evaluation – Quality of Care/Peer Review/Credentials

2. Quality Division Update –Quality Report

C. Pursuant to Gov. Code Section 54956.9(d)(2), Significant Exposure to Litigation; Anticipated Litigation: Conference with Legal Counsel. BETA Claim No. 24-001846

D. Pursuant to Gov. Code Section 54956.9(d)(2), Significant Exposure to Litigation; Anticipated Litigation: Conference with Legal Counsel; Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service and Strategic Planning (1 Item)

E. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (1 Item). Estimated date of Disclosure: January 1, 2026

F. Pursuant To Gov. Code Section 54956.9(D)(2), Conference With Legal Counsel About Recent Work Product (B)(1) And (B)(3)(F): Significant Exposure To Litigation; Privileged Communication (1 Item).

To the extent items on the Closed Session Agenda are not completed prior to the scheduled time for the Open Session to begin, the items will be deferred to the conclusion of the Open Session Agenda.

IV. Adjourn Closed Session and go into Open Session

OPEN SESSION (5:30 PM)

V. Closed Session Action Taken

Pursuant to Gov. Code Section 54957.1; Action(s) to be taken Pursuant to Closed Session Discussion

A. Chief of Staff Report
Recommended Action: Information only; no action taken

B. Quality Review

1. Evaluation – Quality of Care/Peer Review/Credentials
Recommended Action: Approve/Disapprove Report as Given

2. Quality Division Update –Quality Report
Recommended Action: Approve/Disapprove Report as Given

C. Conference with Legal Counsel; Anticipated Litigation (1 Items)
Recommended Action: Approve/Reject Beta Claim No. 24-001846

D. Conference with Legal Counsel; Anticipated Litigation; Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (I Item)
Recommended Action: Information Only: No Action Taken

E. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (1 Item).
Recommended Action: Information Only; No Action Taken

F. Conference with Legal Counsel
Recommended Action: Information Only; No Action Taken

VI. Public Comments

Pursuant to Gov. Code Section 54954.3 - NOTICE TO THE PUBLIC - At this time, members of the public may comment on any item not appearing on the agenda. Under state law, matters presented under this item cannot be discussed or acted upon by the Board at this time. For items appearing on the agenda, the public may make comments at this time or present such comments when the item is called. This is the time for the public to make a request to move any item on the consent agenda to the regular agenda. Any person addressing the Board will be limited to a maximum of three (3) minutes so that all interested parties have an opportunity to speak with a total of thirty (30) minutes allotted for the Public Comment period. Please state your name and address for the record prior to making your comment. Written comments submitted to the Board prior to the Meeting will distributed to the Board at this time, but will not be read by the Board secretary during the public comment period.

VII. Consent Agenda

Recommended Action: Approve Consent Agenda as presented

Background information has been provided to the Board on all matters listed under the Consent Agenda, covering Medical Staff and Hospital policies, and these items are considered to be routine by the Board. All items under the Consent Agenda covering Medical Staff and Hospital policies are normally approved by one motion. If discussion is requested by any Board member(s) or any member of the public on any item addressed during public comment, then that item may be removed from the

Consent Agenda and moved to the Business Agenda for separate action by the Board.

VIII. Approval of Minutes

A. **October 22, 2024 Minutes of the Regular Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove October 22, 2024 Minutes of the Regular Meeting of the Board of Directors

IX. Business Items

A. **October 2024 Financials**
Recommended Action: Approve/Disapprove *October* 2024 Financials

B. **Capital Budget Report Quarter 1**
Recommended Action: Approve/Disapprove Capital Budget Report Q1

C. **Investment Report Quarter 1**
Recommended Action: Approve/Disapprove Investment Report Q1

X. CEO Report

XI. Announcements:

A. Regular Board of Directors Meeting – December 17, 2024 at 5:00 p.m.

XII. Adjournment

PUBLIC NOTICE

Any person with a disability may request the agenda be made available in an appropriate alternative format. A request for a disability-related modification or accommodation may be made by a person with a disability who requires a modification or accommodation in order to participate in the public meeting to Melissa Mitchell, VP of Quality and Regulatory Affairs, Sierra View Medical Center, at (559) 788-6047, Monday – Friday between 8:00 a.m. – 4:30 p.m. Such request must be made at least 48 hours prior to the meeting.

PUBLIC NOTICE ABOUT COPIES

Materials related to an item on this agenda submitted to the Board after distribution of the agenda packet, as well as the agenda packet itself, are available for public inspection/copying during normal business hours at the Administration Office of Sierra View Medical Center, 465 W. Putnam Ave., Porterville, CA 93257. Privileged and confidential closed session materials are/will be excluded until the Board votes to disclose said materials.

Senior Leadership Team	11/26/2024
Board of Director's Approval	
Bindusagar Reddy, MD, Chairman	11/26/2024

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
November 26, 2024
BOARD OF DIRECTOR'S APPROVAL

The following Polices/Procedures/Protocols/Plans have been reviewed by Senior Leadership Team and are being submitted to the Board of Director's for approval:

	Pages	**Action**
Policies:		Approve ↓
• CHC Annual Program Evaluation	2-3	
• Patient Access to Medical Records	4-7	
Plans:		
• Performance Improvement Plan	8-13	
Forms		
• Authorization for Release of a Minor	14-15	
• Medical Record Form	16-17	
Report		
• Quality Report FY 2024	18-32	

SUBJECT: **CHC ANNUAL PROGRAM EVALUATION**	SECTION: ***Administrative*** **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To comply with Code of Federal Regulations 42 part 491.11 at the Sierra View Community Health Center.

POLICY:

The Community Health Center will conduct a biennial evaluation of its total program by forming an Biennial Evaluation Review Committee. The Biennial Evaluation Review Committee will include the Health Clinic Manager, Medical Director, Advanced Practice Provider, Community Health Center Staff member, and a third party (Consultant, Board Member, Hospital Leadership) Sierra View Community Health Center is operated and is fully integrated with Sierra View Medical Center and follows all applicable hospital-wide Policy and Procedures.

AFFECTED PERSONNEL/AREAS:

Health Clinic Manager, Medical Director, Advanced Practice Provider, and Community Health Center Staff Member.

PROCEDURE:

1. A complete biennial program evaluation will be conducted in order to comply with 42 CFR Â§491.11.

2. A Biennial Evaluation Review Committee will be formed for the Community Health Center program to include the following individuals: Health Clinic Manager, Medical Director, Advanced Practice Provider, Community Health Center Staff Member and a third party (see above).

3. The biennial program evaluation includes a review of the following:

    a. Utilization review of all services provided by clinic
    b. Number of patients served and volume of services
    c. A representative sample of both active and closed patient health records
    d. Review of all clinic health care policies

e. Performance Improvement elements are being performed, documented and acted upon.

4. The review will include the following:

   a. Utilization of clinic services, including number of patients served.
   b. Review of 50 medical charts (40 active and 10 closed), CHC policies, SOPs and forms
   c. Formulary
   d. Laboratory processes and procedures, including Quality Control records
   e. Financial analysis, by location, payment source, and /or service line
   f. Staffing effectiveness
   g. Staff Development
   h. Performance Improvement/Quality Assurance
   i. Guidelines for medical management of health problems.

5. Biennial evaluation is to be reported through the hospital's Performance Improvement/Patient Safety Committee, Medical Executive Committee, and to the Board of Directors.

Biennial

REFERENCES:

- Code of Federal Regulations, Title 42- Public Health, Part 49, Subpart A, (2017).

SUBJECT: **PATIENT ACCESS TO MEDICAL RECORDS**	SECTION: **Page 1 of 4**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To comply with federal and state regulations, which outline patient access to his/her health record.

BACKGROUND:

1. Law and regulations provide that any adult patient, any minor patient authorized by law to consent to the treatment to which the record pertains, or any patient's representative, is entitled to inspect the patient record or obtain copies pursuant to the laws, conditions and limitations.

2. Since a patient can authorize release of information to any individual, it is assumed that the patient may authorize disclosure to him/herself. The provider may honor such an authorization if the provider determines that such disclosure will not harm the patient. In this case, the provider may give, but is not required, to allow patient access to his/her own alcohol and/or drug abuse records.

    a. Alcohol and drug abuse records are subject to federal alcohol and drug abuse regulations (42 CFR, Section 2).

POLICY:

1. The Health Information Management Department (HIM) will be responsible for responding to all requests for patient access to medical records, paper or electronic.

    a. Requesting individuals must be notified of a decision to release protected health information within 10 days of the hospital receiving the request.

2. HIM Department staff will not attempt to explain or interpret any part of the record. The patient, or patient's representative, will be referred to the physician or other responsible healthcare professional for any necessary assistance in understanding the information contained in the record.

3. All requests will be filed separately in the patient's medical record together with documentation as to the disposition of the request, type of access, date and name of person processing the request.

PROCEDURE:

1. Business hours for patient access to records are from 8:00 AM to 5:00 PM, Monday through Friday, except holidays.

2. Patients will present a written, signed authorization/request and furnish sufficient photo identification. He/she may request to inspect records, request copies of records or a summary alternative may be given to him/her in lieu of the first two (2) methods of access.

3. Charges will be explained to the patient. He/she will be requested to pay all charges prior to compliance with his/her request. These charges are:

   a. Clerical costs for making the record available: $16.00

   b. Payment for copies furnished: $.25/page

   c. Attending physician sets fee for summary alternative

   d. Postage for mailing records, certified mail

4. A copy of the written, signed authorization/request will be forwarded to the attending physician the first working day after receipt of the request from the patient or his/her representative, for review and approval/denial. The attending physician will notify the HIM Department no later than the fourth working day after receipt of the request, as to whether the request is approved or denied.

5.

   a. If access is approved, the patient, or patient's representative, may have one person of his/her choice present at the inspection. This person may or may not be a healthcare professional. If the patient wishes copies of any part of the record, appropriate release of information (ROI) would be completed.

   b. If access is denied, the patient may designate a licensed physician, psychologist or social worker to review or obtain copies of the patient's record.

   c. Inspection will be carried out within the Health Information Management under the direct supervision of designated HIM staff.

6. Prior to permitting an inspection, or providing copies of records, HIM staff will review the medical record to:

   a. Ensure completeness of the record

   b. Remove any information furnished in confidence by someone other than the patient, or another provider

   c. Consideration of possible adverse consequences to minor patients where psychiatric records or alcohol and/or drug abuse records are concerned

      - The attending physician may be consulted regarding any of the above measures.

7. The attending physician may decide to comply with the patient's request by providing a summary alternative. The attending physician will be responsible for providing the summary. The hospital will transcribe the report.

   a. The summary must include:
   - Chief complaint, including pertinent history
   - Findings from consultations or referrals to other healthcare providers
   - Diagnosis, where this has been determined
   - Progress of the treatment
   - Prognosis, including significant continuing problems, or conditions
   - Reports of pertinent diagnostic procedures and tests
   - Discharge summaries
   - Objective findings from the most recent physical examination, such as blood pressure, weight and actual values from routine laboratory tests (lab tests could be copied separately)
   - Current medications prescribed, including dosage and any sensitivities or allergies to medications prescribed

8. If a summary alternative is used, it must be available to the patient within ten (10) working days after receipt of the written, signed request/authorization.

9. If the patient's stay was a lengthy one, availability of the summary may be extended to 30 calendar days.

10. Records will be made available for inspection within five (5) working days following receipt of the written, signed request/authorization.

11. If copies are requested, they will be sent by certified mail within fifteen (15) calendar days of receipt of the valid written, signed request. Request must specify records desired.

12. If the patient was discharged within ten (10) calendar days prior to the receipt of the request, the period of time in which the summary will be available may be extended to 30 calendar days.

13. If the patient is still an inpatient and requests access to his/her records, access cannot be denied:

    a. Inform his/her attending physician and obtain approval or disapproval

    b. HIM Department or Nursing Services should supervise the review

c. Any questions the patient might have should be referred to the attending physician or other healthcare professional involved in the patient's care

14. If at any time, upon reviewing his/her record, a patient requests to have his/her record changed or amended in any manner, a request for chart amendment would be completed.

15. A minor has the right to inspect or obtain copies of his/her records in any situation where the minor consented to care or is an emancipated minor. In these instances, the parent has no right to see the minor patient's medical record.

16. Patient access to health records refers to all medical records held by the hospital.

17. Patient's representative is defined as the parent or guardian of a patient who is a minor, or the conservator of the patient. Proof of guardianship of minor or conservatorship of a person must be shown.

REFERENCES:

- The Joint Commission (2024). Hospital accreditation standards. IM.02.02.01. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **PERFORMANCE IMPROVEMENT PLAN**	SECTION: ***Performance Improvement*** **Page 1 of 6**

PURPOSE:

Sierra View Medical Center (SVMC) is committed to providing quality health care services to all of our patients. As an organization, we realize that in order to provide this level of care, we must continually measure and assess systems and outcomes related to those services provided. This plan describes the organizational procedures to be utilized in performance measurement, performance assessment and performance improvement activities. It is the intent of the organization's leaders to develop a performance improvement program that allows all departments and services to collaboratively perform improvement activities utilizing the Plan, Do, Study, Act (PDSA) methodology. This plan describes the communication and coordination for all organizational activities directed toward improving patient care services.

POLICY:

A. Authority and Responsibility

1. The Board of Directors has the ultimate authority and responsibility to require and support a Performance Improvement program at Sierra View Medical Center. The Board of Directors has delegated the responsibility of implementing an organization-wide performance improvement program to Administration, the Medical Staff and the Performance Improvement/Patient Safety (PIPS) Committee.

B. Specific Performance Improvement Components

1. **Hospital Support Service**

Senior Leadership shall oversee the development and implementation of performance improvement activities for Nursing and other hospital support services, assuring the integration and coordination of service-specific activities into the organization-wide performance improvement program. The substantive results of support service performance improvement activities will be reported to the Performance Improvement/Patient Safety Committee. A summarized report will be presented to the Board of Directors at least quarterly. Relevant information from the support service performance improvement activities will be shared organizationally as needed.

2. **Medical Staff Peer Review Program**

The Medical Staff has empowered the Medical Executive Committee to develop and oversee the Medical Staff Peer Review Program. The Medical Executive Committee shall assure the integration and coordination of all Medical Staff peer review activities into the organization-wide Performance Improvement Program when indicated.

3. **Medical Staff Committees**

The Medical Staff Committees review quality data and determine necessary actions to make or sustain improvements. The Medical Staff coordinates their improvement activities with other Medical Staff and administrative committees as necessary to achieve

the desired outcome. Medical staff committee reports are submitted to the Medical Executive Committee by the designated chairperson.

4. **Patient Safety Program**

The organization has developed an integrated Patient Safety Program to collect data and investigate occurrences related to patient safety and risk reduction. Hospital occurrences which may be related to patient safety or medical errors are reported to Risk/Patient Safety Management. The Risk/Patient Safety Department assures timely integration of this Risk Management information into the Organizational Performance Improvement Program. Information related to sentinel events and error reduction is reviewed by the Performance Improvement/Patient Safety Committee (PIPS). The PIPS Committee has adopted the failure mode, effects, and analysis (FMEA) model for proactive process redesign.

5. **Performance Improvement/Patient Safety Committee (PIPS)**

The Performance Improvement/Patient Safety (PIPS) Committee has been empowered to develop and oversee the organization-wide performance improvement program with focus on the safe delivery of care. This program supports the integration and coordination of medical staff, nursing and support services in order to be successful in their improvement efforts. The PIPS Committee supports and follows the fundamental principles of performance improvement, collecting and analyzing data, and taking actions to make improvements and/or to sustain achievements. Emphasis is placed on patient outcomes and meeting regulatory requirements that support safe delivery of care.

6. **Process Improvement Teams**

The organization supports the development of process improvement teams to improve patient care and services. Prioritization of team activities are determined based on organization assessment and evaluation of organizational goals. Process Improvement teams are chartered through PIPS to avoid duplication of activities throughout the organization and to standardize the process. Teams will be further prioritized based on organization need with focus on improved patient outcomes, considering high volume and problem prone, high risk and low volume areas. Team activities will be tracked and reported through the Performance Improvement/Patient Safety Committee. Process improvement teams shall follow the PDSA model. Other Performance Improvement teams may be formed within the organization as needed and shall follow the performance improvement model most appropriate for the process which is being reviewed.

AFFECTED PERSONNEL/AREAS: *ALL HOSPITAL STAFF*

PROCEDURE:

A. Reporting and Coordination

1. *Hospital Support Services*: The following hospital support services shall analyze their scope of service and goals and recommend to the appropriate Executive and/or the Performance Improvement /Patient Safety Committee specific quality control and other measures for inclusion in the organization-wide performance improvement program. Hospital support services include:

   a. Care Management
   b. Population Health
   c. Risk/Patient Safety
   d. Donor Network West
   e. Food and Nutrition
   f. Infection Prevention
   g. Laboratory
   h. Pharmacy
   i. Rescue/Resuscitation
   j. Regulatory
   k. Radiology
   l. Physical Therapy
   m. Graduate Medical Education

2. *Hospital Service Departments* – These departments shall analyze their scope of services and goals and recommend to the appropriate Executive and/or the Performance Improvement/Patient Safety Committee specific quality control and other measures for inclusion in the organization-wide performance improvement program. Hospital Service Departments include:

   a. *Critical Care*
   b. *Emergency Services*
   c. *Operative/Invasive Services*
   d. *Renal Services*
   e. *Cancer Treatment Center (CTC)*
   f. *Distinct Part Skilled Nursing Facility (DP/SNF)*
   g. *Wound Care*
   h. *Cardiac Cath Lab*
   i. *Urology Clinic*
   j. *Community Health Clinic*
   k. *Pediatrics*
   l. *Maternal Child Health*
   m. *Academic Health Center*
   n. *Sierra View Multi Specialty Center*

3. *Nursing Care Units/Departments* –Nursing shall analyze their scope of service and goals and recommend to the Performance Improvement/Patient Safety Committee specific

quality measures for inclusion in the organization-wide performance improvement program. Nursing participates in the National Database of Nursing Quality Indicators (NDNQI) program for submitting data for: Restraints, Pressure Ulcers, Falls, Patient Days, Nursing Care Hours, and Unplanned Post-Operative Transfers. Data is analyzed and actions taken to achieve desired goals.

4. *Contract Services* –Contracted services shall be monitored and evaluated yearly by the clinical leaders and medical staff. Improvement efforts will be implemented when contracted services do not meet their determined expectations as defined in their contract. This may include increased monitoring of services, training, and re-negotiation of terms. Applying penalties and termination would be considered as a last resort. Results of the yearly evaluation will be reported to the Governing Board. Oversight of Contract Services is shared with the Compliance Office.

5. *Medical Staff Department/Peer Review Committees* –The Medical Staff departments shall analyze their scope of service and goals and recommend to the Medical Executive Committee specific quality monitoring and other measures for inclusion in the organization-wide performance improvement program. Medical staff peer review committees include:

   a. *Emergency Medicine*
   b. *Family Medicine*
   c. *Pediatrics*
   d. *Radiology/Pathology*
   e. *Internal Medicine*
   f. *OB/GYN*
   g. *Surgery*
   h. *Anesthesia*

6. *Medical Staff Committees* – The following Medical Staff committees shall analyze their scope of monitoring and committee goals and recommend to the Medical Executive Committee specific quality measures for inclusion in the organization-wide performance improvement program by way of a designated Chairperson. Medical Staff Committees include:

   a. *Pharmacy and Therapeutics/Nutrition Care Committee/Infection Prevention*
   b. *Bioethics Committee*
   c. *Utilization Review Committee*
   d. *Performance Improvement/Patient Safety Committee*

B. Individual Practitioner Competence Issues

1. Issues related to the competence of individual physicians, other independent practitioners, or allied health practitioners will be referred to the appropriate Medical Staff peer review committee for review and will be reported on to the Medical Executive Committee and Board of Directors as indicated by defined Medical Staff processes. Advanced practice nurses also fall under the auspice of the Chief Nurse Executive. This includes Certified

Registered Nurse Anesthetists (CRNAs), nurse practitioners, and nurse midwives who are privileged through the medical staff.

2. Issues related to the performance of practitioners who are hospital employees or work under a hospital job description will be referred to the appropriate service director for evaluation and referred to hospital administration and the Board of Directors as indicated.

3. Written complaints or allegations regarding a provider's sexual misconduct or sexual abuse of a patient will be reported within 15 days to the provider's professional licensing board. Provider is defined to include any person with a license to practice in the healing arts.

C. Communication and Coordination of Results

1. The relevant results of Performance Improvement activities are used primarily to study and improve processes that affect patient outcomes and are related to patient safety. When relevant to the performance of an individual, performance improvement information will be utilized in the evaluation of individual capabilities as part of the human resources assessment or Medical Staff credentialing processes. The information will be communicated as may be necessary to achieve this goal.

2. The conclusions, recommendations, actions and results of the actions taken shall be documented and reported through established channels as noted in this plan.

3. Relevant information shall be communicated among departments, services and professional disciplines when opportunities to improve care involve more than one department or service in the organization. The purpose of reporting and communicating is to share information with those in the organization to whom the information is pertinent.

D. Annual Appraisal

1. The Performance Improvement / Patient Safety Committee shall report, on an on-going and periodic basis, an appraisal of the organizational Performance Improvement program. The appraisal should contain information regarding significant opportunities to improve care identified through the performance improvement process and the effectiveness of actions taken. The on-going and periodic appraisal should discuss both the strengths and weaknesses of the existing program, discuss the degree of overall integration and coordination of improvement activities, and contain recommendations for program improvement. The Performance Improvement/Patient Safety Committee shall submit on-going reports to the Medical Executive Committee and Board of Directors.

REFERENCES:

- Centers for Medicaid Services. (2021). The CMS Compliance Crosswalk. § 482.21 Quality Assessment and Performance Improvement Program. Brentwood, TN.

- The Joint Commission. (2024). Hospital Comprehensive Accreditation Manual. Standards: (PI 01.01.01, LD 03.07.01, MS05.01.01, PI 02.01.01 Oakbrook Terrace, IL.

- The Joint Commission (2024) Laboratory and Point-of-Care Testing Standards Manual. Standards – PI 01.01.01, PI 02.01.01, LD 03.07.01, LD 03.05.01, LD 04.03.09 Oakbrook Terrace, IL.

I, (insert name) _____, the

- ☐ parent
- ☐ guardian
- ☐ legally authorized caregiver

of (child's name) _____, authorize

(hospital name) _____ to release my child to:

_____ _____
(name) (area code and telephone number)

_____ _____
(address) (city, state, zip)

I retain all parental rights to his/her custody and control. This authorization authorizes only the release of my child from the hospital to the person named above.

Date: _____ Time: _____ AM / PM

Signature: _____
(parent/guardian/caregiver)

Print name: _____
(parent/guardian/caregiver)

INTERPRETER'S STATEMENT

I have accurately and completely read the foregoing document to (patient or patient's legal representative) _____ in the patient's or legal representative's primary language (identified language) _____ He/she understood all of the terms and conditions and acknowledged his/ her agreement by signing the document in my presence.

_____
Signature of interpreter, or remote interpreter's number Date/Time

_____
Print Name

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257

PATIENT'S LABEL

Yo, (nombre) _____, el

- ☐ padre/madre
- ☐ tutor
- ☐ proveedor de atención debidamente autorizado

de (nombre del menor) _____, autorizo

a (nombre del hospital) _____ a que haga entrega de mi hijo o hija:

_____ _____
(nombre) (número de teléfono)

_____ _____
(dirección) (ciudad, estado, código postal)

Retengo todos los derechos paternos/maternos respecto a su custodia y control. La presente autorización únicamente autoriza al hospital a hacer entrega de mi hijo o hija a la persona arriba mencionada.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(padre/madre/tutor legal/proveedor de atención)

Nombre en letra de imprenta: _____
(padre/madre/tutor legal/proveedor de atención)

INTERPRETER'S STATEMENT

I have accurately and completely read the foregoing document to (patient or patient's legal representative) _____ in the patient's or legal representative's primary language (identified language) _____ He/she understood all of the terms and conditions and acknowledged his/ her agreement by signing the document in my presence.

_____
Signature of interpreter, or remote interpreter's number Date/Time

_____
Print Name

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257

PATIENT'S LABEL

SUBJECT: **MEDICAL RECORD FORMS**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define a single, comprehensive system for the development, communication, and control of new and revised medical record forms.

To assist in interdisciplinary communication and involvement of new or revised medical record forms and forms containing patient health information (PHI).

To assure the appropriate review of medical record forms and forms containing PHI are within acceptable parameters for effective documentation for quality care.

AFFECTED AREAS/PERSONNEL: *ALL HOSPITAL PERSONNEL AND DEPARTMENTS*

DEFINITIONS:

Medical record paper form: Any Sierra View Medical Center (SVMC) approved paper filled permanently in the medical record and identified by an official form number assigned by Materials Management.

Medical record electronic template: Any SVMC electronically-created template for the medical record.

Document owner: The department initiating a new or revised medical record form.

Clinical worksheet: Any clinical worksheet or data collection sheet for internal clinical purposes containing PHI.

POLICY:

1. All new and revised medical record forms that are part of the medical record by either electronic creation, scanning or imaging upload and include, but are not limited to, clinical, administrative, and research information must be submitted to the Health Information Management (HIM) Director.

2. All new and revised medical record forms will be processed through an approval process, which may include approvals by various medical staff and/or committees and final approval by MEC (Med Exec) and the Board.

3. All clinical worksheets or data collection worksheets containing PHI must be submitted to the HIM Director for review and verification of formatting. Must contain: THIS IS NOT PART OF THE PERMAMENT MEDICAL RECORD, RETURN TO:

PROCEDURE:

1. Requests to create or change a medical record form (electronic or paper) are submitted to the HIM Director.

2. All medical record forms must be reviewed and approved by the Director of Health Information Management and all appropriate committees to assure the content, format and completion mechanisms are in place and documentation meets appropriate regulatory requirements

3. The document owner is responsible to verify that the abbreviations on the form comply with the Approved Abbreviation list. Whenever space permits, abbreviations should not be used.

4. The document owner is responsible for any associated policy and procedure update or creation, the education, and implementation of the new or revised form (electronic or paper).

5. Once all appropriate approvals are completed, final approval is provided to the forms vendor for production. Production of a medical record form is 10-15 business days from the approval date.

6. Forms which have been approved may not be altered in any way without re-submission.

7. Delivery of medical records forms include, but may not be limited to:

    a. Clinical Forms are delivered by the vendor in the appropriate unit-specific cart(s).

    b. Non-Clinical forms are delivered and distributed by Materials Management to the appropriate department.

CROSS REFERENCES:

- ABBREVIATIONS IN THE MEDICAL RECORD

Quality Report FY 2024

SIERRA VIEW MEDICAL CENTER

NOVEMBER 2024

Sierra View Medical Center
Prepared by Melissa Mitchell, VP of Quality and Regulatory Affairs

Annual Evaluation:

- **QIP**
- **Patient Experience**
- **Patient Safety/Risk**
- **Care Integration**
- **Infection Prevention**
- **Employee Health Services**
- **Stroke/Sepsis**
- **Regulatory**

Sierra View Medical Center

Mission

Sierra View Medical Center promotes health and ensures access to high quality health care services. This will be achieved:

- Through partnership and collaborations
- By being a good steward of resources to ensure it can contribute to meet the needs of the community

Vision

Strengthen the quality of life through the delivery of integrated health care programs and services that promote access, care coordination and patient care experience.

Values

Compassion: Caring from the heart

Collaboration: Partnering for a common purpose

Accountability: Accepting ownership of our actions

Integrity: Inspiring trust and honesty

Respect: Embracing and appreciating others

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Quality Division Updates

FY 2024 Quality Incentive Program

Metric Code	Metric	Type of metric	SVMC Performance	Minimum Benckmark	Median Benckmark	High Benckmark
Primary Care Access and Preventative Care						
Q-CMS147	Preventive Care and Screening: Influenza Immunization	Priority	41.85%	25.51%	40.39%	75.47%
Q-CMS138	Preventative Care and Screening: Tobacco Use - Screening and Cessation Intervention	Priority				
	• Rate 1 (informational only)		95.35%	N/A	N/A	N/A
	• Rate 2		37.18%	33.21%	55.52%	90.45%
	• Rate 3		77.15%	75.04%	84.96%	95.72%
Overuse/Appropriateness						
Q-QPP415	Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and	Elective	82.47%	89.73%	91.02%	91.99%
Maternal and Perinatal Health						
Q-PC02 ↓	Cesarean Birth (PC02-CH)	Elective	41.26%	25.09%	22.22%	22.00%
Q-PC05	Exclusive Breast Milk Feeding (PC-05)	Elective	32.97%	42.92%	58.33%	72.96%
Experience of Care						
Q-QPP47	Advance Care Plan	Elective	100.00%	55.61%	83.58%	91.99%
Patient Safety						
Q-STK-2	Discharged on Antithrombotic Therapy	Elective	100.00%	99.59%	100%	100%
Q-QPP23	Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	Elective	99.03%	47.61%	89.42%	92.00%
Q-QPP76	Prevention of Central Venous Catheter (CVC) – Related Bloodstream Infections	Elective	72.73%	44.85%	90.40%	92.00%
Q-CDI ↓	Reduction in Hospital Acquired Clostridium Difficile Infections	Elective	0.39	N/A	0.45	N/A
↓ **Indicates better performance**						

The scores reported above reflect the work done from January 2023 through December of 2023. This measurement period, SVMC was able to achieve a quality score of 77.50%. In the previous year, SVMC achieved a quality score of 71.43%. While the payment amount remains unknown, it is anticipated to be near $6 million.

Patient Experience

Program Accomplishments/Performance:

- As per new CMS/Joint Commission guidelines, worked with registration to implement required questions regarding the patient's sexual orientation, gender identity and patient disabilities. Provided registration with scripting when asking these questions which can be a sensitive matter for some patients.
- Worked with education department to create MCH Welcoming video. The purpose is to better educate expecting parents on what to expect when they arrive at our hospital and during their stay with us.
- Worked with nursing to create an online belongings sheet that helped to reduce grievances around lost belongings.
- Worked with ACS to gather data on our patient's socio-economic needs per the new CMS/Joint Commission guidelines and to determine areas of focus to help improve patient's quality of life and reduce hospital visits.
- Working with Silvia Roberts, Manager of Care Integration, to improve transportation resources for our patients to ensure they can get to appointments or obtain rides to their home.
- Partnering with California Quits as a referral point for our patients requesting support to stop smoking/vaping.
- Implemented Rounding on Departments Served: Twice a month EVS and Materials Directors meet with managers, directors in their areas including inpatient units, Emergency Department, outpatient surgery and Cath Lab to have conversations about what is working well and areas to improve.
- Ambulatory Surgery including Flex Care, OR and Cath Lab improved in all 24 patient survey questions compared to FY23.
- Outpatient Imaging including Mammography, MOB Radiology and Main Radiology improved in all 27 patient survey questions compared to FY23.
- We saw improved percentages of positive versus negative patient comments in Ambulatory and Outpatient Surgery, Emergency Department, Outpatient Services and CTC. Rural Health Clinic received 86.1% positive patient comments.
- By continuing to be proactive versus reactive in addressing patients' complaints we realized a decrease in Complaints and Grievances by 10% and a reduction in visits from CDPH compared to FY23.
- Partnered with local schools to have students create holiday cards for employees and patients.
- The MyRounding platform continues to be a great resource for data tracking in many areas.
    - The number of hand hygiene audits increased by 6,400 audits recorded
    - We continue to make discharge phone calls to our Ambulatory Surgery patients
    - Daily Rounding on patients

Areas of Focus for FY25:

- Improving RN/MD Communication using mock role play with residents, applying BETA principles, applying new RN discharge information sheet.
- Health Equity – Continue our work to improve the social determinants of health (SDOH) that affect our community. Partner with community agencies and local government to improve transportation needs, food needs, housing needs, education/literacy and difficulty paying for prescriptions.
- Providing our patients and community resources on smoking/vaping cessation.
- Reestablish our Patient and Family Advisory council (PFAC)

Patient Safety/Risk

Each year SVMC engages with BETA on several patient safety initiatives. This year, every collaborative met or exceeded their validation benchmarks. These programs are designed to increase patient safety, reduce harm events, and improve employee work systems. Each validation results in significant savings in our insurance premiums.

- Employee Safety and Wellness Initiative
  - This is the first-year validation was achieved
- BETA HEART
  - This is the first year that all 5 domains were met
- BETA*rm OB
  - Met Tier 1 requirements
- BETA*rm ED
  - Met Tier 1 and 2 requirements

Care Integration

Program Accomplishments/Performance:

- *Length of Stay*

In this past fiscal year, as an organization we achieved positive progress with more months averaging 3.5, which aligns closely with our target goal. Additionally, we identified fewer months with an average of 4.0 or more, indicating a successful strategy implementation.

Transportation

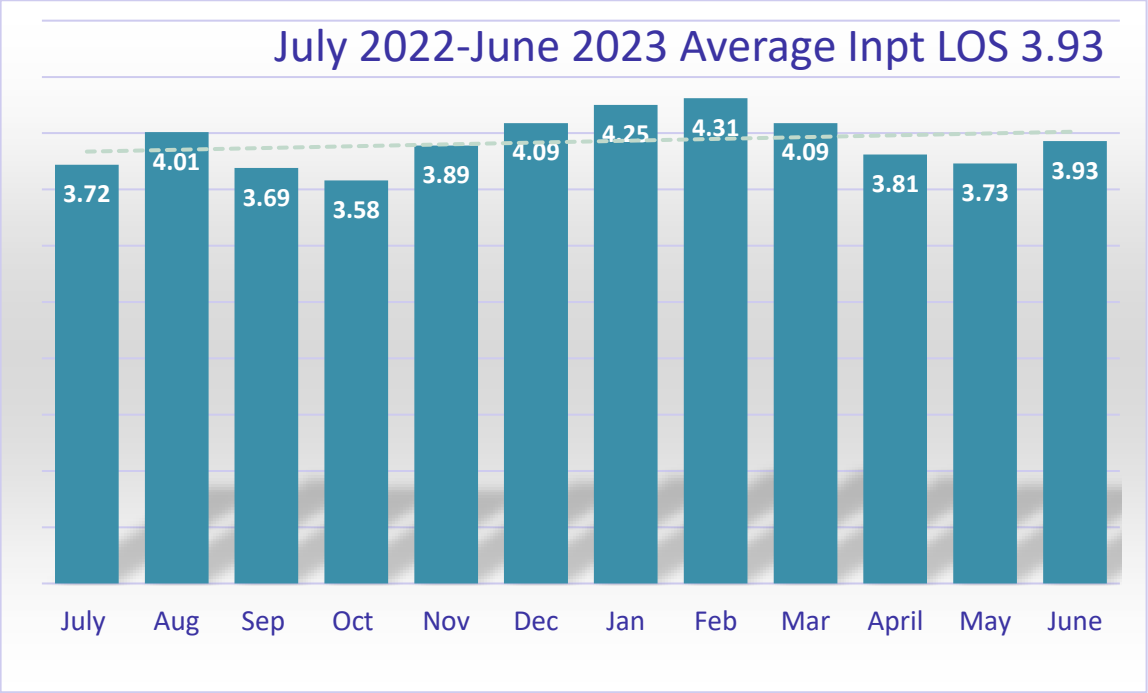
Transportation for been consistently identified as a barrier in various areas of the organization. This past year we implemented the use of Amdal Transportation Services across the acute care

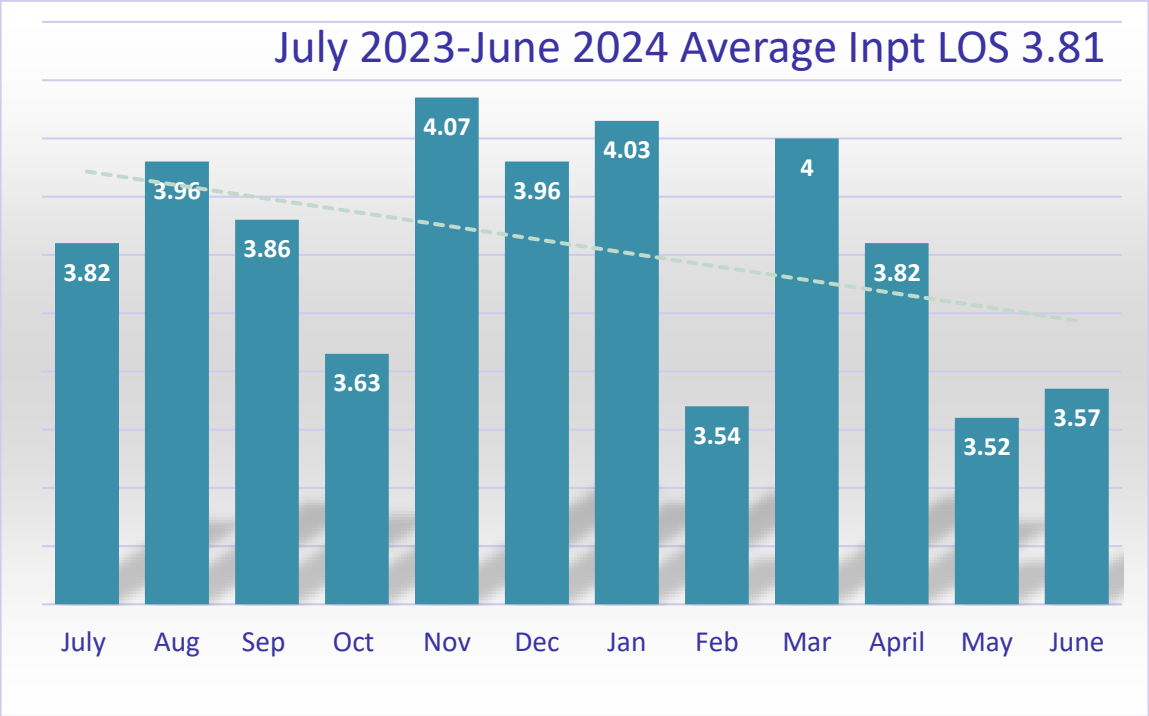
area along with UBER services. The decision to use these services, resulted from numerous instances where individuals faced difficulties accessing transportation services due to insurance and financial barriers. By proactively addressing this issue, there was an effective decrease in the average LOS.

Discharge Team

A communication process was implemented with interdisciplinary team members across the organization. Throughout the day, constant communication takes places with respect to identifying discharges, updates on barriers to discharge, and discharge plans. These interactions culminate in a final in-person meeting.

- This process begins at 9am and takes places 7 days a week with residents initiating the process.
- SVMC GME residency program holds the lowest LOS in the Valley





➢ *Mental Health Evaluations*

Due to new mandates from the California Department Health Care Services, SVMC was required to begin completing mental health evaluations in-house by July 1, 2024.

- New service line brought 12 hour shifts with 7 day social service coverage in the ED
- 5150/5585 psychiatric hold implementation can now be completed by the Care Integration Team, with 8 authorized SVMC employees who can complete the assessments and holds under 2 approved Licensed Clinical Social Workers
- Major strides in cost-saving efforts by opting to train staff rather than outsourcing this service line
- This service line also initiated clinical staff supervision for licensure requirements that has led to staff retention
- There has been a positive impact on the turnaround time for psychiatric placements; and it is important to highlight that there has been a noticeable decrease in the amount of patients who have to go on a second holds

Infection Prevention

The Infection Prevention and Control (IP&C) program goals for 2024 were based on the predictions made in 2023 by the Centers for Disease Control and Prevention (CDC), the Association for Professionals in Infection Control and Epidemiology (APIC), and others at the end of the COVID-19 Public Health Emergency. The CDC predicted that there would be an increase in hospital acquired infections (HAIs) due to the relaxation of the restrictive COVID-19 guidelines. Elevated HAIs could be

avoided if immediate action were taken to get back to evidence-based infection prevention practices. With this in mind, Sierra View Medical Center (SVMC) IP&C focused on improving the following items within our hospital:

1. Maintain or reduce the number of HAIs throughout 2024 using 2023 data as the baseline for comparison
2. Maintain or reduce the number of surgical site infections (SSIs) through increased surveillance activity within the surgical department. The surveillance would include EVS terminal cleaning and surgical procedure observations. Each report was shared with the appropriate staff to provide the IP perspective and advise on evidence-based best practices
3. Increase IP participation in educational opportunities within SVMC and our community to cultivate a healthier community. *(Lunch at the Library, GME IP Seminars, RN Resident's Program Education & Research, CTC Oncology Patient Support Group.)*

Below is an update on the IP&C activities we undertook to reach our goals.

Program Accomplishments/Performance

- *Maintain or reduce the number of HAIs in 2024*

The table below shows 4 quarters of selected HAI statistics that were reported to the National Healthcare Safety Network (NHSN). SVMC was able to maintain or reduce the total number of HAIs reported to date when compared to 2023 and in many instances, performed much better than predicted by the NHSN SIR.

HAI Report
Q3 CY2024

HAI/HAC		Q4	Q1	Q2	Q3	Overall
CAUTI	Actual	1	0	0	**0**	1
	Predicted	1.046	0.996	0.875	**0.793**	3.710
					Better	
CDI	Actual	0	2	0	**0**	2
	Predicted	2.259	2.526	2.437	**2.497**	9.719
					Better	
CLABSI	Actual	0	0	0	**0**	0
	Predicted	0.399	0.300	0.289	**0.294**	1.282
					Better	
MRSA BSI	Actual	0	0	0	**0**	0
	Predicted	0.287	0.282	0.192	**0.209**	0.970
					Better	
SSI	Actual	0	0	1	**0**	1
	Predicted	0.205	0.419	0.393	**0.409**	1.02
					Better	
VRE BSI	Actual	0	0	0	**0**	0
	Prevalence	0.0	0.0	0.0	**0.0**	-

CAUTI – **Catheter-associated urinary tract infection**
CDI – ***C. difficile* infection**
CLABSI – **Central line-associated blood stream infection**
MRSA BSI – **MRSA blood stream infection**
SSI – **Surgical site infection**
VRE BSI – **Vancomycin resistant enterococci blood stream infection**

Predicted = **Standardized Infection Ratio (**SIR**)**

NHSN reported inpatient conditions/surgeries

- *Increased OR surveillance activity to reduce SSIs*

One of the three types of surveillance that the IP Department conducted was the evaluation of OR terminal cleaning using the evidence-based fluorescent marker method. Although there is still room for improvement, the terminal clean surveillance showed an improvement from the 2023 baseline when less than 25% of the observations passed. Currently, more than 60% of all marker spots are removed, which is an improvement, but 100% of all spots must be removed to receive a passing grade. The results were shared with departmental managers and the EVS and OR staff received coaching on how to improve their terminal cleaning proficiency.

OR procedure surveillance was conducted over the last year. The IP-RN utilized an evidence-based survey tool approved by two professional societies (APIC and AORN) to assess the procedure. Minor but potentially important issues were identified. The outcome reports were shared with the Surgical Department Director so that the information could be shared with the appropriate OR staff.

This year, a Mako Surgical Robot was incorporated into orthopedic surgeries at SVMC. A motion study was conducted to assess *from the IP point of view*, that sufficient resources were available to safely and comfortably conduct robot-assisted orthopedic surgeries. Although the final report has not yet been released, the conclusion was that from the infection prevention point of view, the ORs were able to safely accommodate the robotic-assisted surgeries.

Increase educational opportunities within SVMC and our community

The IP&C Department participates in educational opportunities within SVMC and the greater Porterville community. Within SVMC, IP&C participates in educational talks, seminars and activities with such groups at the GME Residents (Understanding Latent Tuberculosis), the RN Nursing Residents (Evidence-based Research in Nursing from an Infection Prevention Perspective), the general clinical and registration staff (5-Minute Huddles, Patient Education and FAQs on various timely topics.) In July, two members of the IP&C department conducted a 'hands-on' hand hygiene demonstration for the children and their parents at the Porterville Public Library under the *Lunch at the Library* program (see photos.) This was a raucous, high-energy community interaction where the youngsters and their parents participated in learning proper hand hygiene. One young man (pictured) told us he is going to be a doctor! In the annual nursing competencies, an escape room format was used to review health care professional competencies. The changed format received positive reviews and we anticipate expanding this format for the FY2025 nursing competencies.

Areas of Focus for FY 25:

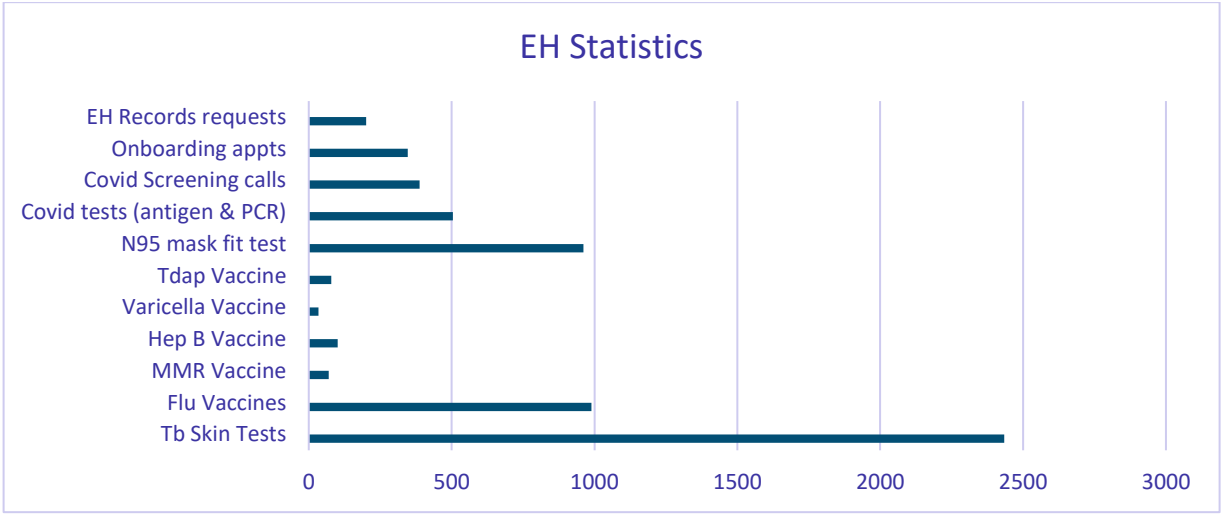
The major focus for FY 2025 is to continue improving and expanding communication within and between departments in SVMC by sharing IP concepts on how to keep our patients, visitors, staff and their families safe and free from HAIs. In addition, IP&C will focus on updating policies to facilitate ease of understanding and their implementation. Further, the CTC has invited the IP&C Department to present at the re-convened patient support group on the importance of infection prevention in the life of oncology patients. The IP&C Department looks forward to a more healthful 2025 with fewer HAIs.

Employee Health Services

Employee Health has spent the last year working on creating new or improving current processes within the department. This includes implementing new regulatory requirements for drug testing within California and meeting the guidelines for SB2188. Updating policies to improve employee satisfaction and simplifying annual and onboarding requirements for staff. Improving safety standards by participating in the BETA's Employee Safety and Wellness Initiative and validating in Workplace Violence resulting in a Workers Compensation premium decrease.

Program Accomplishments/Performance:

- Implemented SB2188 THC testing for reasonable suspicion drug testing
- Streamlined Blood drug testing send outs directly to shorten turnaround times.
- Combined and automated all MRO services for all drug testing types
- Upgrade Agility EH platform including new dictionaries
- Agility /UKG integration
- BETA approval of new Ergonomics policy to as participation in the Employee Safety Initiative
- Workplace Violence Validation resulting in reduction in Work Comp premiums
- Policy change to incorporate remote new hire onboarding requirements defined and implemented through updated policy
- Policy change allowing employees to provide annual Tb documentation from Jan to May of current year to ensure compliance
- Policy changes regarding Flu masking at all times while onsite through flu season
- EH is now providing the follow up and tracking of volunteer and security health requirements to assist with compliance in those areas
- Continuation of regulatory Covid requirements for HCWs to include screening, testing, quarantine exposure follow up and mandatory monthly reporting
- Achieved 99.5% flu and TB compliance rate at the time of the deadline requiring minimal NOCA's be issued.



Areas of Focus for FY25

- Improve new hire requirement completion times for follow up TB's and vaccinations by designating times to follow up with employees to help decrease the amount of no shows for these items.
- BETA ESWI Validation in Ergonomics
- Decrease the number of Needlesticks within the organizational

Stroke & Sepsis Program

Stroke

As a Joint Commission certified Primary Stroke Center, we are required to track several metrics that reflect the performance of our stroke program. When the numerator and denominator of all of those metrics are combined, we call it our "composite score." For FY2024, we ended the year with a composite score of 99%.

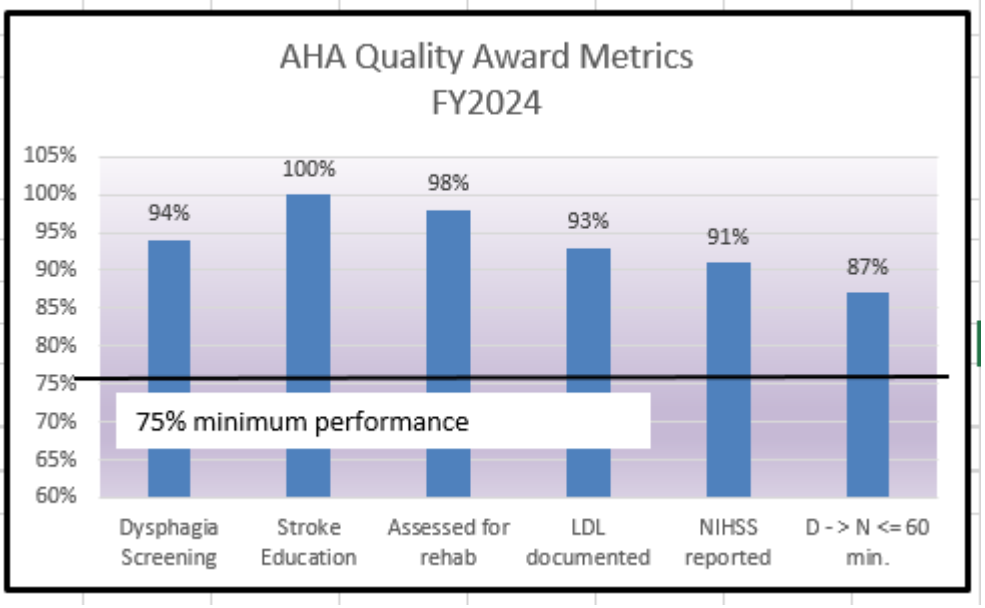
Program Accomplishments/Performance:

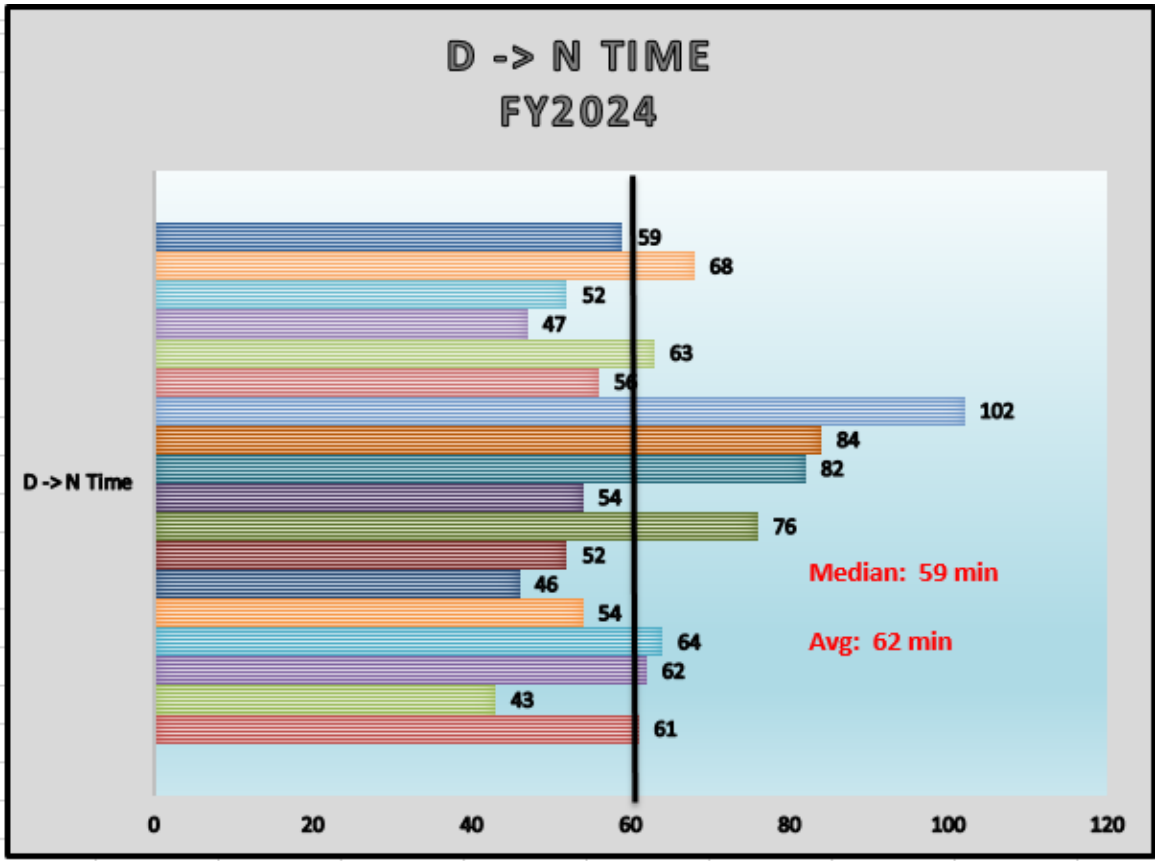
- We gave thrombolytics (the "clot-busting" drug) a total of 19 times during FY2024.
- Our cumulative door to needle time was 59 min (median) – under the requirement of 60 min.
- We received the Gold Plus award from American Heart Association for our stroke program performance. This is the highest award given by AHA for stroke. We also made the honor roll for our treatment of diabetes in stroke.
- It is forecasted that we will receive an additional quality award that includes:
  - Screening stroke patients to make sure they swallow safely (94%)
  - Providing proper stroke education (100%)
  - Assessing stroke patients for their rehabilitation potential (98%)
  - Screening the lipid / cholesterol levels in the blood of stroke patients (93%)
  - Reporting a standardized stroke scale score (91%)
  - Achieving a door to needle time (the time the patient enters our organization to the time the clot busting drug is given) of less than 60 min, at least 75% of the time. (87%)

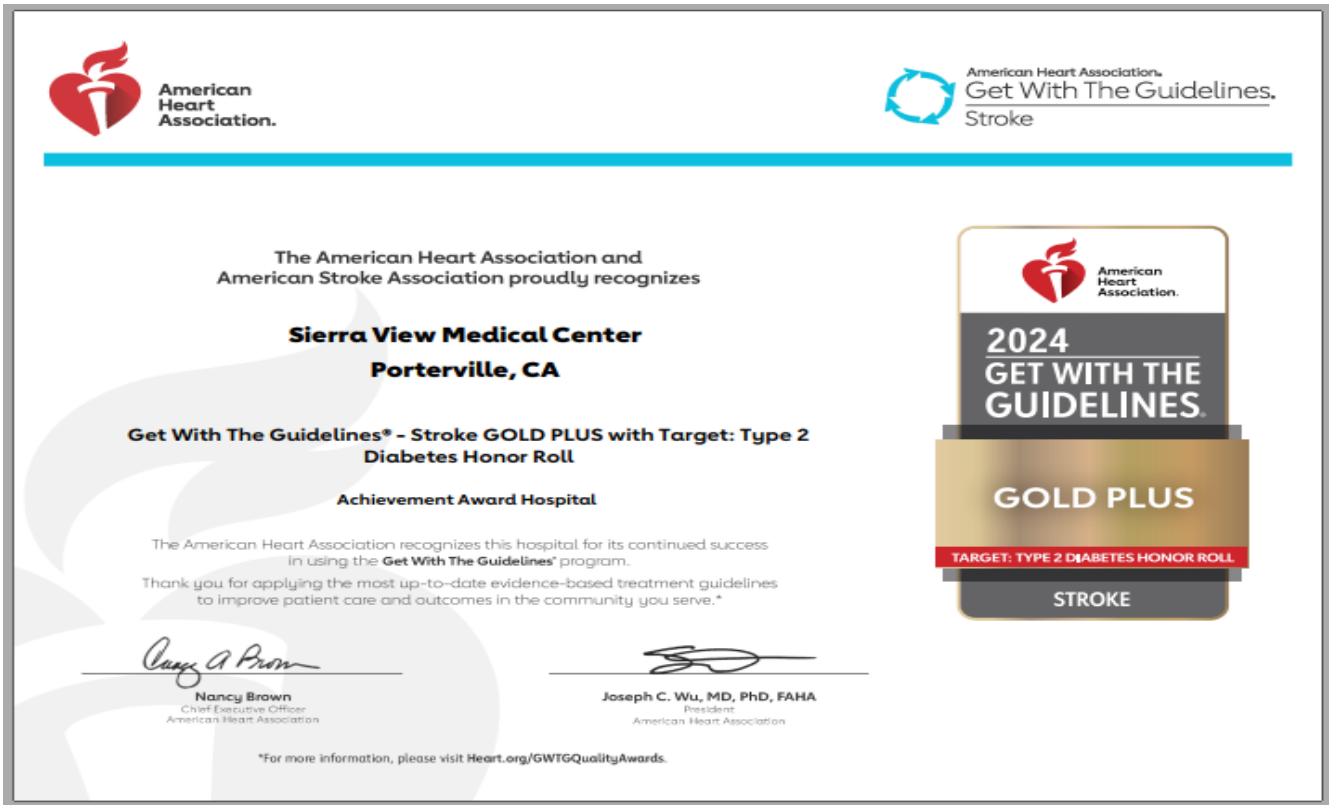
Areas of Focus for FY25:

- Door to needle time

- Quality award metrics
- Titration of anti-hypertensive drugs
- Blood pressure control after thrombolytics







American Heart Association.

American Heart Association.
Get With The Guidelines.
Stroke

The American Heart Association and
American Stroke Association proudly recognizes

Sierra View Medical Center
Porterville, CA

Get With The Guidelines® - Stroke GOLD PLUS with Target: Type 2 Diabetes Honor Roll

Achievement Award Hospital

The American Heart Association recognizes this hospital for its continued success in using the **Get With The Guidelines®** program.
Thank you for applying the most up-to-date evidence-based treatment guidelines to improve patient care and outcomes in the community you serve.*

Nancy Brown
Chief Executive Officer
American Heart Association

Joseph C. Wu, MD, PhD, FAHA
President
American Heart Association

*For more information, please visit Heart.org/GWTGQualityAwards.

American Heart Association.
2024
GET WITH THE GUIDELINES
GOLD PLUS
TARGET: TYPE 2 DIABETES HONOR ROLL
STROKE

Sepsis

Program Accomplishments/Performance:

- In FY24, the sepsis program provided care for 1292 patients with signs/symptoms of sepsis, an 1% decrease from the previous year
- SVMC's publicly reported SEP-1 score increased by 6%, landing on a total SEP-1 score of 80%.
- The sepsis program consistently performed better than like-size California hospitals – out of the total of 42 similar California hospitals, the average SEP-1 score was 60%. As mentioned, the SVMC SEP-1 score for the year was 80%. We perform better than average.
- The maternal sepsis program was developed and refined during FY2024, it launched in September 2024 (FY2025)

Areas of Focus for FY25:

- Continue to refine the maternal sepsis program as needed
- Improve Antibiotic administration times
- Focus on early recognition and suspicion of sepsis to provide early intervention and prevention of disease progression

Regulatory

Survey Highlights:

Type of Survey	# of Surveys	Findings
CDPH Regulatory Visits Complaint Surveys	29	1 Deficiency with resolution 1 Deficiency with penalty 19 with zero findings 8 Open Cases
CDPH Relicensing	1	DPSNF Relicensing Survey zero condition findings
CMS(CDPH) - Complaint Validation	1	1 with zero findings
EMTALA	2	1 Revisit 1 zero findings
TJC	2	1 Complaint Validation with zero condition findings 1 Lab Recertification with zero condition findings

Program Accomplishments/Performance:

- Opening of the Sierra View Multispecialty -Operative Specialties Clinic. Introducing, Timothy Tan, M.D., Orthopedic Surgeon and the relocation of Christina Kwock, M.D. General and Colorectal Surgeon to 263 N Pearson Dr. Suite 100

- Life Safety Assessment 2024

MEDICAL EXECUTIVE COMMITTEE	11/06/2024
BOARD OF DIRECTORS APPROVAL	
	11/26/2024
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
November 26, 2024 BOARD APPROVAL

The following Policies/Procedures/Protocols/Plans/Forms have been reviewed by the Medical Executive Committee and are being submitted to the Board of Directors for approval:

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SUBJECT: **ABBREVIATIONS IN THE MEDICAL RECORD**	SECTION:

PURPOSE:

To define the standardized abbreviations and symbols acceptable for use in the medical record at Sierra View Medical Center.

POLICY:

There shall be an approved abbreviation list available for use throughout the Hospital. Only abbreviations from this list shall be used in the medical record.

Only those abbreviations from the medical staff list of approved abbreviations will be utilized for documentation.

Pre-printed forms shall not include any abbreviations identified on the "Do Not Use" list. All pre-printed forms include, but not limited to, physician orders forms, protocols, clinical practice guidelines and pathways.

AFFECTED AREAS/PERSONNEL: *ALL CLINICAL DEPARTMENTS*

PROCEDURE:

1. The HIM Director, Vice President of Patient Care Services and the Vice President of Quality and Regulatory Affairs shall have the authority to add, delete, and otherwise update the abbreviation list as the needs of the hospital shall dictate.

2. The abbreviation list shall be submitted to the Medical Executive Committee for review and approval.

3. The abbreviation list shall be an addendum to this policy and shall be available in all copies of the manual.

REFERENCE:

- The Joint Commission. (2024). Hospital accreditation standards. IM.02.02.01. Joint Commission Resources, Oakbrook Terrace, Illinois

CROSS REFERENCE:

- Health Information Management Policy: Subject: Medical Record – Unacceptable Abbreviations and Symbols.

SIERRA VIEW MEDICAL CENTER
APPROVED ABBREVIATION LIST
ATTACHMENT A

A

@	at
a	before
A1	aortic first sound
A2	aortic second sound
aa	of each
A	assistance
AAA	abdominal aortic aneurysm
AaDO2	alveolar-arterial oxygen difference
AAROM	active assisted range of motion
A&O	alert and oriented
A&P	auscultation and percussion
AB	abortion
ABD	abduction
abd	abdomen
abd pol	abductor pollicis
ABG	arterial blood gas
abn	abnormal
ABX	antibiotics
a.c.	before meals
AC	acromioclavicular
ACL	anterior cruciate ligament
ACLS	Advanced Cardiac Life Support
ACT	activated clotting time
ACTH	adrenocorticotrophic (hormone)
ACVD	arteriosclerotic cardiovascular disease
A.D.	right ear (auris dextra)
ADA	American Diabetic Association
Adapt.	Adaptive
ADC	average daily census
ADD	attention deficit disorder
ADH	antidiuretic hormone
ADL	activities of daily living
ad lib	as desired
add pol	adductor pollicis
ADM	administrative
adm	admission
adq	abductor digiti quinti (muscle)
AE	above elbow
AFB	acid fast bacilli
A-fib	atrial fibrillation

ag	antigravity
AgNO3	silver nitrate
A/G Ratio	albumin-globulin
AGA	appropriate for gestational age
AGE	acute gastroenteritis
AHD	acute hemodialysis
AI	aortic insufficiency
AIDS	autoimmune deficiency syndrome
AIN	allergic interstitial nephritis
AK	above knee
AKA	above knee amputation
alb	albumin
alk.p'tase	alkaline phosphatase
alk.	alkaline
ALOC	altered level of consciousness
ALS	amyotrophic lateralizing sclerosis
a.m.	morning
AMA	Against Medical Advice
amb	ambulatory
AMI	acute myocardial infarction
amp	ampule
amt	amount
anes	anesthesia
angio	angiogram
ANS	autonomic nervous system
ant	anterior
A/O	alert and oriented
AOCD	Anemia of chronic dsease
AODM	adult onset diabetes mellitus
AP	anterior-posterior
APAP	acetaminophen (not abbrev. brand name)
APB	abductor pollicis brevis
APL	abductor pollicis longus
A/P	auscultation and percussion
ap	apical pulse
approx	approximately
appt	appointment
appy	appendectomy
APS	Adult Protective Services
ARDS	adult respiratory distress syndrome
ARF	acute renal failure
AROM	artificial rupture of membranes
ART	Accredited Record Technician
art.	arterial
art.line	arterial line
artic	articulation

A.S.	left ear (auris sinistra)
AS	arteriosclerosis
ASA	acetylsalicylic acid (aspirin)
ASAP	as soon as possible
ASCVD	atherosclerotic cardiovascular disease
ASD	atrial septal defect
ASHD	arteriosclerotic heart disease
ASIS	anterosuperior iliac spine
ASO	antistreptolysin titre O
Assoc.	association
asst	assistance
as tol	as tolerated
ASVD	arteriosclerotic vascular disease
asym	asymmetrical
A.T.C.	around the clock
A.U.	both ears
auth	authorize(d)
A-V	arteriovenous
AV	arterioventricular
AVB	atrioventricular block
AWMI	anterior wall myocardial infarction
ax	axilla

B

B+C	board and care
Bab.	Babinski
Bact	bacterium(a)
bal	balance
Baso	basophils
BBB	bundle branch block
BBS	bilateral breath sounds
BC	blood culture
BG	blood glucose
BIB	brought in by
b.i.d.	twice daily
bilat; bil	bilateral
BILI	bilirubin
bio	biological
BE	barium enema
BF	breast feeding
BK	below the knee
BKA	below knee amputation
bld	blood
BLE	bilateral lower extremities
BLS	basic life support

BM	bowel movement
BMEVT	bilateral middle ear ventilation tubes
BMR	basal metabolism rate
BMT	bilateral myringotomy/tube placement
BOA	born out of asepsis
BOM	bilateral otitis media
BOME	bilateral otitis media with effusion
BOOP	bilateral organizing obstructive pnemonia
BOW	bag of waters
BP	blood pressure
BPH	benign prostatic hypertrophy
BPPN	benign paroxysmal postural nystagmus
BPPV	benign paroxysmal positional vertigo
BR	bedrest
BRB	bright red blood
B.R.P.	bathroom privileges
Bs; B/S	blood sugar
bs	breath sounds
BS	bowel sounds
BSA	body surface area
BSC	bedside commode
BSGT	bedside glucose tolerance
BSO	bilateral salpingo-oohorectomy
BST	breast stimulation test
BSW	Bachelor of Social Work
BTL	bilateral tubal ligation
BUE	bilateral upper extremities
BUN	blood urea nitrogen
BUR	back up rate
BUS	Bartholin, urethral and Skenes glands
BTL	bilateral tubal ligation
btl.	bottle
bx	biopsy

C

C/O	complaints of
c	with
C	centigrade (celsius)
C&S	culture and sensitivity
Ca	cancer/carcinoma
Ca++	calcium
CABG	coronary artery bypass graft
CAD	coronary artery disease
cal	calorie
Cap.	Capsule

CAPD	continuous ambulatory peritoneal dialysis
CAT	CAT Scan
Cat	cataract
cath	catheter/catheterization
Cauc	caucasian
CAVH	continuous arteriovenous hemoperfusion
CAVHD	continuous ateriovenous hemodialysis
CBC	complete blood count
CBOME	chronic bilateral otitis media with effusion
CBS	chronic brain syndrome
cc	cubic centimeter
CC	chief complaint
CCPD	Continuous Cycling Peritoneal Dialysis
CCS	California Children's Services
C.C.S.	Certified Coding Specialitst
CCU	coronary care unit
CDB	cough & deep breathe
CDC	Centers for Disease Control and prevention
CEA	carcinoembryonic antigen
CEO	Chief Exective Officer
ceph.floc.	cephalin flocculation test
cert.	Certification
cerv.	Cervical
CFO	Chief Financial Officer
CGA	Contact Guard Assist
CHAL	central hyperalimentation dialysis
CHD	coronary heart disease
CHF	congestive heart failure
chg	charge
CHO	carbohydrate
chol	cholesterol
Chole	cholecystectomy
CHT	Certified Hand Therapist
CI	cardiac index
CIE	counter immunoelectrophoresis
CIN	cervical intraepithelial neoplasia
circ	circumcision
CIS	carcinoma in situ
Cl	chloride
Cllig	clear liquid
cm	centimeter
CMCJ	carpometacarpal joint
CMV	cytomegalovirus
CNA	Certified Nurse Assistant
CNM	Certified Nurse Midwife
CNS	central nervous system

CO	cardiac output
c/o	complaint(s) of
CO2	carbon dioxide
Cocci	coccidioicomycosis
Cog	cognitive
COG	center of gravity
comp	compliance
conc.	Concentration
cong.	Congestion/congested
conj.	Conjunctiva(l)
cont.	continuous
contr.	Contractions
COO	Chief Operating Officer
COPD	chronic obstructive pulmonary disease
COS	Chief of Staff
COTA	Certified Occupational Therapy Assistant
C/P	cardiopulmonary
CP	cerebral palsy
cp	cold pack
CPAP	continuous positive airway pressure
CPD	cephalopelvic disproportion
CPK	creatinine phosphokinase
CPM	continuous passive motion
CPR	cardiopulmonary resuscitation
CPS	Child Protective Services
C/R	cardiorespiratory
CRC	Cypress Rehabilitation Center
CRF	chronic renal failure
CRNA	Certified Registered Nurse Anesthetist
Cr nn 2-12	cranial nerves two through 12
CRS	community re-entry skills
CRT	Certified Radiology Technician
C/S	cesarean section
CSF	cerebrospinal fluid
CSM	circulation, sensation, motion
CSOM	chronic suppurative otitis media
C-spine	cervical spine
CST	Certified Scrub Technician
CT	computerized axial tomography
CTR	carpal tunnel release
CTS	carpal tunnel syndrome
ctx	contraction
cu	cubic
cu.in.	cubic inch
C/V	cardiovascular
CVA	cerebrovascular accident

CVD	cardiovascular disease
CVP	central venous pressure
cx	cervix
CXR	chest x-ray

D

D&C	dilation and curettage
D&I	dry and intact
DAT	diet as tolerated
DB	diaphragmatic breathing
DBW	desired body weight
dc	discontinue
dep	dependent
DC	discontinue
dc'd	discontinued
D5W	IV Dextrose, 5% in water
DDS	Doctor of Dental Surgery
DDSc	Doctor of Dental Science
decub	decubitus
demo	demonstrate
Dept	department
diam	diameter
diff	differential
dig.	Digoxin,Lanoxin
dil	dilute(d)
DIPJ	distal interphalangeal joint
disch	discharge
dist	distilled
DJD	degenerative joint disease
DM	diabetes mellitus
DMV	Department of Motor Vehicles
DNR	Do Not Resuscitate
DOA	dead on arrival
DOB	date of birth
DON	Director of Nursing
DPM	Doctor of Podiatric Medicine
DPT	diphtheria, pertussis, tetanus
Dr.	doctor
dr.	dram
drng	drainage
dsg	dressing
DT	diphtheria/tetanus
D.T.'s	delirium tremens
DTRs	deep tendon reflexes
dtr.	daughter

dur.	duration
DVT	deep vein thrombosis
Dx	diagnosis

E

E coli	escherichia coli
e.g.	for example
ea	each
EBL	estimated blood loss
EBV	Epstien-Barr virus
ECF	extended care facility
ECG;EKG	electrocardiogram
ECHO	echocardiogram
Ed	education
ED	emergency department
EDC	estimated date of confinement
EDD	estimated date of delivery
EDW	estimated dry weight
EEG	electroencephalogram
EENT	eye, ear, nose and throat
EFM	external fetal monitor
EGD	esophagogastroduodenostomy
EJ	external jugular
ELF	elective low forceps
elix	elixir
emerg	emergency
EMG	electromyo(myelo)gram
EMS	Electric muscle stimulation
EMT	Emergency Medical Technician
ENG	electroneptagmogram
ENT	ear, nose and throat
EOA	esophagogastric oral airway
EOB	edge of bed
EOM	extraocular movements
eos	eosinophils
EPB	extensor pollicis brevis
EPC	electronic pain control
Epi	epinephrine
epi	epidural
EPL	extensor pollicis longus
Equip	equipment
equiv	equivalent
er	external rotation
ERD	emergency room
ERCP	endoscopic retrograde cholangiopancreatography

ERS	extension rotation sidebend
ES	electrical stimulation
ESR	erythrocyte sedimentation rate
ESRD	end stage renal disease
est	estimated
ESWL	extracorporeal shockwave lithotripsy
et	and
etal	and others
ET	endotracheal
ETA	estimated time of arrival
Etc.	et cetera (and so forth)
ETCO2	end tidal carbon dioxide
ETIOL	etiology
ETOH	ethyl alcohol
ev	eversion
eval	evaluate(ion)
ex	exercise
exam	examination
exp	expiratory
exs	exercises
ext	external
exte	extension
extr	extraction

F

F	fundus
F/B	followed up
FB	foreign body
FBS	fasting blood sugar
F.C.	FlexCare
FCE	functional capacity evaluation
FCH	Fresno Community Hospital
FCU	flexor carpi ulnaris
FDP	flexor digitorum profundus
FDS	flexor digitorum superficialis
fe	female
Fe	iron (ferrum)
FESS	functional endoscopic sinus surgery

Fetal positions and presentations:

LFA(RFA)	left frontoanterior (right)
FP(RFP)	left frontoposterior (right)
LFT(RFT)	left frontotransverse)right)
LMA(RMA)	left mentoanterior (right)

LMP(RMP)	left mentoposterior (right)
LMT(RMT)	left mentotransverse (right)
LOA	left occiput anterior
LOP	left occiput posterior
LOT	left occiput transverse
LSA(RSA)	left sacrum anterior (right)
LSP(RSP)	left sacrum posterior (right)
LST(RST)	left sacrum transverse
ROA	right occiput anterior
ROP	right occiput posterior
ROT	right occiput transverse
FEV	timed forced expiratory volume
FFC	fixed flexion contracture
FFP	fresh frozen plasma
FH	family history
FHM	fetal heart monitor
FHR	fetal heart rate
FHT	fetal heart tones
FI	fiscal intermediary
fib	fibrillation
FIL	fetal intolerance tolabor
Flliq	full liquid
FIM	Functional Independent Measure
Fi02	fraction of inspired oxygen
fl	fluid
fl oz	fluid ounces
flex	flexion
FLM	fetal lung maturity
FMS	fine motor skills
FNP	Family Nurse Practitioner
FOP	foot of bed
FPB	flexor pollicis brevis
FPL	flexor pollicis longus
FR	fluid restriction
Fr.	French
FRC	Functional Residual Capacity
freq	frequency
Fri	Friday
FROM	full range of motion
FRS	flexion rotation sidebend
FS	frozen section
FSH	follicle stimulating hormone
FT	fullterm
ft.	foot(feet)
FTA	fluorescent treponema antibody

F/U	followup
FUO	fever unknown origin
FVC	forced vital capacity
FVD	fluid volume deficit
FVE	fluid volume excess
FWB	full weight bearing
FWW	front wheeled walker
fx	fracture

G

G	gravid
GA	gestational age
GB	gallbladder
GBS	Guillian-Barre' Syndrome
GC	gonorrhea
GCS	Glasgow Coma Scale
gd	good
gen	general (appearance, anesthetic, etc)
GERD	gastroesophageal reflux disease
GH	glenohumeral
GI	gastrointestinal
gm	gram
GMC	gross motor control
gr	grain
GSW	gunshot wound
GT	gastrostomy tube
GTT	glucose tolerance test
gtt	drop
gtts	drops
GU	genitourinary
Gyn	gynecology(ist)

H

(H)	hypodermic into subcutaneous tissue
h	hour
H/H	hemoglobin/hematocrit
H&H	hemoglobin and hematocrit
HA	headache
hams	hamstrings
HB	heart block
HBP	high blood pressure
HCL	hydrochloric acid
HCO3	bicarbonate
Hct	hematocrit

HCVD	hypertensive cardiovascular disease
Hct	hematocrit
HD	hemodialysis
HEENT	head,eyes,ears,nose and throat
HEP	Home Exercise Program
Hep	hepatitis
Hg	mercury
Hgb	hemoglobin
hgm	hemogram
HHA	Home Health Agency
CHHA	Certified Home Health Aide
HHN	Hand Held Nebulizer
HHRN	Home Health Registered Nurse
HHVN	Home Health Vocational Nurse
hi cal	high caloric
hi chd	high carbohydrate
hi pro	high protein
hi vit	high vitamin
HIE	hypoxic encephalopathy
HIV	human immunosuppressive virus
HL	heparin lock
HLP	hyperlipoproteinemia
HM	Human milk
HNP	herniated nucleus pulposus
H/O	history of
HOB	head of bed
HOH	hard of hearing
HONK	Hyperosmolar nonketosis
hosp	hospital
H&P	history and physical examination
HP	hot packs
HPF	high power field (microscopic field)
HPI	history of present illness
HPPE	hyperpermeability pulmonary edema
HR	heartrate
hr	hour
h.s.	at bedtime
ht	height
HTL VIII	lab test for AIDS virus
HTN	hypertension
H2O	water
H2O2	hydrogen peroxide
HVD	hypertensive vascular disease
Hx	history
H20	water

I

I	independent
I131	radioactive iodine
IABP	intra-aortic balloon pump
IAC	ineffective airway clearance
IBCLC	International Board Certified Lactation Consultant
ibid	in the same place (ibidem)
IBW	ideal body weight
IC	iliac crest
ICN	Infection Control Nurse
ICP	intracranial pressure
ICS	intraclavicular space
ICT	intermittent cervical traction
ICU	Intensive Care Unit
ID	identification
I&D	incision and drainage
IDDM	insulin dependent diabetes mellitus
i.e.	that is (id est)
IGE	impaired gas exchange
IHSS	idiopathic hypertrophic subaortic stenosis
ILS	independent living skills
IM	intramuscular
IMI	brand name abbreviation for a radiant
Imp.	impression
IMV	intermittnet mandatory ventilation
in.	inch
inc.	increase
inf	inferior
inf mono	infectious mononucleosis
init	initial
inj	injection
insp	inspiration(ory)
int	internal
INTF	interferential
I&O	intake and output
IOL	intraocular lens
IPD	Intermittant Peritoneal Dialysis
IPJ	interphalangeal joint
IPPB	intermittent positive pressure breathing
I.Q.	intelligence quotient
IR	internal rotation
irrig	irrigate
I/S	incentive spirometry
ISE	internal scalp electrode

IUD	intrauterine contraceptive device
IUP	intra uterine pregnancy
IUPC	intrauterine pressure catheter
IV	intravenous
IVAB	intravenous antibiotics
IVC	inspiratory vital capacity
IVF	IV fluids
IVP	intravenous pyelogram(phy)
IV push	intravenous push
IVPB	intravenous piggyback
IVSS	intravenous soluset

J

J.P.	Jackson Pratt (hemovac/bulb)
JRA	juvenile rheumatoid arthritis
JV	jugular venous
JVD	jugular venous distention
JVP	jugular venous pressure or pulse
jt.	joint

K

K	potassium
KCI	potassium chloride
KDDH	Kaweah Delta District Hospital
kg	kilogram
K&K	Kline and Kohlmer (test for syphilis)
KUB	kidneys, ureters, bladder (x-ray)
KVO	keep vein open

L

L	liter
LAB	laboratory
LAD	lactic acid dehydrogenase
Lap	laporoatomy
LAO	left anterior oblique
LAQ	long arc quads
lat	lateral
LBBB	left bundle branch block
LBQC	large base quad cane
lb	pound
LC	Lactation consultant
LCL	lateral collateral ligament
LCSW	Licensed Clinical Social Worker

LD	left deltoid
LDH	Lindsay District Hospital
LE	lupus erythematosus
LF	left forearm
LFT	lower function test
Lg	large
LGA	large for gestational age
Litho	lithotripsy
LLE	left lower extremity
LLH	left lateral heelstick
LLL	left lower lobe
LLQ	left lower quadrant
LMH	left medial heelstick
LMP	last menstrual period
LOB	loss of balance
LOC	loss of consciousness
LOS	length of stay
LP	lumbar puncture
LR	lactated ringers
LS	lumbosacral
L-spine	lumbar spine
LSC	left subclavian
LSD	lysergic acid diethylamide
Lt	left
LTV	long term variability
LUE	left upper extremity
LUL	left upper lobe
LUQ	left upper quadrant
LVF	left ventricular failure
LVH	left ventricular hypertrophy
LVN	Licensed Vocational Nurse
L&W	living and well
LWBS	left without being seen
lymph	lymphocyte
lytes	electrolytes

M

M	male
m	minim
M1	mitral first sound
M2	mitral second sound
MA	milliamperes
MAC	monitored anesthesia care
macro	macrocytic(scopic)
MAE	moves all extremities

man.	manual(ly)
MAR	medication administration record
MAT	multifocal atrial tachycardia
max.	maximum
MAX A	maximum assistance
MCA	motorcycle accident
mcg	microgram
MCH	mean corpuscular hemoglobin
MCL	mid clavicular line
MCV	mean corpuscular volume
MD	Doctor of Medicine
mec	meconium
MED/SURG	medical/surgical unit
meds.	medications
MEF	maximal expiratory flow
mEq	milliequivalent
mg	milligram
Mg.	Magnesium
mgmt.	Management
mgr.	Manager
MI	myocardial infarction
micro	microscopic(cytic)
mid.	middle
MIN A	minimal assistance
min.	minute
ml	milliliter
Mlat	mediolateral
mm	millimeter
MMT	manual muscle test
mn	midnight
mo.	month
mob.	mobility
mod.	moderate(ly)
MOD A	moderate assistance
MOM	milk of magnesia
Mon.	Monday
monos	monocytes
MR	mitral regurgitation
MRI	Magnetic Resonance imaging
MRSA	methicillin resistant staphylococcus aureus
MS	morphine sulfate
M/S	multiple sclerosis
MSG	massage
MSS	medical social services
MSW	Medical Social Worker
MT	Medical Technologist

MTT	manual therapy
M+T	myringotomy and tubes
multip	multiparous
MVA	motor vehicle accident
MVP	mitral valve prolapse
MVV	maximum voluntary ventilation

N

N	nitrogen
N/A	not applicable
Na	sodium
N.A.	nursing assistant
NaCl	sodium chloride
NAD	no acute distress
NaHCO3	sodium bicarb
NB	newborn
NBN	newborn nursery
N/C	no charge
neg	negative
neuro	neurology(ist)(ical)
NG	nasogastric
NGT	nasogastric tube
NH3	ammonia
NICU	Neonatal Intensive Care Unit
NIDDM	noninsulin dependent diabetes
NKA	no known allergies
NKDA	no known drug allergies
NKDC	nonketotic diabetic coma
NKHHC	nonketotic hyperglycemic-hyperosmolar coma
nl	normal
NMES	Neuromuscular Electrical Stimulation
NN	nerves
No.	number
noc	at night (nocturia)
norm.	normal
NP	non-productive
NPO	nothing by mouth
NS	normal saline
N/S	no show
NSA	no significant abnormality
NSAID	nonsteroidal anti-inflammatory drugs
nsg.	nursing
NSR	normal sinus rhythm
NST	non-stress test
NSY	nursery

NT	non-tender
N/T	not tested
N&T	nose and throat
NTG	nitroglycerine
nullip	nulliparous
N&V	nausea and vomiting
NWB	nonweight bearing

O

O2	oxygen
OA	occiput anterior
OB	obstetrics
obl	oblique
OBS	organic brain syndrome
occ	occasional
OCG	oral cholecystogram
OCT	oxytocin challenge test
O.D.	right eye
od	overdose
OK	okay
OM	otitis media
OME	otitis media with effusion
OOB	out of bed
OPD	outpatient department
ophth	opthalmology
OPS	outpatient surgery
OR	operating room
ORIF	open reduction internal fixation
ortho	orthopedics
O.S.	left eye
os	mouth
O.T.	occupational therapy
O.U.	both eyes
oz	ounce

P

p	after
P	pulse
pa	pulmonary artery
PA	Physician Assistant
P&A	percussion and auscultation
PA-C	Physician Assistant-Certified
PAC	premature atrial contractions
PACO2	partial pressure carbon dioxide (arterial)

PACU	post anesthesia care unit
PAEDP	pulmonary artery end diastolic pressure
PAF	paroxysmal atrial fibrillation
PAFIB	paroxysmal atrial fibrillation
PA&L	poseterior, anterior and lateral chest x-ray
palp	palpate(ion)
PAP	Papanicolaou smear(test)
PAR	post anesthesia room
Para	parous(number of viable children)
PAT	paroxysmal atrial tachycardia
pap	papanicolaou, smear test
para	parity
path	pathology
PAWP	pulmonary artery wedge pressure
PBI	protein bound iodine
p.c.	after meals
PCA	patient controlled analgesia
PCE	physical capacity evaluation
PCL	posterior cruciate ligament
PCN	penicillin
pCO2	partial pressure CO2
PCV	packed cell volume
PCWP	pulmonary capillary wedge pressure
PDA	posterior descending artery
PDR	Physician's Desk Reference
PE	physical examination
PE tubes	pressure equalizaer tubes
ped.	pediatric
PEG	percutaneous endoscopic gastrostomy
PEEP	positive end expiratory pressure
per	by or through
peri	perineal
PERRLA	pupils equal, regular, react to light and accommodation
pf	plantar flexion
PF	peak flow
PFT	pulmonary function test
pg.	page
pH	hydrogen iron concentration
PH	past history
phal	phalanx
PI	present illness
PID	pelvic inflammatory disease
PIP	proximal interphalangeal joint
Pit	pitocin
PJC	premature junctional contractions
PKU	phenylketonuria

P.M.	afternoon
PMD	private medical doctor
PMH	past medical history
PMI	point of maximum impulse
PMR	polymyalgia rheumatura
PMS	premenstrual syndrome
PN	parenteral nutrition
PNC	premature nodal contraction
PND	paroxysmal nocturnal dyspnea
pneumo	pneumoencelphalogram
PNG	peripheral nerve glides
P.O.	phone order
p.o.	per mouth
pO2	partial pressure of oxygen
pO4	phosphate
POC	position of comfort
POD	postoperative day
Polys	polymorphonuclear leukocytes
POS	positive
post	posterior
postop	postoperative
POT	plan of treatment
POV	private vehicle
PP	postpartum
P&PD	percussion and postural drainage
PPD	purified protein derivative (tuberculin)
PRBC	packed red blood cells
PRBOW	prolonged ruptured bag of waters
pre	before
preg.	pregnancy
preop	preoperative
prep	preparation
prev.	previous
primip	primiparous (first birth)
prn	as necessary; when indicated
PROM	premature rupture of membranes
iPROM	prolonged ruptre of membranes
prog	progress
pro time	pro-thrombin time
prox.	Proximal
PSIS	posterior superior iliac spine
P.T.	physical therapy(ist)
PT/PTT	pro-thrombin/partial thromboplastin (time)
pt	patient
PTA	Physical Therapy Assistant
P.T.A.	prior to admission

PTC	prior to consult
PUD	peptic ulcer disease
PUW	pick-up walker
PVC	premature ventricular contractions
PWB	partial weight bearing
PXR	portable chest xray

Q

q	every
qam	every morning
qh	every hour
qhs	every bedtime
qid	four times a day
qns	quantity not sufficient
qs	to make sufficient quantity
qt	quart
QUAD	quadrant
quads	quadriceps

R

R	right
(R)	rectal thermometer
RA	rheumatoid arthritis
Rad	radiology
RB	read back
RBBB	right bundle branch block
RBC	red blood cell
RBOW	ruptured bag of water
RBS	random blood sugar
RCNA	restorative certified nursing assistant
R.D.	Registered Dietitian
RDS	respiratory distress syndrome
recert.	recertification
reg.	regular
rehab	rehabilitation
reps	repetitions
resp.	respiration(ory)
resist.	resistance
Rh	Rhesus factor
RHD	rheumatic heart disease
RHIT	Registered Health Information Technician
RL	ringers lactate
RLE	right lower extremity
RLH	right lateral heel

RLL	right lower lobe
RLQ	right lower quadrant
RMH	right medial heel
RML	right middle lobe
RN	Registered Nurse
RNA	ribonucleic acid
RNFA	Registered Nurse First Assistant
RNIP	Registered Nurse Interim Permittee
R/O	rule out
RO	routine orders
ROA	right occiput anterior
ROM	range of motion
ROP	right occiput posterior
ROS	review of systems
ROT	right occiput transverse
rot	rotation
RP	renal panel
RPR	rapid plasma regain test (for syphilis)
RR	respiratory rate
rrot	right rotator cuff
RSV	respiratory syncytial virus
R/T	released to
RTW	return to work
RTC	return to clinic
RUE	right upper extremity
RUL	right upper lobe
RUQ	right upper quadrant
RV	right ventricle
Rx	prescription

S

s	without
SAB	spontaneous abortion
sang.	Sanguineous
SAQ	short arc quads
Sat	Saturday
sat	saturated
SBA	stand by assist
SBO	small bowel obstruction
SCH	supra condylar humerus
Schiz	shizophrenia
SCI	spinal cord injury
SCM	sternocleidomastoid (joint)
sec	second(s)(ary)
sed.rate	erythrocyte sedimentation rate (blood)

segs	segmented neutrophils
serol.	serology
serosang.	Serosanguineous
SF	side flexion
SFB	superficial femoral artery
S/G	Swan-Ganz
SGA	small for gestational age
SGOT	serum glutamic oxaloacetic transaminase
SGPT	serum glutamic pyruvic transaminase
SH	social history
Shldr	Shoulder
SI	sacroiliac joint
SIADH	syndrome of inappropriate antidiuretic hormone secretion
SL	sublingual
SLE	systemic lupus erythematosus
SLR	straight leg raising
SNF	skilled nursing facility
SOAP	subjective/objective/assessment/plan
SOB	shortness of breath
sol	solution
SOM	serous otitis media
S/P	status post
spec	specimen
SPgr	specific gravity
SR	sinus rhythm
SROM	spontaneous rupture of membranes
ss	one half
SS	soapsuds
SSE	soapsuds enema
SS#	social security number
S/S	signs and symptoms
stab	band cell
staph	staphylococcus
stat	at once
strep	streptococcus
STSG	split thickness skin graft
STV	short term variability
St WP	sterile whirlpool
Sub-L	sublingual
Sub-Q	subcutaneous
Sun.	Sunday
sup	superior
surg	surg(ical)ery
SVD	spontaneous vaginal delivery
SVDH	Sierra View District Hospital
SVT	supraventricular tachycardia

Sx	symptom
sym	symmetrical

T

T	thermoscan (thermometer)
T&A	tonsillectomy and adenoidectomy
tab	tablet
TAB	therapeutic abortion
T&C	type and crossmatch
TAH	total abdominal hysterectomy
TAR	treatment authorization request (MediCal)
TAT	tetanus antitoxin
T.B.	tuberculosis
TBA	to be admitted
T.C.	traffic collision
Tbsp	tablespoon
TCDB	turn, cough, deep breathe
TCDHS	Tulare County Department of Health Services
TCU	Transitional Care Unit
TEA	thromboendarterectomy
tech	technician(ologist)
TED	antithromboembolic stockings
temp	temperature
TENS	transcutaneous electrical nerve stimulator
TFT	Thyroid Function Test
THEX	therapeutic exercise
THR	total hip replacement
thru	through
Thur.	Thursday
TIA	transient ischemic attack
TIC	transitional inpatient care
tid	three times a day
tinct	tincture
TJR	total joint replacement
TKO	to keep open
TKR	total knee replacement
TLC	triple lumen catheter
TM	tympanic membrane
TMJ	temporomandibular joint
TMJD	temporomandibular joint dysfunction
TMs	tympanic membranes
TNS	transcutaneous nerve stimulation
TO	telephone order
tol.	tolerate(d)
TOLAC	trial of labor after cesarean

tomo	tomogram
TORB	telephone order read back
TORCH	toxoplasmosis, syphilis, rubella, cytomegaloviras, herpes
TPA	tissue plasminogen activator
TPN	total parenteral nutrition
TPR	temperature, pulse, respiration
TR	transfer
trach	tracheostomy
tsp	teaspoon
T-spine	thoracic spine
Tues.	Tuesday
T.U.R.	transurethral resection
TURBT	transurethral resection of bladder tumor
TURP	transurethral resection of prostate
TVH	total vaginal hysterectomy
TV	tidal volume
Tx	treatment

U

U	uranium
Ua	urinalysis
UAC	umbilical artery catheter
U/C, UC	uterine contraction
UBW	usual body weight
U.C.	unit clerk
UCG	urine chorionic gonadotropin
UGI	upper gastrointestinal
UE	upper extremity
UF	ultrafiltration
UKE	unknown etiology
UMC	University Medical Center
UO	undetermined origin
Upper GI	upper gastrointestinal
URI	upper respiratory infection
Uro	urology(ist)
U.S.	both eyes
US	ultrasound
USP	United States Pharmacopoeia
UTI	urinary tract infection
UV	ultraviolet

V

VA	visual acuity
Vag	vaginal

VBAC	vaginal birth after cesarean section
VC	vital capacity
VCH	Valley Children's Hospital
VD	venereal disease
VDRL	Venereal Disease Research Laboratory
VE	vaginal exam
Vent	mechanical ventilator
VFD	visual field deficit
V-fib	ventricular fibrillation
via	by way of
Vit	vitamin
VO	verbal order
vol	volume
VORB	verbal order read back
VPB	ventricular premature beat
Vre	Vancomycin Resistant Enterococci
VS	vital signs
v, vs	versus
VSD	ventriculoseptal defect

W

w/a	while awake
WB	weight bearing
WBAT	weight bearing is tolerated
WBC	white blood count(cells)
W/C	wheelchair
WDWN	well developed, well nourished
W &	white female
W %	white male
Wed.	Wednesday
WFL	within functional limits
WIC	Women, Infants & Children (assistance program)
wk	week
wlkr	walker
wnd	wound
WNL	within normal limits
w/o	without
WP	whirlpool
wt	weight

X

x	times
XRT	radiation therapy

Y

yd.	yard
yrs	years

SUBJECT: **ADMINISTRATION OF HEPATITIS B VACCINE TO EMPLOYEES**	SECTION: **Page 1 of 4**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY

PURPOSE: To assure that a standard procedure is in place for the administration of hepatitis B vaccine to candidate employees who meet specific criteria set by the Centers for Disease Control and Prevention (CDC) for vaccination.

A. **BACKGROUND**: Hepatitis B is one of a number of vaccine-preventable communicable diseases. Having eligible employees vaccinated against hepatitis B will greatly reduce morbidity and mortality within the hospital from the hepatitis B virus (HBV). The Advisory Committee on Immunization Practices (ACIP) of the CDC defines employee eligibility for hepatitis B vaccination.

B. **PREREQUISITES**: According to the CDC, in order to be eligible for hepatitis B vaccination, the following criteria must be met:
   a. The candidate employee must be 18 years of age or older
   b. The employee has not yet received a complete hepatitis B vaccine series
   c. The employee is part of a group that has an occupational risk of infection through exposure to blood or blood-contaminated bodily fluids. This includes health care workers, public safety workers, trainees in a health professional or allied health school, housekeeping staff and others.

C. **CONTRAINDICATIONS AND PRECAUTIONS**:
   a. The candidate employee has experienced anaphylactic reactions to a prior dose of the vaccine or any of the vaccine's components. (See the manufacturer's package insert for a list of vaccine components, or visit the website www.immunize.org/fda for package inserts or vaccine product approvals.)
   b. Candidate employees with moderate or severe acute illness with or without fever should wait until resolution of the acute illness
   c. Pregnancy testing is not required before vaccination, but of the vaccines available, the following vaccines, Engerix-B, Recombivax HB or Twinrix, have data that supports safe vaccination during pregnancy. Thus, providers should vaccinate pregnant people needing hepatitis B vaccination with one of these 3 vaccines

D. **RESPONSIBILITIES:**
   a. Any of the following health care professionals with current California licenses may administer the vaccine: Licensed Vocational Nurse (LVN), Registered Nurse (RN) or a physician (MD or DO).
   b. A copy of the most current Vaccine Information Statement (VIS) in the appropriate language must be provided to the vaccine recipient and recorded, along with the publication date of the VIS, in the medical record or office log. (See Appendix A for a hyperlink to examples in various languages.)

PROCEDURE

A. **Assess** the employee for the need of HBV vaccination. This is accomplished by authorized personnel reviewing the employee records for vaccination status.

B. **Screen** the candidate employee for precautions and contraindications against HBV vaccination, which include but is not limited to:

   a. Precautions

      i. Moderate or severe acute illness (with or without fever)

   b. Contraindications

      i. A history of a severe allergic reaction (anaphylaxis to a vaccine component or following a prior dose of the same vaccine

      ii. A history of hypersensitivity to yeast

C. **Education**: provide the VIS form and document that the form was given (see Documentation for instructions)

D. **Prepare** materials to administer the vaccine
   a. See **Table A** to select the appropriate needle gauge, length and injection site

E. **Administer** the HBV vaccine and notify the recipient of the vaccination schedule
   a. See **Table B** for criteria and guidance on dosage, route and vaccination schedule

F. Be prepared to manage any **medical emergency** related to the administration of the vaccine. The recipient should be monitored for at least 15 minutes after administration of the vaccine. The following items should be available at the time of vaccination:
   a. A written emergency protocol specifically for vaccination reactions
   b. Equipment and or medications described in the written emergency protocol

G. **Documentation**: Document the vaccination in the medical record, if kept, the Employee Health log and complete the personal immunization record card. Items that should be documented in the medical record are:
   a. Date of vaccination and number of the series
   b. The manufacturer and lot number
   c. The vaccination site and route
   d. The name and title of the person administering the vaccine
   e. Note if the VIS was provided to the recipient. Also include the language and publication date of the VIS
   f. Record if the vaccine was not administered, record the reason(s), and discuss the need for vaccination with the candidate employee.

REFERENCES:

Weng MK, Doshani M, Khan MA, et al. Universal Hepatitis B Vaccination in Adults Aged 19–59 Years: Updated Recommendations of the Advisory Committee on Immunization Practices — United States, 2022. MMWR Morb Mortal Wkly Rep 2022; 71:477–483.
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Immunize.org for Professionals. Standing Orders for Administering Hepatitis B Vaccine to Adults, Oct. 23, 2023. Available on the internet at: www.immunize.org/catg.d/p3076.pdf item #P3076 (retrieved Oct. 8, 2024).

California Code of Regulations: 22 CCR 5 § 70739 Licensing and Certification of Health Facilities, Home Health Agencies, Clinics and Referral Agencies, Chapter 1, General Acute Care Hospitals.

TABLES:

Table A – Prepare to Administer Vaccine, guide to choose the needle gauge, needle length and injection site according to the following chart (Modified from *Standing Orders for Administering Hepatitis B Vaccine to Adults*)

Gender & Weight	Needle Gauge	Needle Length	Injection Site
Female or male 130 – 200+ lbs.	22 – 25	1" – 1 ½"	Deltoid muscle of arm
Female or male Any weight	22 – 25	1" – 1 ½"	Anterolateral thigh muscle

Table B – Recommended doses and schedules of hepatitis B vaccine, Engerix-B, for adults >18 years and persons between 11-19 years (Modified from *MMWR, Vol. 71, No.13, 2022.*)

HepB vaccine/Age	Dose (ug)	Vol (mL)	Schedule
Engerix-B			
11 – 19 years	10	0.5	3 doses: 0, 1, 6 mos
≥ 20 years	20	1.0	
Adults: HD and IC*	40	2.0	4 doses: 0, 1, 2, 6 mos

* Adults ≥ 20 years, HD = hemodialysis; IC = immunocompromised

APPENDIX A

To find the most current VISs in different languages go to the CDC or Immunize.org websites via the following hyperlinks:

https://www.cdc.gov/vaccines/hcp/vis/vis-statements/hep-b.html

https://www.immunize.org/vis/

SUBJECT:	SECTION:
ADMINISTRATION OF TETANUS-DIPTHERIA TOXOIDS & PERTUSSIS VACCINE TO ADULTS (Employees)	***Surveillance, Prevention, Control of Infection (IC)***

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY

PURPOSE: To assure that a standard procedure is in place for the administration of the Tetanus-Diphtheria Toxoids and Pertussis (**Tdap**) Vaccine for employees who meet criteria established by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices.

A. **BACKGROUND:** Diphtheria, pertussis (whooping cough) and tetanus are 3 devastating diseases that are no longer common in the U.S. due to the availability of vaccines. Two of these diseases (diphtheria and pertussis) are spread from person to person by respiratory droplets while the other, tetanus, enters the body through cuts or wounds. Because of the mode of transition for these 3 diseases, the Tetanus, Diphtheria and Pertussis (**Tdap**) vaccine is used to protect adults, especially healthcare professionals (HCP) within the healthcare setting.

B. **PREREQUISITES:** According to the Centers for Disease Control and Prevention (CDC), adults/HCP who meet the following criteria are eligible for **Tdap** vaccination or a booster (**Table 1**):
   1. Adults who have *never* received **Tdap** vaccination
   2. If 10 years have passed since your last **Tdap** vaccination/booster
   3. If you have had a severe or dirty wound or burn and it's been 5 years or more since your **Tdap** vaccination/booster
   4. If pregnant and due for 10 year booster, vaccinate, preferably in the 3rd trimester, to help protect the newborn infant from pertussis. If prior dose was given within the last 10 years, vaccinate in the immediate postpartum period

C. **PRECAUTIONS:** The following should be taken into consideration before a **Tdap** vaccination:
   1. The HCP should wait to be vaccinated if moderately or severely ill. However, the individual may be vaccinated if the illness is minor, such as a cold
   2. The HCP should wait to be vaccinated if your health care provider decides to postpone the **Tdap** vaccination/booster

D. **CONTRAINDICATIONS AND RISKS**: Tell your vaccination provider if:
   1. The person receiving the vaccination/booster has had an allergic reaction after a previous dose of any vaccine that protects against tetanus, diphtheria or pertussis, or has any severe, life-threatening allergies
   2. The person receiving the vaccination/booster has had a coma, decreased level of consciousness or prolonged seizures within 7 days after receiving any pertussis vaccine (DTP, DTaP, or **Tdap**)
   3. The person receiving the **Tdap** vaccination/booster has had seizures or another nervous system problem

4. The person receiving the vaccination/booster has had Guillain-Barre Syndrome after a previous dose of *any* vaccine that protects against tetanus or diphtheria
5. Lesser risks of a vaccine reaction include pain, redness or swelling where the injection was given, mild fever, headache, feeling tired, nausea, vomiting or stomachache after **Tdap** vaccination/booster

E. **RESPONSIBILITIES**:
1. Any of the following health care professionals with current California licenses may administer the vaccine: Licensed Vocational Nurse (LVN), Registered Nurse (RN), or a physician (MD or DO).
2. A copy of the most current Vaccine Information Statement (VIS) in the appropriate language, must be proved to the vaccine recipient and recorded, along with the publication of the VIS, in the medical record or office log. (See References for URL and the PDMS Link for the most current VIS.)

PROCEDURE:

A. **Assess** the employee for the need of **Tdap** vaccination (see Prerequisites above). This is accomplished by authorized personnel reviewing employee records and via interview with the employee.
B. **Screen** the candidate employee for **precautions** and **contraindications** (see full list above) against **Tdap** vaccination, which includes but is not limited to:
   a. **Precautions**
      i. Moderate or severe acute illness (with or without fever)
   b. **Contraindications** (examples)
      i. A history of a severe allergic reaction (*e.g.* anaphylaxis) to a vaccine components or excipients such as aluminum, etc. (Appendix B, *The Pink Book,* for Tdap excipients)
      ii. A history of a serious reaction to any similar vaccines or following a prior dose of the same vaccine
      iii. A history of encephalopathy within 7 days following vaccination given at 7 years or older
      iv. A history of Guillain-Barre Syndrome within 6 weeks after any vaccination
C. **Education** of patient – provide each vaccinated adult patient the VIS in the appropriate language if available and document in the electronic medical record (EMR) that the VIS was reviewed and given
D. **Prepare** materials and injection site to administer vaccine to HCP
   a. See **Table 2** to select the appropriate needle gauge, length and injection site
E. **Administer** the vaccine
   a. See **Table 3** for criteria and guidance on dosage, route and vaccination schedule

F. Be prepared to manage any **medical emergency** related to the administration of the vaccine. The recipient should be monitored for at least 15 minutes after administration of the vaccine. The following items should be available at the time of vaccination:
   a. A written emergency protocol specifically for vaccination reactions
   b. Equipment and/or medication described in the written emergency protocol

G. **Documentation** - the following items should be documented in the medical record:
   a. Date of vaccination and number of the series
   b. The manufacturer and lot number
   c. The vaccination site and route
   d. The name and title of the person administering the vaccine
   e. Note of the VIS was provided to the recipient. Also include the language and publication date of the VIS
   f. Record if the vaccine was not administered, record the reasons(s), and discuss the need for vaccination with the candidate employee

REFERENCES:

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Shefer, A., Atkinson, W., Friedman, C., et al. Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP). Recommendations and Reports, MMWR Morb Mortal Wkly Rep 2011; 60(RR07);1-45. Retrieved Oct. 9, 2024; Available on the internet at: https://www.cdc.gov/mmwr/indrr_2011.html

CROSS REFERENCES:

Tdap Vaccine Information Statement (Tdap VIS)

TABLES:

Table 1 – Immunizing agents, schedules, indications, contraindications and special considerations
(Compiled from *Prevention of Pertussis, Tetanus, and Diphtheria with Vaccines in the United States: Recommendations of the Advisory Committee on Immunization Practices/ACIP*)

TABLE 1. Immunizing Agents and Immunization Schedules for Health-care Personnel (HCP)

Generic name	Primary schedule and booster(s)	Indications	Major precautions and contraindications	Special considerations
Tetanus and diphtheria (toxoids) and acellular pertussis (Tdap)	1 dose IM as soon as feasible if Tdap not already received and regardless of interval from last Td. After receipt of Tdap, receive Td for routine booster every 10 years.	All HCP.	History of serious allergic reaction (i.e., anaphylaxis) to any component of Tdap. Because of the importance of tetanus vaccination, persons with history of anaphylaxis to components in Tdap or Td should be referred to an allergist to determine whether they have a specific allergy to tetanus toxoid and can safely receive tetanus toxoid (TT) vaccine. Persons with history of encephalopathy (e.g., coma or prolonged seizures) not attributable to an identifiable cause within 7 days of administration of a vaccine with pertussis components should receive Td instead of Tdap.	Tetanus prophylaxis in wound management if not yet received Tdap

Table 2 – Prepare to Administer Vaccine, guide to choose the needle gauge, needle length and injection site according to the following chart (Modified from *Standing Orders for Administering Td/Tdap Vaccine to Adults)*

Gender and Weight	Needle Gauge	Needle Length	Injection site
Female or male < 130 lbs.	22 – 25	5/8* – 1"	Deltoid muscle of arm
Female or male 130 – 260+ lbs.	22 – 25	1 – 1 ½ "	Deltoid muscle of arm
* A 5/8" needle may be used in patients weighing < 130 lbs. (< 60kg) for IM injection in the deltoid muscle only if the skin is stretched tight, the subcutaneous tissue is not bunched, and the injection is made at a 90° angle to the skin			

Table 3 –Administer Vaccine, 0.5 mL, via the intramuscular (IM) route, according to the following criteria and schedule*: (Modified from *Standing Orders for Administering Td/Tdap Vaccine to Adults)*

History of Previous Tdap Vaccination	Dose and Schedule for Administration
0 (zero) documented doses ***or*** none known	Give Tdap as: Dose #1. Give dose #2 at least 4 weeks later, and dose #3 6 – 12 months after dose #2.
1 previous dose (not Tdap)	Give Tdap as dose #2 at least 4 weeks after dose #1. Give dose #3 6 – 12 months after dose #2
3 or more previous doses (none Tdap)	Give Tdap as soon as possible. (You do not need to wait 10 years from previous dose.)
3 or more previous doses (including 1 dose of Tdap) booster	Give Tdap **booster** every 10 years unless patient needs prophylaxis for wound management sooner.

***During Pregnancy**: Tdap should be administered early in the third trimester of each pregnancy, preferably in the early part of gestational weeks 27 – 36.

SUBJECT:	SECTION:
ALTERED NUTRITIONAL STATUS IN THE PEDIATRIC PATIENT	**Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To follow the nutritional status of an infant/child.

POLICY:

Definition: A state in which a person experiences or is at risk of experiencing alteration of normal weight according to age and body build.

Assessment: Observation/Findings

- Normal weight for age and size
- Weight loss or gain
- Prescribed diet, fluid intake
- Type of feeding – oral, tube, parenteral
- Anorexia, dysphagia, vomiting, nausea
- Nutritional status
- Medication history

Goal: Patient's nutritional status will be maintained to meet body requirements
Patient will consume adequate caloric intake
Patient will gain weight

AFFECTED PERSONNEL/AREAS: *MCH/PEDIATRICS*

PROCEDURE:

1. Assess cause(s) for alteration in weight.
2. Provide prescribed diet and fluids.
3. Measure and record intake as needed.
4. Assist patient in selection of beneficial foods for age.
5. Place patient in comfortable position for eating.
6. Promote small frequent meals as needed.
7. Assist with feeding as necessary.

8. Administer or assist with oral hygiene.

9. Assess medications for side effects causing decreased appetite.

10. Evaluate knowledge based about nutrition of patient, parents and/or legal guardian and refer to dietician as needed.

11. Weigh patient as needed at same time with same clothing and scale.

12. Maintain tube or parenteral feedings as ordered.

13. Assess cultural/ethnic preferences and provide where possible.

14. Develop schedule of intake.

15. Consult dietician to assist with calorie count or to determine cal/kg/day.

REFERENCE:

- Bowden, G.V. & Greenberg, C.S. (2016). Pediatric Nursing Procedures (4th ed.) Philadelphia: Lippincott Williams & Wilkins pp 318-345

SUBJECT:	SECTION:
ANIMAL-ASSISTED PATIENT ACTIVITIES AND ANIMAL- ASSISTED THERAPY	**Page 1 of 5**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To govern conscientious and professional involvement of animals in Animal-Assisted Activities and Therapy at Sierra View Medical Center (SVMC).

To utilize the animal/human bond to provide and enhance quality of life, non-medical and non-painful in focus, for residents and their families during their hospital stay.

Description:

Animal-Assisted Activities (AAA) provides opportunities for motivational, educational, recreational, and/or therapeutic benefits to enhance quality of life. Animal-Assisted Activities is delivered by specially trained professionals, paraprofessionals, and/or volunteers in association with animals that meet specific criteria.

Animal-Assisted Therapy (AAT) is a goal-directed intervention in which an animal that meets specific criteria is an integral part of the resident's treatment process. Animal-Assisted Therapy is directed and/or delivered by a health or human service professional with specialized expertise, and within the scope of practice and/or cognitive functioning. Animal-Assisted Therapy may be group or individual in nature. The process is documented and evaluated. Definitions are taken from Delta Society's "Standards of Practice in Animal-Assisted Activities and Therapy."

Scope:

This procedure applies to Animal-Assisted Activities / Animal-Assisted Therapy in all hospital departments excluding the Emergency Department, intensive care units, surgical areas, operating rooms, and other areas not open to the general public.

Definitions:

Animals – Currently, animals approved to be in the program are limited to dogs, birds, guinea pigs, cats and hamsters. Other animals may become registered as Pet Partners (see definition below), but the Infection Control Committee must approve the inclusion of other animals in this program.

Delta Society Pet Partners® and affiliate groups such as ***PAWS4Healing*** are nationally recognized training and registration programs for participating in AAA/T for people and their pets. All animals must pass health, skills and aptitude screenings. Handlers must demonstrate knowledge of various recipient populations by passing a written test. Handler/animal must pass evaluation by a Delta Society licensed evaluator. Volunteer handler/animal teams are covered by a $1,000,000 liability insurance policy. Sierra View Medical Center employees who become pet partners must become volunteers to be covered by the Delta Society Pet Partner liability insurance while volunteering "off the clock" for Sierra View.

Delta Society® -- A national, non-profit organization dedicated to promoting animals helping people improve their health, independence, and quality of life. The Delta Society administers the Pet Partners program and is located at 875 124th Avenue NE Ste. 101, Bellevue, WA 98005.

Objectives:

Some objectives of Animal-Assisted Activities/Animal-Assisted Therapy include, but are not limited to:

- Decrease feelings of institutionalization;
- Provide safe and pleasant tactile and sensorimotor stimulation;
- Foster patients' ability to nurture and play;
- Improve balance, postural control;
- Provide a situation of empowerment for residents within an environment where they have very little power and control;
- Divert attention from daily hospital activities in which pain and discomfort may figure prominently;
- Provide an acceptable outlet for energy, encourage activity;
- Brighten affect;
- Provide a mode of contact to enhance children's natural communication through spontaneous play and interaction;
- Provide an activity which is totally non-medical in content;
- Foster communication between the resident and caregiver;
- Provide a bridge to communication between the resident and staff;
- Provide staff an opportunity for interaction with the animals, and reduce staff stress.

POLICY:

Administration and Organization:

1. The Paws4Healing Coordinator or Delta Society Registered Pet Partner Coordinator will oversee testing and standards for both human and animal volunteers in addition to Pet Partners requirements. All Pet Partners must maintain their current legitimate registered therapy team status and PAWS4Healing and Delta. In addition, all Pet Partners are to: attend volunteer hospital orientation without their animal; be assigned to work with an experienced Pet Partner.

2. A qualified Pet Partner handler will be with their animal at all times. At no time will an animal be left alone with a patient, family, or staff member.

3. Hospital Administration and Infection Control approval and support of the program will be maintained.

4. A veterinarian must certify yearly that the animal is healthy; free of infection, contagious disease, or dermatological problems; and immunizations as recommended by Pet Partner's veterinarian must be current. The yearly exam follows requirement of Delta's "Pet Partners Animal Health Screening Form" (attached). Animal health documentation shall be kept in the volunteer's personnel file.

5. Sierra View Medical Center will not assume any liability or responsibility for the safety, health, or security of Therapy Animals.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

PROCEDURE:

Pet Therapy Visitations:

1. ***Attire***: Volunteers will wear the Delta/PAWS4Healing required uniform and closed-toe, soft-soled shoes. Pets and volunteers will wear ID badges from both SVMC and Delta.

2. ***Preparation:*** Pets will be bathed the day of visit or day prior (Exception: Pets making more than one visit per week.)

   a. Thoroughly brushed prior to visit to remove loose hair.

   b. Nails will be trimmed and filed smooth.

   c. Eyes, ears and nose will be free of any matter.

   d. Free of any external parasites (e.g. fleas, ticks, etc.).

   e. No flea collars will be worn in the hospital.

3. ***Handling:*** Dogs will remain on a leash at all times. The volunteer is responsible for their animal's behavior and welfare. At no time will the animal be left unattended or under control of any person other than its Pet Partner Handler.

4. ***Scheduling:*** Visitations may be scheduled for any day of the week. No visitations will be scheduled while a patient is eating. Animals will be removed from any area where food is being served. Visits should not be longer than one hour. If they do exceed one hour, the animal is to be given a rest period every hour for 20 minutes, working no more than three hours in a day.

5. Before entering the elevator, the volunteer will inquire if any occupants object to the animal being on the elevator. If there is an objection, the volunteer and animal will wait for the next available elevator.

6. Both the volunteer and the resident will use hospital-provided hand sanitizing solution before and after each visit. When visiting groups of four or more residents, a hospital staff member will be responsible for sanitizing resident's hands.

7. Interactions:

   a. Visits will be primarily with individual residents, although some small group interactions may occur, if appropriate.

   b. Pet partners can only visit residents who have been cleared by the nurse's station. Two or more Pet Partner teams will work together. If less, they need to be accompanied by a hospital staff member. The Pet Partner team must abide by all privacy rules when asking for information about the residents. The staff will only take Pet Partner teams to residents who are open to their visits and are not allergic to the animals.

   c. Volunteer will ask the resident and roommate if the team may visit.

   d. Volunteer will introduce self and pet.

   e. Volunteer will ask the patient's preference for placement of the animal.

      - On the bed
      - If the resident requests the animal on the bed, volunteer will inquire about any special precautions (recent surgery, pain, medical or surgical equipment, etc.).
      - Volunteer will then place a clean sheet over the resident's bed, gently lift, and position the animal on the bed.
        - On a chair alongside the bed.
        - On the floor.

      - Behavior of the animal:
        - May "visit" on command (placing front paws on edge of bed, wheelchair, arm or knee), if under patient's consent.
        - May not lick the resident.
        - No eating while at the hospital.

   f. Residents, staff and visitors will be discouraged from feeding, although fresh ice and water may be provided in clean containers. Pet Partners are to clean up any dripping water from the animal's mouth or the floor.

g. On completion of visit, the animal will be removed from the bed, top sheet rolled and removed.

h. Unusual Occurrences:

Volunteers will immediately remove animal from visitation if any of the following occurs:

- Improper behavior (growling, barking, scratching, biting)
- Resident, staff or visitor's request
- Allergic response
- Medical emergency
- Animal fatigue
- The PAWS4Healing Coordinator and staff in charge of the Pet Partners will confer to see if a "Delta Incident" report is required.

8. Departures: At the conclusion of the visit, the volunteer will return to the volunteer department to complete documentation of attempted and completed visits and record observed resident and staff responses. Volunteer will then sign out and exit the hospital.

REFERENCE:

- Delta Society Pet Partners, 345 118th Ave SE #200, Bellevue, WA 98005
  Copyright © 2019 Pet Partners. www.deltasociety.org.
- **Paws for Healing, 345 118th Ave SE #100,** Bellevue, WA 98005, **Copyright** © 2020, retrieved from https://pawsforhealing.org

SUBJECT: **BLOOD LOSS**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

Unexpected Blood Loss may occur during Hemodialysis Treatment.

POLICY:

Blood loss during Hemodialysis Treatment

AFFECTED AREAS/ PERSONNEL: *NURSING PERSONNEL*

DEFINITION:

Loss of blood volume from extracorporeal system.

CAUSES:

- Blood Line Separation
- Dialyzer Leak or Rupture
- Clot in blood line

SIGNS:

- Blood Leak Detector Alarm
- Light Pink to Red-tinged Dialysate
- Clot visualize

PROCEDURE/TREATMENT:

1. Blood Line Separation:
   a. Clamp affected lines.
   b. Evaluate blood loss.
   c. Do STAT hematocrit.
   d. Notify physician - If blood loss significant, obtain order for type and cross match and replace as ordered
   e. If blood leak is minor - repeat hematocrit next dialysis treatment.

2. Blood Leak (Hollow Fiber):

   a. Massive blood leak:

   - Call Rapid Response Team alert.
   - Notify physician.

PREVENTATIVE MEASURES:

- Use safety devices or Tape all connections to avoid line separations.
- Monitor blood leak detector to ensure no leak is observed

NURSING OBSERVATIONS AND DOCUMENTATION:

- Record estimated blood loss in patient record.
- Monitor vital signs. Observe for symptoms of shock.

REFERENCES:

- Counts, C. (2020). Core Curriculum for Nephrology Nursing, 7th edition. Pitman, New Jersey. American Nephrology Nurses Association.

CROSS REFERENCES:

- RAPID RESPONSE TEAM ADULT & PEDIATRIC

SUBJECT: **CARDIAC CATH LAB DISCHARGE CRITERIA**	**1 of 3**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To establish safe parameters for the discharge of patients undergoing Cardiac Cath procedures

POLICY:

To provide safe guidelines for the discharge /transfer of the patient undergoing procedures in the Cardiac Cath Lab.

All patients having a procedure in the Cardiac Cath Lab shall meet the following discharge criteria prior to leaving the facility/Department.

AFFECTED PERSONNEL/AREAS:

CARDIAC CATH LAB, ICU, TELEMETRY

EQUIPMENT:

Patient monitoring equipment. Electronic medical record.

PROCEDURE:

A. Patients will be continuously monitored until all criteria are achieved or the variance is reported to the physician and orders are received.

1. Three systolic blood pressures are within 20mm of each other and/or the blood pressure is within normal limits for the patient unless being treated with medication for hypertension.
2. ECG rhythm is within normal limits for the patient.
3. Aldrete score of 8 or within 2 points of their pre-procedure baseline.
4. Hemostasis is achieved at puncture site with no active bleeding or swelling.
5. Post procedure pulses are equal to pre-procedure pulses.
6. Patient is able to verbalize understanding of unit discharge instructions.
7. Be able to take oral fluids with minimal nausea and no vomiting.
8. Ambulate without dizziness, consistent with developmental age and procedure.
9. Pain is manageable. Adequate response to analgesia with no adverse reaction noted.
10. Dressing is dry and intact.

11. Have a responsible adult escort.

B. Patients and their families or significant others should receive printed discharge instructions and verbalize an understanding of the instructions. Verbal repetition is necessary of specific care aspects such as:

1. Signs of infection.

2. Potential or anticipated post sedation effects and limitations on activities.

3. Emergency contact arrangements and follow-up appointment.

C. If patient fails to meet discharge criteria at the termination of the procedure, the Cardiologist will be notified of the variance.

1. The Admit/ Recovery RN will contact the Cardiologist and obtain orders for the care and possible transfer of the patient to the appropriate unit.

2. Receiving area will be given hand off communication prior to patient transfer to include but not limited to:

(a) Identity of patient

(b) Procedure performed with interventions if any

(c) Type of sedation/patient specific information regarding care

(d) Procedure or sedation complications

(e) Amount of I.V. fluids given

(f) Urinary output in Cath Lab and recovery area

(g) Status of dressing; amount and type of drainage if any

(h) Vital signs – Temp, Pulse, Respirations, Blood Pressure, SpO2.

(i) Level of comfort, any medications given in recovery and patient response

D. A cath lab/IR staff member will transport the patient to the room and assist with transfer onto bed and ensure that staff is available to assume care of the patientPatients transported to

ICU/CCU are transported with 1 ACLS-certified nurse and staff member in attendance with a monitor and portable oxygen if continuously required.

REFERENCES:

- American College of Cardiology/ American Heart Association Guidelines; Abstract 2023.
- Nettina, S. M. (2019). *Lippincott Manual of Nursing Practice 11th Edition.* Philadelphia: Wolters Kluwer Health.

SUBJECT: **CERTIFIED NURSING ASSISTANT CERTIFICATION VERIFICATION**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

It is the policy of this facility to hire only nursing assistants who are currently certified by the state in which they are employed.

AFFECTED PERSONNEL/AREAS: *CERTIFIED NURSING ASSISTANT (CNA), HUMAN RESOURCES*

PROCEDURE:

1. Human Resources will obtain a copy of the Nursing Assistant certification identification card.

2. Human Resources will verify Certified Nursing Assistant's current status by contacting the State Nurse Aid Registry prior to employment. This also includes a criminal background check. (See State Nurse Assistant Registry Reference Check.) Out-of-state registries will be contacted when there is evidence that the nurse assistant was employed out of state.

3. The Staff Developer verifies the Certified Nursing Assistant's certification during the employee's annual review process.

4. The Staff Developer will conduct the following competencies for all CNAs upon hire and annually thereafter:

    a. Communication personal skills

    b. Basic nursing and personal skills

    c. Mental health and social services needs

    d. Basic restorative services

    e. Resident's rights and responsibilities

5. Annual performance reviews will be completed by the Director and Staff Developer, which includes annual competencies identified in this policy and any special needs of residents identified by unit staff.

6. All Certified Nursing Assistants will be provided a minimum of 24 hours of in-service education per year.

REFERENCES: Thomson Reuters: (2016-2020) Barclay's California Code of Regulations, Title 22, Division 6, HR. 01, 02, 05/EP-2, EP-3, EP-6, San Francisco, California,

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.75 (e) United States of America, Med Pass Inc.

- California Department of Public Health (2020). Licensing and Certification. Retrieved from https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LandCProgramHome.aspx.

SUBJECT: **CHANGE OF SHIFT REPORT**	SECTION:

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To provide communication and continuity of resident care.

POLICY:

It is the policy of this facility that a resident status report will be given at each change of shift.

AFFECTED PERSONNEL/AREAS:

RN, LVN, CNA

PROCEDURE:

LICENSED

1. On-duty nurse prepares the nursing report which includes pertinent information:
    a. Change of condition
    b. Transfers, discharges
    c. Admissions
    d. Medications/treatment changes
    e. Any unusual occurrence or event
    f. Resident/family complaints
2. Report is given to the on-coming nurses for the next shift, during walking rounds.
3. This cycle is repeated every shift.

LICENSED TO NON-LICENSED (CNA)

1. Non-licensed staff will meet with the licensed staff at the designated time for report.
2. CNA staff going off duty will do walking rounds/ ADL Care with the oncoming CNA staff.
3. Licensed staff will give information pertaining to their specific assignments, which will include:
    a. Special needs
    b. Change of condition

4. This cycle is repeated every shift.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, 2547, San Francisco, California, Title 22.

SUBJECT: **CHC MEDICAL STAFF COMPOSITION**	SECTION: *Workforce* **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To outline the Medical Staff Composition at the Sierra View Community Health Center (SVCHC).

POLICY:

It is the policy of the Sierra View Community Health Center to maintain minimum staffing requirements, including practitioner mix, consistent with Rural Health Clinic Program requirements.

AFFECTED PERSONNEL/AREAS:

ALL CHC STAFF, PHYSICIANS, AND ADVANCED PRACTICE PROVIDERS

PROCEDURE:

1. The Medical Staff will be led by a physician, MD or DO, under contract with the District, licensed and in good standing with the State of California Medical Board who meets the organization's credentialing requirements and provides care to patients of the Sierra View Community Health Center.

2. The Medical Staff will include, at minimum, one Family Nurse Practitioner or Physician Assistant, (aka Advanced Practice Provider) employed by the District, licensed and in good standing with the State of California who meets the organization's credentialing requirements and who provides primary care to patients of the Clinic. Advanced Practice Provider will be on the premises an average of 50% of the CHC's operating hours and available to treat patients during those hours.

3. Additional members of the Medical Staff may include:

    a. Primary care physicians (MD and/or DO) under contract with the CHC, including Family Practice, Pediatrics, Internal Medicine, Gynecology, general medicine licensed and in good standing with the State of California authorities responsible for oversight who meet the organization's credentialing requirements.

    b. Specialty practitioners (MD, DO, DC, DPM) under contract with the District who are licensed and in good standing with the State of California. Specialties may include, but are not limited to: radiology, surgery, cardiology, dermatology, mental health, podiatry, chiropractic, urology.

    c. Licensed Clinical Social Workers and/or Marriage and Family Therapists who are licensed and in good standing with the State of California authorities responsible for oversight who meet the organization's credentialing requirements. Licensed Clinical Social Workers and/or Marriage and Family Therapists may be under contract with the District or may be employed.

    d. Certified Diabetic Educators who are licensed and in good standing with the State of

California. Certified Diabetic Educators may be under contract with the District or may be employed.

4. All members of the Medical Staff, including the Medical Director, must undergo a background check, provide a BLS certificate from the American Heart Association and meet the Hepatitis B requirements upon hire. The Clinic Manager will oversee the process.

SUBJECT:	SECTION:
CODE BLUE / CODE WHITE	***Provision of Care, Treatment and Services (PC)***

PURPOSE:

To define the emergency life support measures to be taken for patients experiencing cardiopulmonary emergencies.

DEFINITIONS:

1. Code Blue: Cardiac/respiratory arrest situation in an adult patient

2. Code White: Cardiac/respiratory arrest situation in a pediatric patient.

1. All hospital employees with direct patient care shall be current in Basic Life Support (BLS) and shall administer Basic life Support to a patient in an arrest situation unless there is an order in the patient's medical record that they or their decision-maker request a Do Not Resuscitate or Comfort Measures.

2. All Clinical Patient Care Providers will participate on the Code Blue Team as outlined in this policy.

3. RNs qualified to work in Emergency Department (ED), Intensive Care Unit (ICU), Telemetry, Clinical Decision (Observation), Labor and Delivery, Interventional Radiology, Cardiac Catheterization Lab, and Surgical Services units shall hold a current Advanced Cardiac Life Support (ACLS) provider card.

4. Clinical Pharmacists and Respiratory Therapists (RT) shall hold a current ACLS provider card.

5. ED RNs, Pediatric Area RNs, and RTs shall hold a current Pediatric Advanced Life Support (PALS) provider card.

    a. All other clinical RNs, LVNs, CNAs, and NAs will complete the annual Code Blue competency.

    b. All licensed clinical care providers will read and verbalize understanding of Code Blue/Code White Form and documentation guideline.

AFFECTED PERSONNEL/AREAS: *ALL CLINICAL STAFF/PATIENT CARE AREAS*

EQUIPMENT:

- Crash Cart with medications / Back Board/ bag-valve-mask with oxygen source and/or an Oxygen tank
- Monitor / Defibrillator / AED
- Code Blue/ Code White Form
- Code Blue/ Code White Evaluation Form

PROCEDURE:

A. Initiation of Code Blue / Code White in the Hospital (licensed staff, all others respond per direction of the RN).

1. **Discovery Person/First (1st) Responder**, upon discovery of an arrest situation will:

   a. Activate the Code Blue/Code White Team.

      - Trigger the Code Blue button in the patient room when possible.
      - When Code Button not able to be activated, dial 55 and state "CODE BLUE" for an adult patient. For a pediatric patient, state "CODE WHITE."
      - Give location of unit and room number.

2. **Switchboard** will announce the code overhead according to the Overhead Paging policy, and then call the ED to ensure the ED responds to all CODE BLUE/CODE WHITE calls.

3. **1st Responder** will:

   a. Remain with the patient and begin CPR with high quality chest compressions using mouth to mask device or bag-valve-mask with high oxygen source delivery, and/or *(provide hands-only CPR if neither of these are immediately available)*

   b. Provide report of patient condition/time found to patient's assigned RN or Code Team Leader

4. **2nd Responder** will:

   a. Bring the Crash Cart to the room/location and assist with placement of the backboard

b. Assess the patient to determine if adequate CPR is being performed

c. Provide/attach the bag-valve-mask to the O_2 source if not done

d. Allow RT to take over the bag-valve-mask upon their arrival

e. Take over compressions when relieved of bag-valve-mask

5. **3rd responder** will:

a. Attach monitor pads to patient and turn machine "ON"

b. Check that suction is working correctly

c. Ensure that patient has IV access x 2, preferably with two large bore IV catheters

d. Hang Normal Saline IV Fluid without additives

6. **Recorder** will:

a. Begin documentation using *Code Blue/Code White Form*

b. Monitor patient's vital signs including Pulse Oximetry ($SaPO_2$)

c. Ensure patient's chart is available at the scene

B. Initiation of Code Blue / Code White Outside of the Main Hospital:

1. Staff in outpatient locations on campus, such as Ambulatory Surgical Department (ASD), Cancer Treatment Center (CTC), Dialysis Center, Laboratory (LAB), Urology Department, Wound Healing Department, Mobile Imaging Trailers off the immediate hospital campus, and Medical Plaza Building will dial 9-911 and then initiate CPR as first responder when a cardiopulmonary emergency situation occurs. Notify the Emergency Department about pending arrival of patient from their location.

Mobile Imaging Trailers on campus will initiate a Code Blue/White.

C. Code Blue Team Members and Responsibilities:

1. CODE TEAM LEADER:

a. ED Charge Nurse/designee is the Code Team Leader until a responding physician is available, for all first floor codes and CODE WHITE/pediatric codes

b. ICU Charge Nurse/designee is the Code Team Leader until a responding physician is available, for all CODE BLUE/adult codes on floors 2, 3 and 4

2. Responsibilities of Code Team Leader:

a. Assess CPR effectiveness

- Make necessary suggestions for improvement, if indicated
- Rotate staff providing compressions as needed to ensure adequate compressions are delivered throughout the code

b. Interpret EKG patterns via crash cart monitor/defibrillator

c. Direct code interventions based on EKG rhythm interpretations and patient assessment/responses to interventions using ACLS / PALS guidelines.

d. Oversee reviewing and labeling of code strips

- Place number at lower right corner of each strip, if necessary
- Give patient's rhythm strips to patient's assigned RN

e. Direct staff to collect patient's vital signs data at appropriate intervals and report to Recorder

f. Keep Recorder apprised of all interventions and patient responses

g. When physician arrives:

- Update with report of patient diagnosis, history, current status, assessments / interventions, patient responses
- Assist as needed

3. RECORDER – Licensed staff not providing compressions, ventilations, medications;

a. Report time when code began to Code Team Leader

b. Ensure complete and accurate documentation of the event using *Code Blue/Code White Form* - record times and dosages of medications administered during code

c. Ensure *Code Blue/Code White Form* has all appropriate signatures at end of code

d. Ensure complete and accurate documentation of *Code Blue/Code White Evaluation Form* at end of code

e. Communicate time of next dose of medication as directed by code leader.

4. IV / MEDICATION NURSE:

a. Observe for presence of a patent IV site, start second IV line of Normal Saline (NS) at rate to keep vein open (TKO) or as instructed

b. Prepare and administer medications as ordered by Code Team Leader

c. Announce administration of drugs, with dosages and routes, to the recorder

5. COMPRESSOR – BLS Certified Employee

a. Provide chest compressions

b. Place backboard under the patient as soon as possible

6. VENTILATOR – Primarily the Respiratory Care Practitioner , may be any BLS provider in rotation to ensure adequate ventilations over time

a. Ventilate patient using bag-valve-mask device attached to supplemental oxygen

b. Make necessary adjustments to head position and mask to assure adequate chest expansion

c. Assist with endotracheal tube (ETT) or laryngeal mask (LMA) intubations, and announce tube size and placement location to Recorder as appropriate

d. Ensure proper taping and securement of the ETT/LMA

e. Assure suction equipment is available and suction as necessary

7. PRIMARY CARE NURSE –

a. Provide patient's chart and information to the Code Team Leader, including patient's condition prior to arrest and other pertinent recent history

b. Inform attending physician and family members of patient's condition

c. Perform other duties as assigned by Code Team Leader.

d. Mount patient's rhythm strips and place in their chart under tab labeled "STRIPS". (Make sure strips are in numerical /chronological order)

8. SUPERVISING RN – Unit Director and/or Clinical Manager, Charge Nurse/Resource Nurse, Administrative/House Supervisor: *NOTE: In the absence of any above mentioned personnel, Code Team Leader will fill in and provide data to proper personnel on their arrival.*

a. **Responsible to attend all codes**.

b. The following duties may be accomplished through delegation:

- Ensuring proper recording/documentation of Code Blue/Code White Form and Code Blue/Code White Evaluation Form
- Notification of the family
- Controlling staff traffic in the room
- Controlling visitors
- Supplying medications as needed
- Ensuring patient privacy, etc.
- Ensure names and signatures lines on the Code Blue/Code White Form are completed
- Ensure accurate completion of Code Blue/Code White Form in conjunction with Recorder (Original white copy is placed in patient chart, canary copy is sent or faxed to Pharmacy)
- Ensure Code Blue/Code White Form goes to the clinical manager of the unit

9. ADDITIONAL RESPONDERS:

a. Radiology Tech – as assigned to unit

b. Laboratory Tech – as assigned to unit

c. Security – for vertical transportation and as requested for crowd control

10. ADDITIONAL RESPONDERS – During normal working hours:

a. Chaplain/Chaplain Assistant

b. Case Manager – as assigned by unit

c. Pharmacist – as assigned by unit

D. Documentation:

1. The patient's Primary Care RN is responsible for completion and disposition of an Occurrence

2. For other documentation needs, refer to *Code Blue/Code White Form DOCUMENTATION GUIDELINE*

REFERENCES:

- American Heart Association Program Administration Manual (2020). Retrieved on 08-11-2021 from https://cpr.heart.org/pam/course-information
- The Joint Commission (2020). Hospital accreditation standards. PC 02.01.11. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **CONTINUOUS VISUAL MONITORING**	SECTION: ***Provision of Care, Treatment and Services (PC)*** **Page 1 of 13**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:
To provide continuous visual monitoring guidelines using the tele sitter to create a safe environment for patients at risk for sustaining or causing harm to themselves or others. The guidelines provide selection criteria for the appropriate use of patient observation interventions.

AFFECTED PERSONNEL/AREAS: Patient Care areas

EQUIPMENT:

- **Mobile tele sitter monitor**

POLICY:

A. The least restrictive method of continuous visual monitoring can be provided by technology along with trained personnel to keep patients at risk for harm, falls, and destructive behavior to themselves or others to maintain a safe environment for patients and others.

B. Initiation of continuous visual monitoring is a nursing intervention. The nursing staff uses tele Sitter Solution and technology as an intervention to help prevent adverse events such as falls, patient injury, and other events that could harm the patient or staff members. Nursing interventions are initiated based on nursing assessment, evaluation, and recommendation.

C. All patients that do not meet exclusion criteria and have a request to use a direct care safety attendant, will undergo a minimum of a two (2) hour tele sitter Required Trial.

D. The patient's right to privacy should be respected at all times

Criteria:

Inclusion Criteria: Patients appropriate for continuous visual monitoring and the use of the tele sitter:

1. Patients who warrant a closer observation level based on assessment and clinical judgment and do not meet any exclusion criteria. Examples of inclusion criteria include:
   a. History of falls or identified as an acute risk for falls based on fall risk assessment
   b. Drug or alcohol withdrawal
   c. Delirium/Restlessness
   d. Confusion, acute or chronic
   e. Use of Clinical Institute Withdrawal Assessment (CIWA) Protocol
   f. Safety restraints for medical device protection
   g. Elopement risk
   h. General safety concerns for staff and patient (e.g., inappropriate and, or escalating behaviors of patient and, or family, suspected contraband, suspected medication diversion or self-medication, etc.)
   i. Consider middle-aged patients with multiple or suspected co-morbidities, substance

abuse history, overestimated functional ability, or postoperative with potential risk for delirium or orthostatic loss of consciousness due to anesthesia, blood loss, and uncontrolled pain.

Exclusion Criteria: Patients and care situations that may not be appropriate for continuous visual monitoring or the use of the tele sitter alone are:

- **Behavioral restraints – four (4) point**
- **Suicide Risk**

Procedure:

E. **Continuous Visual Monitoring**
   1. The Registered Nurse (RN) completes the inclusion and exclusion criteria review after the need for continuous monitoring is identified.
   2. The RN completes all other associated tasks with continuous monitoring to ensure the patient's safety and well-being.
      a. Refer to Roles and Responsibilities section

F. **Tele Sitter Required Trial:** A two (2) hour tele sitter Required Trial is completed for any patient that **does not meet** exclusion criteria

G. **Step 1:** During 2-hour trial, if any of the following 3 situations are present, notify the charge nurse or designee and initiate Step 2:
   - Numerous re-directions in a short amount of time that interferes with the ability to safely monitor other patients
   - Activation of the Stat Alarm more than 3 times in 30 minutes
   - Clinical staff requests re-assessment of continuous visual monitoring appropriateness

Step 2: Implement adjunct measures to continue tele sitter use. These may include, but are not limited to:

- Diversional activities
- Review Medication Administration Record (MAR)
- Move patient closer to nursing station
- Engage family
- Floor staff member at the bedside (temporarily) and tele sitter in place. There may be times when direct patient supervision is required (for a short period of time) while adjunctive safety measures are applied.

GOAL: Exhaust all resources available, in conjunction with the tele sitter, to keep patient safe before escalating to a direct care safety sitter at the bedside.

Step 3: If Step 2 is unsuccessful or does not change the perceived risk, a conversation must take place between the primary caregiver and charge nurse or designee, to determine if the patient's current situation warrants the deployment of a direct care safety attendant at the bedside. Once a decision is made notify the house supervisor of the patients need for

a direct care safety sitter.

H. **Triage from Continuous Visual Monitoring**

1. When requests for continuous visual monitoring exceeds the number of available tele sitter devices, the charge nurse of each area that has devices in use initiates the following triage process:
   - Evaluate the each with low interventions and are potentially appropriate to discontinue the continuous visual monitoring.
   - Consult with the RN and Monitor Staff to validate the patients appropriate for removal from continuous visual monitoring and prioritize.
2. When triage does not support removal of a patient from continuous visual monitoring, the house supervisor will consider moving the high acuity tele sitter candidate to a direct care safety attendant temporarily until a device becomes available.

I. **Privacy Mode**

1. The tele sitter can and should be placed into privacy mode during such activities, including, but not limited to, personal hygiene and physician/provider request during rounds or examinations.
2. A patient in a monitored room not requiring surveillance (semi-private) should have their privacy respected. A privacy curtain should be pulled in front of the camera view, allowing the monitoring of designated patient only.
3. Communication is required between caregiver and Monitor Staff regarding privacy needs prior to initiating privacy feature. Privacy granted to hospital staff only.
4. Tele sitter software does not record audio or video.

J. **Removal of Tele Sitter Monitoring**

1. Reassess the patient every shift and as needed to determine the need for continuous visual monitoring.
   a. RN assessment of the patient's behavior, activity, compliance to safety protocol, and clinical necessity are important assessment points to determine if it is appropriate to discharge/discontinue a patient from continuous visual monitoring. Sustained behavior/signs/symptoms include but is not limited to:
      - No longer meets inclusion criteria
      - No longer displays withdrawal symptoms
      - No longer restless
      - No longer at risk for elopement
      - Appropriate behaviors resumed
      - Need for direct care safety attendant
2. Once removal of continuous visual monitoring is determined:
   a. RN to notify Monitor Staff. Communicate patient, room number, device number, and reason for removal and document.
   b. Remove the tele sitter device from the patient room and clean. Refer to the tele sitter cleaning document for cleaning instructions and guidelines on how to clean device.

c. Monitor Staff documents the reason for removal into tele sitter software and finalizes the removal of the continuous visual monitoring.
d. Deploy the device to the next patient on the waitlist with highest priority or if not needed place the device in the storage area.

K. Roles and Responsibilities:

1. **Registered Nurse**
   a. Refer to Fall Risk assessment score and assess the patient for appropriateness of continuous visual monitoring
   b. Notify the Monitor Staff and house supervisor of the patient candidate for continuous visual monitoring.
   c. If the patient meets the criteria and is approved for continuous visual monitoring, follow policy.
   d. Implement other recommended safety measures if the patient is not approved for continuous visual monitoring.
   e. If there are no tele sitter devices available, notify the charge nurse/house supervisor to initiate triaging of all patients currently being monitored. If a device is unavailable
   f. Document all communication in the patient EHR as a nursing intervention to include:
      1) Tele Sitter/Continuous Visual Monitoring
      2) Reason for monitoring
   g. Educate patient and family. Obtain the monitoring equipment.
   h. Call Monitor Staff with a complete report on the patient. Be prepared to provide information on diagnosis, behaviors, the reason for monitoring, primary language, mobility, assistive devices, and location, etc.
   i. Facilitate the initial introduction of the Monitor Staff with patient to be monitored (if appropriate).
   j. Reassess the patient at least every shift for the need to continue monitoring using the tele sitter.
   k. Respond immediately to the Monitor Staff calls or the sounding of the Stat Alarm.
   l. Follow through communication
      1) Notify Monitor Staff if patient privacy is needed and when need is complete. (example: bedpan, physician visit, clergy visit, etc.).
      2) Notify Monitor Staff before removing the patient from the room for test, therapy, walks, etc.
      3) Notify Monitor Staff and charge nurse when the patient meets the criteria to discontinue tele sitter monitoring.
      4) Provide Monitor Staff with end of shift report. Provides updates on changes with patient. (example: New IV, no longer has a need for O2, oncoming clinical staff name and contact numbers).
   m. Removal of device

2. **House Supervisor or designee**
   a. Designated to cover daily shifts
   b. Assists the Monitor Staff and clinical staff in determining appropriate patients for tele sitter monitoring using inclusion and exclusion criteria.
   c. Monitor the ongoing utilization of devices.
   d. Works in conjunction with other nursing leadership to ensure patient safety is optimized throughout the hospital.
   e. May be a Manager, Hospital Supervisor, Unit Supervisor, Charge Nurse, or another delegate.
      1) Hospital Supervisor: Typically designated as the Gatekeeper for initiation and removal of appropriate patients for continuous visual monitoring.
      2) Charge Nurse role considerations:
         a) Obtains end-of-shift report from RN to ensure the appropriateness of patients for continuous visual monitoring. Report findings to the House supervisor/designee.
   f. Responsibilities include but are not limited to; round on units to evaluate patient safety needs, monitor waitlist for devices, and make decisions regarding the utilization of the devices.
      1) Coordinate utilization during their shift and planning for the next.
      2) Monitor waitlist for continuous visual monitoring and maximize the use of the tele sitter solution to enhance patient safety.
      3) Evaluate device utilization periodically throughout the shift.
      4) Evaluate patients on the tele sitter Required Trial
      5) Approve patient removal from the tele sitter to direct care safety attendant.
      6) Triage to reassign tele sitter to a patient at higher risk of adverse events.
3. **Tele Sitter Monitor Staff**
   a. Receive report on continuous visual monitoring candidate from RN.
   b. Place patient under continuous visual monitoring only after receiving report from the RN.
   c. Ensure that appropriate patient information is entered into software correctly.
   d. Introduce self to the patient via headset upon initiation and every shift (if appropriate).
   e. Document initiation of tele sitter on the patient log.
   f. Perform hourly virtual rounds on the patients. Rounds include but are not limited to environmental safety evaluation and verbal communication with the patient if appropriate.
   g. Continuously monitor patients and attempt to verbally redirect, as necessary.
   h. Call floor staff directly via communication device if an issue arises with the patient that requires staff attention.
   i. Activate Stat Alarm when a patient is not following direction, or the situation is emergent.
   j. Initiate electronic privacy curtain upon request from clinical staff and follow up when the allotted time has expired.
   k. Update status of the patient when patient is out of the room (POOR) and follow up with expected return times.
   l. Documentation

1) Document events prevented in the Intervention Log within software (if applicable).
2) Document adverse events in the Adverse Event Log within software (if applicable).
3) Document patient's activities **every hour and PRN**

m. House Supervisor Assistance
1) Assist House supervisor/ designee and other nurse leaders as appropriate in identifying patients that could potentially be removed from the tele sitter.
2) Notify House Supervisor/ designee of any available tele sitter devices.

n. Provide report to oncoming floor and monitor staff regarding patient status and activity for the shift. Include notable behaviors or trends in overall patient activity.

o. Communication Escalation Plan: In the event the patient needs assistance at the bedside the C.N.A. assigned to the patient will be called first if there is no answer or they are unable the bedside RN will be called. If the bedside nurse is not reach the charge nurse of the unit the patient is admitted will be called. If there is no reach person the tele sitter alarm will be activated

Patient and Family Education:

A. Educate the patient and family on continuous visual monitoring using the tele sitter
1. Criteria supporting the patient's placement on continuous visual monitoring.
2. How the tele sitter ensures the patient's safety.
3. When the tele sitter would be discontinued or disabled.

B. Document all education, including patient and family teach-back response and any follow-up needed in the Patient's EMR education record.

Documentation:

A. The Monitor Staff and the RN or patient care assistant are responsible for documenting witnessed observations and data regarding the patient's activity while monitored on the TeleSitter.
B. Utilization of continuous visual monitoring using the TeleSitter.
C. Patient/family education related to the TeleSitter.

Downtime:

A. Unplanned
1. Monitor Staff
a. Patient safety is the priority. Notify the RN immediately if visualization of the patient is lost.
b. Response Protocol (in order):
1) Notify the patient's RN of unplanned downtime.
2) Notify the Charge nurse of unplanned downtime.
3) Notify the House supervisor of unplanned downtime.
4) Initiate basic troubleshooting. Refer to the troubleshooting guide located at the monitor station.
5) Notify hospital IT Support or Tele sitter Support if needed.

c. Continue to keep the RN updated on the progress of troubleshooting.
d. When downtime is anticipated to be longer than 15 minutes, notify the Charge Nurse and House supervisor to initiate a contingency plan for monitoring affected patients.

2. The RN will evaluate each patient on a tele sitter device and follow downtime procedure.
3. Continuous visual monitoring staff to document action steps for downtime.

B. Planned

1. Software updates or hospital network updates may require planned downtime.
2. Hospital IT and Tele sitter Clinical Program Lead (Clinical Director or Manager) must approve any scheduled downtime.
   a. At least 24 hours prior to downtime, or as soon as possible.
      1) Hospital IT and the Clinical Program Lead must ensure all clinical staff is aware, and there is a plan in place for patient safety.
      2) Monitor Staff will confirm that coverage for the patients is in place prior to system downtime.
   b. Clinical Program Lead and Monitor Staff coordinate efforts:
      1) Authorize the facility and tele sitter system to commence with downtime.
      2) Confirm when downtime is complete that the system is restored, and all patient information is accurate.
      3) Inform all clinical staff that the system is restored.

REFERENCES:

AvaSure, a division of AvaSure Holdings Inc. (2016). AvaSys Video Monitoring System: www.avasure.com and AvaSys Adoption Assurance (2016). Belmont, MI: AvaSure, Inc.

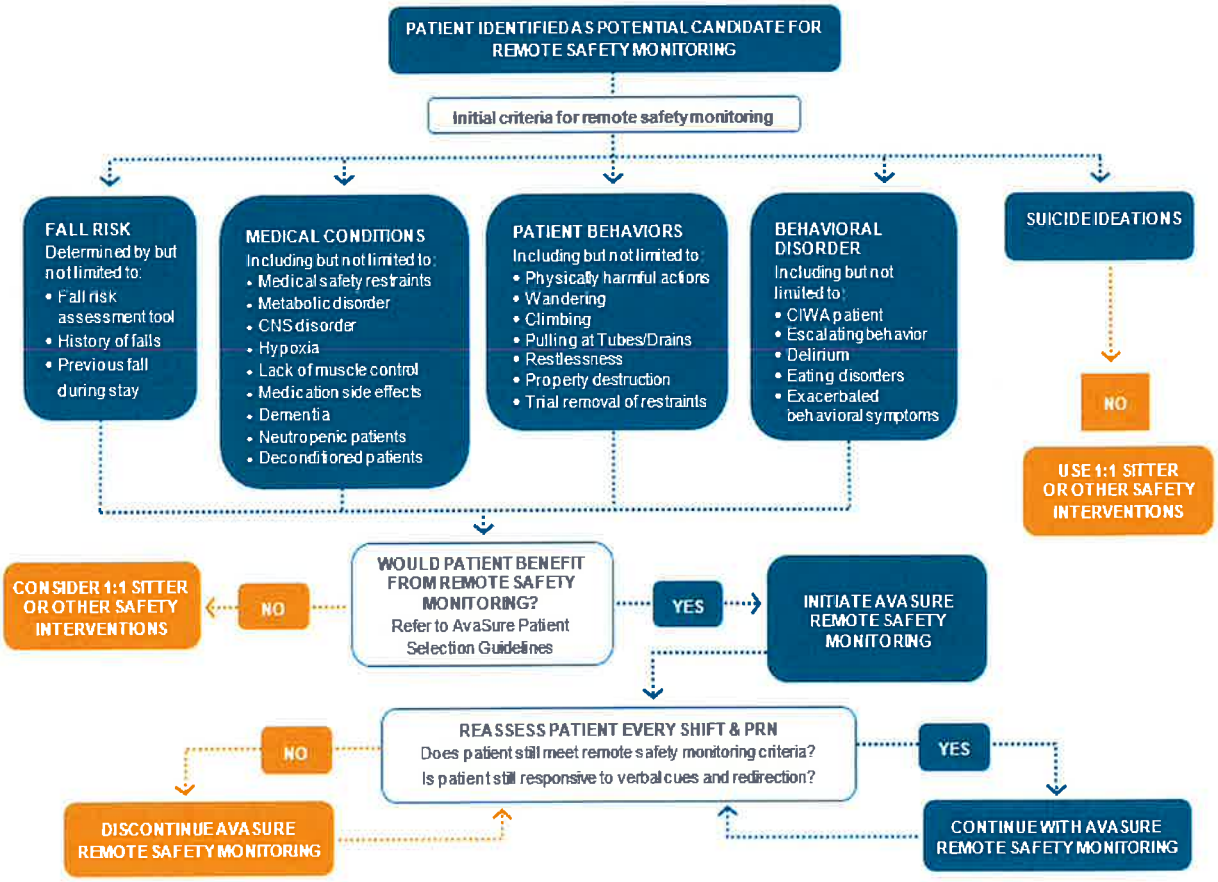
Purvis, S., Kaun, A., McKenna, A., Weber-Viste, J., & Fedorov, E. (2018). Outcomes of clinical nurse specialist practice in the implementation of video monitoring at an academic medical center. *Clinical Nurse Specialist, 32*(2), 90-96.

CROSS REFERENCES:

Fall Prevention (Adult and Pediatric)

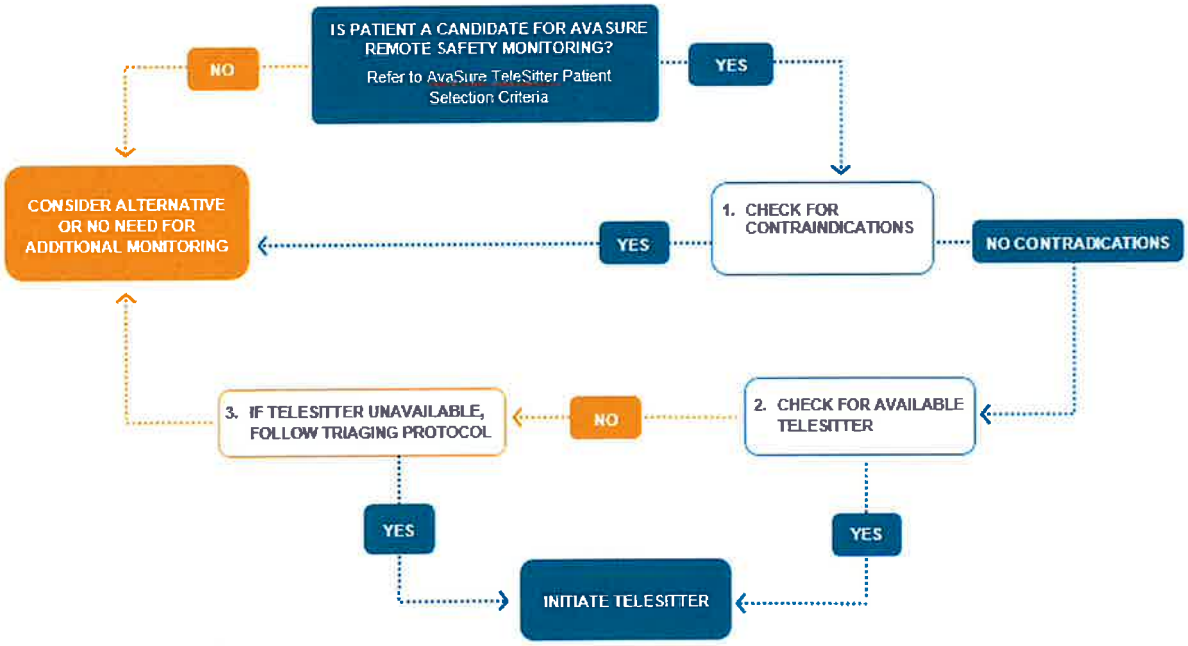
ATTATCHMENT A

TELESITTER® PATIENT SELECTION CRITERIA



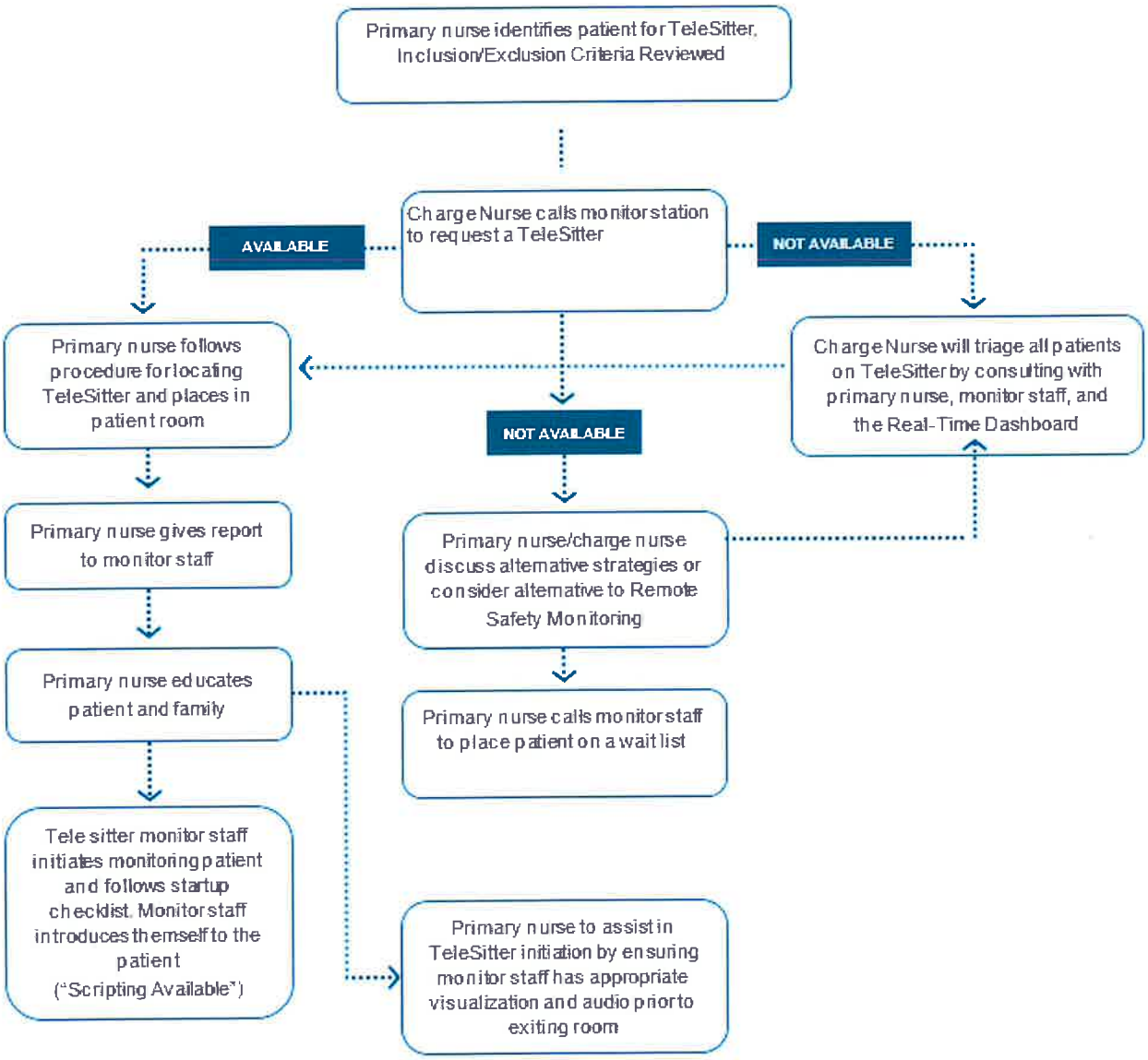
ATTATCHMENT 2

AVASURE TELESITTER® PATIENT SELECTION CRITERIA



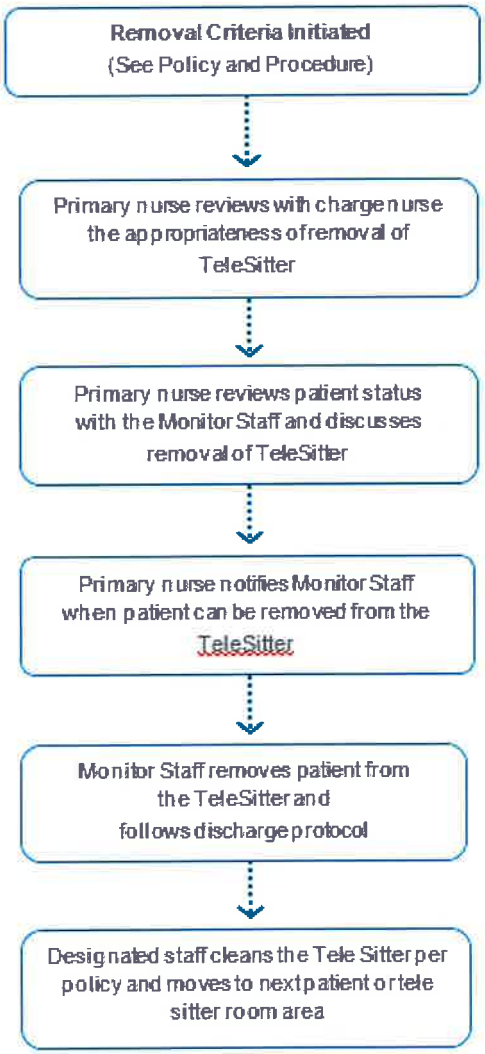
ATTATCHMENT 3

INITIATION OF MONITOR TELESITTER



ATTATCHMENT 4

REMOVAL OF AVASURE TELESITTER



ATTATCHMENT 5

TRIAGING OF AVASURE TELESITTER

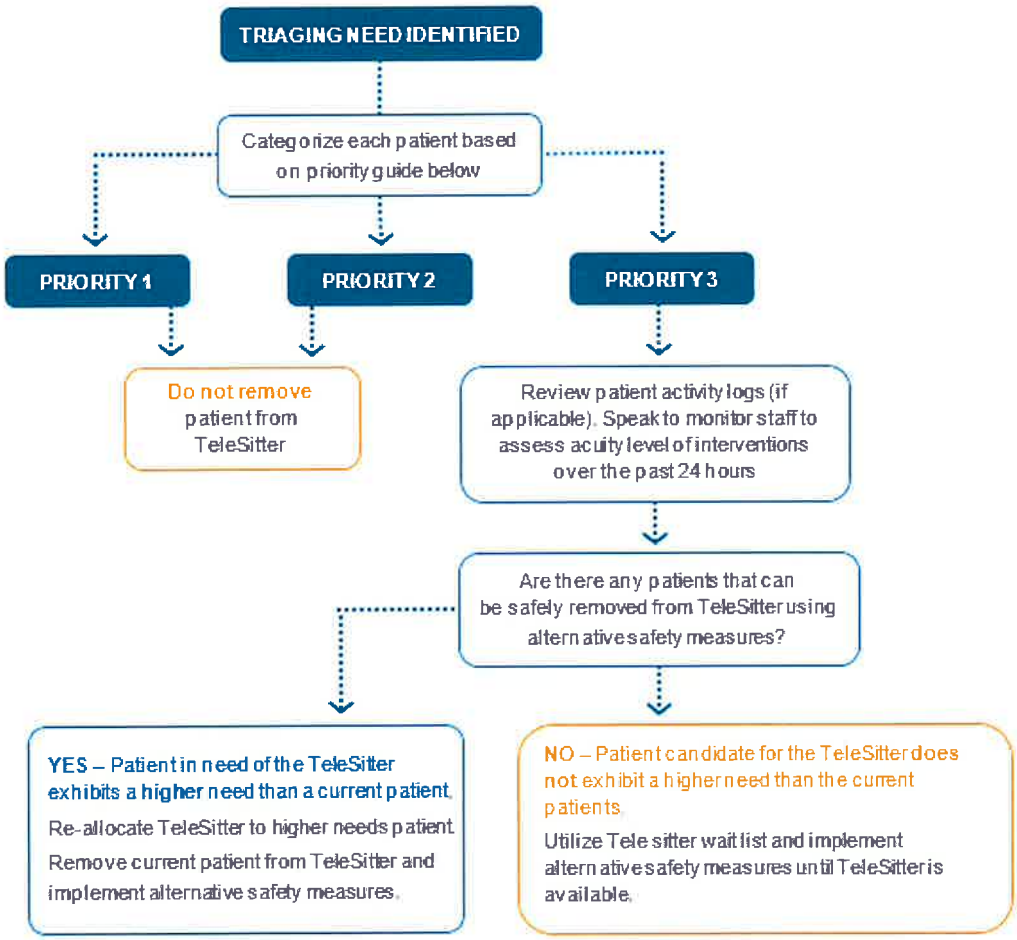
Patient Priority Guide

The TeleSitter should be placed or kept on patients who meet the following criteria in the follow order:

PRIORITY 1
Patient **meets** criteria for a 1:1 sitter **and exhibits the majority** of TeleSitter inclusion criteria behaviors.

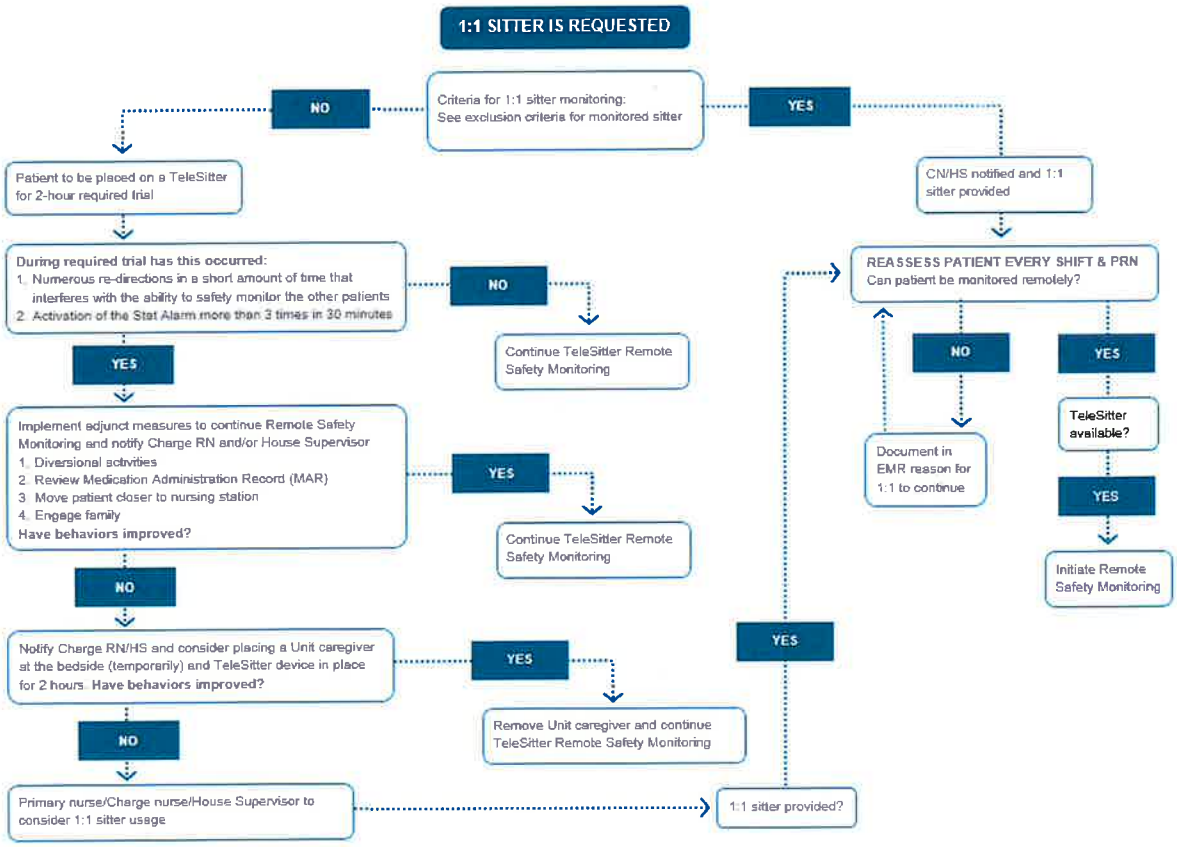
PRIORITY 2
Patient **does not** meet criteria for a 1:1 sitter but **exhibits the majority** of TeleSitter inclusion criteria behaviors

PRIORITY 3
Patient **does not** meet criteria for a 1:1 sitter but **exhibits at least one** of the TeleSitter inclusion criteria behaviors.



AvaSure

1:1 SITTER REQUEST PROCESS



SUBJECT: **DECONTAMINATION; RECEIVING AND HANDLING**	SECTION: ***Surveillance, Prevention, Control of Infection (IC)*** **Page 1 of 3**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To establish procedures for the decontamination of medical devices returned to the Central Processing Department (CPD).

POLICY:

CPD decontamination area will render all medical devices received free of disease causing organisms, thereby making the device(s) safe for handling by hospital personnel and safe for patient use.

AFFECTED AREAS/PERSONNEL: *CPD STAFF, ALL STAFF RETURNING ITEMS TO CPD*

GENERAL CONSIDERATIONS:

1. All items disposable and non-disposable devices received from all areas shall be handled appropriately by discarding them or preparing them for reissue. All used devices are received in the decontamination area and are considered contaminated.

    a. All items received will be decontaminated according to the manufacturer's written directions, using hospital-approved enzymatics and detergents.

    b. Handle delicate, precision items with care to avoid damage and repair.

    c. Inspect returned items to determine if all parts have been returned. Notify the operating room (OR)/CPD Manager of any missing parts or instruments.

    d. Brush all lumens with appropriate sized cleaning brushes.

    e. Open all locked instruments and disassemble parts prior to cleaning. This is also applicable to equipment handling and applies to mechanical cleaning and manual cleaning.

    f. Any sterile disposable item that is returned to this area shall be considered contaminated and is to be discarded.

    g. Instruments in trays should be organized in a manner to prevent injury to staff and prevent instrument damage.

    h. All reusable cleaning brushes are to be cleaned daily in the Washer/Disinfector and replaced when brushes show excessive wear.

2. Traffic control shall be strictly regulated. The doors must remain closed at all times when not in use to provide access of instruments/staff.

PROCEDURE:

1. All surgical items are received via dedicated dumbwaiter. Other departments' items are hand carried and received directly in decontamination area in a bio-hazard container or bag.

2. Patient care equipment is manually cleaned using manufacturer's directions and hospital approved cleaners, and then returned to distribution storage area.

3. Surgery linen and trash bags are labeled with tray name and number. In the event an instrument is missing, a search can be conducted more efficiently.

4. Instruments that can be immersed are removed from tray and placed in washing solution for initial manual cleaning. Items grossly contaminated will be presoaked according to manufacturer's direction. After manual cleaning, items are totally submerged in separate rinse solution. Total submersion minimizes aerosolization of contaminants.

5. Items which cannot be totally immersed (power equipment) are cleaned manually under running water with approved detergent as directed by manufacturer directions.

6. If allowed by manufacturer, immersable items of like composition are then placed in ultrasonic cleaner. (See ultrasonic cleaner procedure for operation.) Instruments with lumens are connected to fill hoses to ensure solution fills entire lumen for optimum cleaning. After completion, items are thoroughly rinsed by total immersion.

7. Items are organized and placed in wire basket and transferred to washer/disinfector and washed again. (See Washer/Disinfector procedure for operation)

8. All rigid containers are completely disassembled and cycled through the Washer/Disinfector before being used again and can be hand washed with sani wipes or alcohol.

9. All items are thoroughly dried prior to assembly and sterilization.

10. Staff working in the decontamination room will wear general-purpose utility gloves, and a liquid-resistant covering with sleeves and shoe covers. If there is risk of splash or splatter, personal protective equipment (PPE) should include a fluid resistant face mask and eye protection.

REFERENCES:

- American National Standard Institute/Association for Advancement of Medical Instrumentation. (2017). Comprehensive guide to steam sterilization and sterility assurance in health care facilities. Arlington, VA. ST79:2017

- Association of Perioperative Registered Nurses (AORN), Standards and Recommended Practices, Instrument Cleaning 2024.

SUBJECT: **DIALYSIS CATHETER CARE**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To reduce the risk of catheter-related infections during catheter system connect, disconnect, and dressing procedures.

POLICY:

Meticulous skin preparation and strict aseptic technique will be used to prevent contamination of the catheter system, including the use of a surgical mask for both staff and patient and clean gloves for all catheter system connect, disconnect, and dressing procedures. Only trained dialysis nursing staff will perform dressing changes/catheter manipulation.

AFFECTED AREAS/ PERSONNEL: *DIALYSIS NURSING PERSONNEL*

PROCEDURE:

Accessing Catheters

1. Perform hand hygiene and don clean gloves.

2. The catheter exit site will be examined for proper position of the catheter and absence of infection by experienced nursing personnel before accessing the bloodstream at each hemodialysis (HD) session.

3. A mask will be worn by the patient and a mask with eye protection will be worn by the nurse the entire time that the catheter is being manipulated. A face shield alone will not suffice. A mask must be worn under the face shield.

4. Scrub catheter hubs with an appropriate antiseptic after cap is removed and before accessing. Perform every time catheter is accessed or disconnected. If a closed needleless connector device is used, disinfect connector device per manufacturer's instructions. (Note: Always clamp the catheter before removing the cap. never leave an uncapped catheter unattended.) After removing the cap, the hub will be wiped with chlorhexidine gluconate (CHG), alcohol, or povidone iodine. Scrub the sides, threads and end of the hub thoroughly with friction, making sure to remove any residue. This procedure will also be followed at the time the patient is disconnected.

5. A fresh pair of disposable gloves will be worn for the connection procedure (dialysis session initiation).

6. Catheter lumens will be kept sterile.

7. To prevent contamination, the lumen and tip will never remain open to the air. A cap or syringe will be placed on or within the catheter lumen while maintaining a clean field under the catheter connectors.

Catheter Exit-Site Care

1. Skin cleansing will include the following steps:
   a. Apply solution/swab in a circular motion, working from catheter exit site outwards.
   b. Cover an area 10 cm in diameter.
   c. Allow solution to dry completely before applying a dressing.
2. The catheter exit site dressing will be changed every seven days using an antimicrobial patch and transparent dressing, in addition to whenever the dressing is wet or soiled.

REFERENCE:

Best practices for bloodstream infection prevention in dialysis setting. (2024, March 29).

Dialysis Safety. https://www.cdc.gov/dialysis-safety/hcp/clinical-safety/index.html

SUBJECT: **DISPOSAL OF EFFLUENT**	SECTION: **Page 1 of 1**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

- To provide safe disposal of peritoneal dialysis effluent.

POLICY:

Dialysis staff will follow proper procedure to ensure the safe disposal of effluent.

AFFECTED PERSONNEL/AREAS: *DIALYSIS STAFF*

Equipment:

- Personal protective equipment
- Bleach
- Bag of effluent
- Disposable scissors (optional)

PROCEDURE:

1. Put on personal protective equipment.
2. Using the inflow line, open the clamp and allow the effluent to drain into the hopper or toilet. If using scissors, cut a port on the drain bag and pour effluent into hopper or toilet, taking care to avoid splashing.
3. When the effluent is done draining, close all clamps.
4. Dispose of bag, lines and scissors if used.
5. If patient is Hepatitis B positive or HIV positive pour one cup of bleach into the hopper or toilet and flush.

REFERENCE:

American Association of Kidney Patients. (2022). what is the proper way to dispose of PD fluid? Retrieved January 20,2022. from **https://aakp.org/what-is-the-proper-way-to-dispose-pd-fluid/**

SUBJECT: **DP/SNF RESIDENT/FAMILY COUNCIL POLICY AND PROCEDURE**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

For the residents living in the Sierra View Medical Center (SVMC) Distinct Part-Skilled Nursing Facility to have the right to form and run a self-governing council.

This council provides the residents with opportunities to participate in decision making through voicing their views and will help resolve issues and concerns.

POLICY:

The Resident Council is the voice of the individuals who reside in the facility. Many who cannot voice their opinions will rely on those who are capable and interested to speak for them.

PROCEDURE:

1. A president, vice president and secretary/treasurer should be elected from the residents willing to participate in the Council.

2. During a survey, the surveyors will ask to speak with the president and/or vice president, and also will lead a Resident Council meeting with only the residents involved to determine whether there are any issues the residents might want to confide in them without staff present.

3. The regular monthly meeting will consist of all interested residents, representative from the Ombudsman Program, any representatives of the residents choosing to speak for them and a staff member responsible for assisting the resident council.

4. The resident council members need to approve the staff member or visitors to the meetings. They can also request no staff members to attend if they want to meet to discuss issues confidentially.

5. The Resident Council is required to take place once a month. The chairperson keeps the minutes of these meetings and a list of attendees. The chairperson (activity coordinator) must document the facts and issues, be specific, and not include long narratives verbalized by the council members.

6. A copy of the minutes always goes to the administrator for review so they are always current on issues, concerns and resolutions.

7. The chairperson (activity coordinator) is responsible for scheduling the monthly meetings, announcing the meetings, creating an agenda, facilitating the meeting, recording the minutes and taking the issues and concerns to the responsible department head for review and resolution.

8. Agenda should consist of:

   a) Welcome
   b) Attendance
   c) Review of the last month's minutes

d) Review of past month's resolutions to issues
e) Review of specific departments involved
f) New business and issues
g) Request for visitors for the next month's meeting

9. All grievances and concerns need to be resolved by the identified departments. The department must write a plan of action, date it and sign it on the council's form, then return it to the chairperson.

10. All minutes must be filed and made available for surveyor review, administrative review and ombudsman review. They are a legal document.

11. Family Council:

- The day of Resident Council a list of family members, significant others, or resident representatives for the non- responsive residents (those who cannot speak for themselves) are called to discuss any concerns or issues they would like brought forward to the Interdisciplinary Team. The Chairperson will go over the resident's activity care plan, discuss what has been done for the resident for activities and to see if they have any new recommendations for the pertaining resident.

- The survey comment form is filled out with who was contacted and any concerns they may present. If unable to reach the resident representative on file, a message is left if able and documented as such.

- Documentation is made in the PCS Activity Participation Record, Resident Council section, the person who was contacted and if a Plan of Correction was filled out because an issue/ issues were brought forward by them.

AFFECTED PERSONNEL/AREAS: *DIRECTOR, MANAGER, ACTIVITY COORDINATOR, SOCIAL SERVICE DESIGNEE, LICENSED NURSES, CNA, DIETARY, RESPIRATORY, THERAPIES, MAINTENANCE*

REFERENCES:

- The National Long-Term Ombudsman Resource Center at the National Consumer Voice for Quality Long Term Care (2021). https://theconsumervoice.org/.

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations. 483.15(c)(6), 483.15(c), United States of America, Med Pass Inc.

SUBJECT: **ELEVATED CULTURE RESULTS ON DIALYSIS MACHINE**	SECTION: **Page 1 of 1**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To isolate the source of dialysate contamination as indicated by a high bacterial count. To disinfect the dialysate flow path to ensure patient safety.

POLICY:

Dialysis machine culture results greater than the standard 200 colonies/ml will be disinfected again and repeat cultures obtained.

AFFECTED AREAS/ PERSONNEL: *NURSING PERSONNEL*

PROCEDURE:

- If 1st culture sample is above the standard, Bleach and disinfect the affected machine and rinse thoroughly.
- Obtain repeat culture after rinsing bleach and disinfectant from the system before patient treatment.
- If 2nd cultures are still above standard, remove machine from service and bleach and disinfect again.
- After bleach and disinfectant are rinsed from system, repeat the cultures again.
- The effected machine will remain out of service until the cultures are within normal limits

DOCUMENTATION:

- Record in the culture log book that repeat cultures were obtained. Record in the log book which machines had high culture results so that these machines will be properly treated and the patients running on the machine can be observed more closely for pyrogen reaction.
- Record the number of machine, initial culture results, repeat cultures obtained, results of repeat cultures.

Note: Patients running on these machines will be observed more closely for pyrogenic reaction.

REFERENCES:

- Centers for Disease Control. (2018). *Water Use in Hemodialysis.* Retrieved on 9/11/24 from https://www.cdc.gov/dialysis-safety/hcp/recommendations-resources/water-use-in-dialysis.html?CDC_AAref_Val=https://www.cdc.gov/dialysis/guidelines/water-use.html

SUBJECT: **EMERGENCY EVACUATION – CLAMP AND CUT PROCEDURE**	SECTION: 1 **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

In the event of fire or other imminent danger threatening a facility necessitating immediate evacuation, dialysis will be terminated as quickly as possible. This highly irregular procedure is used only when the danger does not allow the time for blood return.

POLICY:

Emergency Evacuation

AFFECTED AREAS/ PERSONNEL: *NURSING PERSONNEL*

PROCEDURE:

- Access the Emergency Disconnect kit and remove the contents from the clear bag.
- Turn blood pump off. Clamp both arterial and venous lines with two tubing clamps each. . If the lines have pinch clamps, pinch all four closed.
- Unscrew the lines between the four closed clamps and cap the ends of the needle's or catheter lines with the caps provided in the emergency disconnect kit.
- Secure necessary supplies for maintaining the catheter or removing or maintaining fistula needles. Take saline and administration set to maintain access for fluid replacement.
- Transfer patient to designated area use bed or wheel chair if available (patient may be unstable due to blood loss). Assess the patient's condition including vital signs, condition of access and patients subjective complaints. A normal saline infusion may be used as volume replacement if required.
- Notify nephrologist of event and secure orders.
- Document all information regarding emergency evacuation in patient medical record.
- If time allows and the danger is not immediate, return blood in the usual manner. Complete blood return will aid in stabilizing patient for evacuation and eliminate patient's blood loss. Attach syringes to catheter or fistula needles, clamp and tape securely to extremity. Proceed with evacuation.

REFERENCE:

- National Kidney Foundation. (2016). Kidney living retrieved from https://www.kidney.org/sites/default/files/01-65-7279_EBG_KidneyLiving15.pdf
- Bin Nafisah, S. ., & Alammi, S. . (2023). Evacuating Patients with Ongoing Dialysis. *The Journal of Medicine, Law & Public Health*, *3*(3), 254–257. https://doi.org/10.52609/jmlph.v3i3.90

SUBJECT: **FINANCIAL COUNSELING IN DP/SNF**	SECTION: *Social Services* **Page 1 of 1**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define the Patient Accounting responsibility for assisting residents with income maintenance and benefits during their stay in the DP/SNF.

AFFECTED PERSONNEL/AREAS: *DP/SNF DIRECTOR, SOCIAL SERVICE DESIGNEE, PATIENT ACCOUNTING*

POLICY:

The Patient Accounting Designee is responsible to provide financial tracking for each resident to ensure income maintenance and a means of payment for care and services.

1. When a resident without income is admitted, the Patient Accounting Designee will research and advise the resident and/or responsible party of potential sources of income for the resident such as Supplemental Security Income, Social Security, VA (Veteran Affairs), benefits, or disability benefits. Upon request, or in the absence of a responsible party, the Patient Accounting Designee will assist with the research and application process to establish a source of income to meet resident's needs.

2. The Patient Accounting Designee will work with the resident/responsible party and benefit agencies to keep abreast of changes in resident's funding status, share of cost determinations, and all other such circumstances affecting resident's income or payment for care.

3. Each resident shall have a "Financial Face Sheet" maintained in the Social Service office, in the "Financial Tracking Log." These sheets shall be reviewed at least quarterly to make sure all information remains current and correct.

4. General Accounting will maintain an ongoing record of communication with all agencies involved in the resident's income or payer source. All pertinent phone calls and correspondence shall be maintained in the "Financial Tracking Log" in the General Accounting Office. Significant communication and changes should also be shared as needed with the Social Service Designee and Director of the DP/SNF and others who need to know. Pertinent communication with responsible party, family, etc., should be recorded in the Electronic Health Record (EHR).

5. No facility staff shall accept any type of payment, e.g. Medi-Cal Share of Cost, trust fund deposits, etc. from a resident or responsible party wishing to transact business at a time when the appropriate office is not available.

REFERENCES

- Thomson Reuters (2016-2020) Barclay's California Code of Regulations, Title 22, Division 6, #72453, 72529, San Francisco, California.

SUBJECT: **FOOD AT BEDSIDE- STORAGE**	SECTION:

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

The purpose is to maintain freshness of foods stored at bedside and prevent contamination by pests.

POLICY:

It is the policy of this facility that all food items stored at the bedside shall be kept in airtight containers labeled with the resident's name and dated.

AFFECTED PERSONNEL/AREAS: *RN, LVN, SOCIAL SERVICES, NUTRITION SERVICES*

PROCEDURE:

1. Inform the resident and family of food storage policy upon admission.
2. Airtight labeled containers are to be provided by the individual(s) supplying the food item(s).
3. Food items brought to the resident by others shall comply with physician orders regarding diet. Items needing refrigeration can be placed in the refrigerator in the pantry only if they are unopened and have not been taken into the resident's room first.
4. Dietitian will be available to discuss appropriate foods which can be kept at bedside and which will comply with physician's dietary orders.
5. Check for expiration dates. If resident refuses to follow dietary orders, it will be documented in the care plan in the EMR.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §73723, §72343, San Francisco, California, Title 22.

SUBJECT: **FREE CHOICE**	SECTION: **Page 1 of 1**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To ensure the resident's right to free choice and self-determination in decision-making and care and treatment.

POLICY:

The resident will have the right to choose a personal attending physician. The resident will be fully informed in advance about care and treatment and any changes in that care or treatment that may affect his or her wellbeing. Unless adjudicated incompetent or otherwise found to be incapacitated under state law, the resident will participate in planning care and treatment or changes in care and treatment.

AFFECTED PERSONNEL/AREAS: *NURSING, SOCIAL SERVICES, PHYSICIAN, INTERDISCIPLINARY TEAM*

PROCEDURE:

1. During the admission process, the Social Worker Designee will inform the resident of their right to choose an attending physician. This process will be implemented in accordance with the policy and procedure" Physician Services."

2. The Social Worker Designee will inform the resident or significant other of the interdisciplinary team processes and the right to attend the meetings with staff and physician to participate in his/her plan of care. The Social Worker Designee will ensure the resident and responsible party is invited to the meetings routinely and is represented, as needed, when unable to attend.

3. The physician will ensure the resident/responsible party receives information necessary about his/her medical status to make health care decisions, including options, alternatives, benefits and risks, as needed, to make informed consent prior to initiation (refer to procedures for "Informed Consent").

4. The Interdisciplinary Team will inform and consult with residents with impaired decision-making and those formally declared incompetent to the extent practicable about their personal preferences (i.e., schedules, activities, care planning).

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, Resident's Rights, 42 CFR § 483.10, United States of America, Med Pass Inc.

CROSS REFERENCES:

- DP/SNF Policy and Procedure: PHYSICIAN'S SERVICES

SUBJECT: **FUNCTIONAL SCREENING,ASSESSMENT & REASSESSMENT**	SECTION: ***Provision of Care, Treatment and Services (PC)*** **Page 1 of 5**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To establish guidelines for the treatment of inpatients requiring Rehabilitation services.

POLICY:

1. Functional screening will be performed on those patients who trigger the Rehab criteria during the nursing assessment.

2. Initial patient assessment for rehabilitation services will be performed on all patients referred to the Rehabilitation Services Department by an ordering physician.

3. All assessments/screens will be performed by a licensed / registered rehabilitation services professional.

4. Treatment plans will be developed for all patients who are determined to be candidates for beneficial outcome from rehabilitation services.

AFFECTED AREAS/PERSONNEL: *ALL REHABILITATION PERSONNEL*

PROCEDURE:

PATIENT INITIAL SCREENING / ASSESSMENT:

1. Nursing, during their initial assessment, will do a functional screen, and will notify the rehabilitation department if the following criteria are triggered.

   a. For PT:

      - Recent change in functional mobility.
      - Newly identified weakness or paralysis.

   b. For ST:

      - Difficulty during feeding / drinking
      - New onset of difficulty in speaking.

   c. The evaluating therapist will determine if the patient requires the need for skilled services, and will notify the physician if the patient is a candidate for a Rehabilitation assessment / evaluation.

2. Based on an initial assessment of the patient's physical, cognitive, emotional and social status, a Rehabilitation treatment plan will be developed and documented in the patient's electronic health record (EHR).
   a. An initial evaluation of every patient will be performed by a licensed / registered therapist to determine a treatment plan that is based upon the prescription of the referring physician and the specific individual needs of the patient.

   b. Changes to, or modifications of objectives will be performed only by a licensed therapist.

   c. The treatment plan will identify the specific modalities, procedures or events that will be utilized in order to reduce or eliminate the presenting problems and facilitate achieving the identified long term functional objectives.

   d. The patient will, if possible, participate in establishing their own objective and development of the treatment plan, and the proposed plan of care will be mutually agreeable to the patient and the clinician.

   e. Patient and family education and instruction are considered part of the treatment plan and will be recorded appropriately.

3. The treatment plan/assessment shall include whenever possible, but not be limited to:

   a. Patient's personal rehabilitation goals and expectations;

   b. Rehabilitation goals and objectives in relationship to activities of daily living, learning and working;

   c. Realistic, attainable time frames and measurements for goal / objective accomplishment;

   d. Contributing factors related to use of rehabilitation services and goal / objective accomplishment.

   e. Development of goals dependent upon patient condition.

      - These will be functionally related;
      - Developed with participation from patient / family whenever possible;
      - Developed with participation from other members of the health care team, as appropriate.
      - Support issues, clinical, physical and psychosocial;
      - Barriers to goal / objective accomplishment.

f. As an inpatient stay is usually short, these goals will be updated if the patient's length of stay is protracted. Any two-week goals require identification of new goals when these are reached.

g. The Sub-Acute goals that are established during the evaluation will be the long term goals.

h. Initial Assessment information will be documented in the patient's electronic medical record, and will be completed by the individual performing the assessment.

i. Physical Therapy to do an additional joint mobility assessment form for Sub-acute.

j. Frequency and anticipated duration of treatment.

k. Assistive devices used and/or anticipated.

l. There must be clearly defined goals and the patient should have the potential for improvement.

4. Treatment Orders:

a. On the Acute Floor:

- Complete appropriate assessment in the EHR.

b. On the Sub-Acute Unit:

- All 3 therapies will input a telephone order (TORB) in the EHR.

REASSESSMENTS

1. In accordance with the resident's plan of care, progress and changes in clinical condition, functional reassessments will be performed on an ongoing basis.

a. This is reflected in the daily note, with treatment procedures and responses documented.

b. For SNF there will be a record of daily treatment minutes across all Rehabilitation services.

c. If the patient has restraints, document the removal and reapplication of the restraints during the treatment session. Since most patients who are being restrained are confused or exhibit other similar symptoms, it should be documented that staff member was in attendance during the entire treatment session.

2. Plan of Patient Care and Documentation will be followed as per hospital and departmental guidelines:

   a. The Plan of Patient Care is an individualized plan of care for each patient.

   b. In the Plan of Patient Care (PPC), problems are identified and corresponding goals developed.

   c. Other disciplines utilize these problems with a plan of action to collaborate regarding patient status.

   d. The Plan of Patient Care allows for identification of patient problems and interventions to reach stated goals. It should include, but not limited to:

      - The section marked "date" addresses when the PPC should be reevaluated, and on the Sub-Acute unit this is driven by the MDS dates.
      - Objectives
      - Precautions
      - Problems that will affect treatment and obtaining goals.

   e. PPC must be kept up-to-date with regard to current treatment and goals.

3. Reassessments

   a. Gains must be documented daily in the treatment note for each therapy..

   b. If the patient does not display gains, clearly state the rationale in the progress notes.

   c. Emphasize why skilled services are indicated and modify treatment goals consistently with functional changes, as needed.

   d. If the patient exhibits no gain within a two-week period, other alternatives should be considered.

   e. Reassessments include, but are not limited to:

      - Current functional status;
      - The resident's response to rehabilitation interventions;
      - Changes in the resident's condition;

- Choices for alternative interventions;
- Progress toward meeting rehabilitation goals and objectives.

4. Time tracking log will be utilized on the SNF/Sub-Acute unit to track minutes required for the MDS, and will be completed after each treatment.

5. Discharge to Restorative Nursing on Sub-Acute:

   a. Input order in the EHR to begin restorative nursing (RNA) program.

   b. Verbally notify the restorative nursing aide that a new patient has been added.

   c. In the PT notes specify that the patient is being discharged to RNA and it should reflect the patient's current status at the time of discharge.

   d. Resolve the Plan of Patient Care by putting the discharge date in the "date resolved" column. Enter the restorative problems and goals in the PPC.

6. Discharge from the Facility:

   - No doctor's orders are required for therapy discharge, if the patient leaves the facility during the course of treatment.

7. This facility shall provide space and equipment commensurate with the rehabilitation services rendered.

REFERENCE:

- The Joint Commission Hospital Standards Manual. (2024, July 1*). Provision of Care, Treatment and Services.*
- Centers for Medicare & Medicaid Services. (2020, January 1). *Billing and Coding: Therapy Evaluation, Re-evaluation and Formal Testing.* Retrieved September 19, 2024, from https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=53309

SUBJECT: **HAIR AND SCALP, CARE OF**	SECTION:

PURPOSE:

To provide comfort, increase circulation, maintain cleanliness, provide an attractive appearance, and improve a resident's self-image.

POLICY:

It is the policy of this facility to provide hair and scalp care as a component of a resident's hygienic program as necessary.

Shampooing of the hair shall be performed as part of a resident's bathing program per facility schedule. Residents who have physician orders for therapeutic shampoo will have them administered per order.

AFFECTED PERSONNEL/AREAS: *CNA, LVN, RN*

PROCEDURE:

A. DAILY GROOMING

EQUIPMENT:

1. Comb and brush
2. Towel

B. PROCEDURE:

1. Explain the procedure to the resident and bring equipment to the bedside. Provide privacy. Wash hands thoroughly/wear gloves.
2. Assist resident to a comfortable position.
3. Begin combing/brushing at end of hair and work toward head.
4. Observe condition of hair and scalp.
5. If hair is tangled, cream rinse may be used to assist with removal.
6. Comb hair to desired style.
7. Hair may only be trimmed by a facility-contracted, licensed and insured cosmetologist with resident/family consent.
8. Report any unusual observations to the licensed nurse for follow up.

9. Document on the nurse assistant Activities of Daily Living (ADL) Care in the electronic medical record (EMR).

C. ROUTINE SHAMPOO

1. Coordinate with the resident's shower schedule.
2. Collect shampoo and towel.
3. Wet the hair and apply shampoo.
4. Lather shampoo and massage into hair and scalp.
5. Rinse hair thoroughly and towel dry.
6. Comb or brush hair to desired style.
7. Return shampoo to designated area.
8. Place soiled linen in laundry hamper.
9. Ensure the resident is comfortable.
10. Report any unusual observations to the licensed nurse for follow up.
11. Document in the nurse assistant flow sheet.

D. THERAPEUTIC SHAMPOO

PURPOSE:

1. To soothe an irritated scalp.
2. To remove scales and debris, ointments, or creams previously applied.
3. To administer medication.

EQUIPMENT:

1. Medicated shampoo, with physician's order
2. Towels
3. Washcloth
4. Other linen as needed

PROCEDURE:

1. Coordinate shampoo with other procedures such as resident shower schedule or per physician orders.
2. Collect materials needed.
3. Explain procedure to resident.
4. Wet the hair and apply medicated shampoo.
5. Leave medicated shampoo on hair for prescribed length of time.
6. Rinse hair thoroughly. Last rinsing should be tepid to cool.
7. Remove scales and debris using comb.
8. Towel-dry hair.
9. Apply cream or ointment as prescribed.
10. Comb or brush hair to desired style.
11. Return shampoo to designated area.
12. Dispose of used linens appropriately.
13. Ensure the resident is comfortable.
14. Report any unusual observations to licensed nurse for follow up.
15. Document in nurses' ADL care in the EMR.
16. Licensed nurse will document treatment on the resident's treatment sheet and record the effectiveness of the treatment.

SHAMPOO IN BED:

A cleansing or therapeutic shampoo may be done in the resident's bed if the resident is confined to the bed or refuses to go to the shower.

EQUIPMENT:

1. Large pitcher

2. Shampoo/ non-rinse or Redibath Cap (shampoo cap-no rinse)
3. Absorbent peach pads
4. Towels
5. Comb and brush

PROCEDURE:

1. Explain the procedure to the resident and bring equipment to the bedside. Provide privacy. Wash hands thoroughly.
2. Remove pillow and place absorbent peach pads under resident's head.
3. Fill pitcher with warm water.
4. Place waterproof sheeting under pail at the head of bed.
5. Lower head of bed to comfortable position. Make sure resident does not have respiratory difficulty.
6. Unfasten gown and bring down to resident's shoulders.
7. Wet hair with water; apply shampoo, massaging scalp and hair well. Rinse with clear water. Repeat shampoo and rinse well until all shampoo has been removed unless a no-rinse shampoo is used.
8. Towel dry hair.
9. Comb hair to desired style. Blow dry hair if necessary.
10. Assist resident to comfortable position.
11. Make sure linen is dry. Change bed linens if needed.
12. Report any unusual observations to a licensed nurse for follow up.
13. Record in the nurses' ADL care in the EMR .
14. If using the Redibath Cap, warm cap as instructed by manufacturer, place on head, massage onto head and leave for 10 minutes. Remove cap and comb hair.

REFERENCES:

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, §72315 (d), San Francisco, California, Title 22.

SUBJECT: **HAIR REMOVAL AT PROCEDURAL SITE**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To provide guidelines for appropriate preoperative hair removal to reduce the incidence of surgical site infection.

POLICY:

Hair at the surgical site should be left in place (i.e. not removed) whenever possible as hair removal has been found to increase the risk of surgical site infection. The necessity for hair removal depends on the amount of hair, the location of the incision, and the type of procedure to be performed.

AFFECTED AREAS/ PERSONNEL:

FLEX CARE, SURGERY, EMERGENCY DEPARTMENT, MATERNAL/CHILD SERVICES, NURSING UNITS / REGISTERED NURSES (RNs), TECHNICIANS, CERTIFIED NURSING ASSISTANTS (CNAs), CARDIAC CATH LAB

GENERAL INFORMATION

Hair at the surgical site may be removed when indicated based on individualized patient assessment. Hair removal may be indicated when the presence of hair interferes with vision in the surgical field, interferes with wound closure, causes the drape or dressing to not adhere, and creates a fire risk with alcohol based skin antiseptic.

a) When hair removal is indicated, the amount of hair removed should be kept to a minimum.

b) If indicated, remove hair at the surgical site by clipping in a manner that minimizes injury to the skin.

c) When hair removal is indicated, remove hair as close to the start of surgery as feasible in a location outside the OR or procedure room.

d) When removing hair outside the OR or procedure room is not possible, remove the patient's hair in a manner that prevents dispersal of hair into the air of the OR or procedure room (e.g., wet clipping, use of a vacuum device).

e) Use single-use clipper heads and dispose of them after each patient use.

f) Disinfect the reusable clipper handle after each use, in accordance with the manufacturer's instructions for use (IFU).

g) Document in the patient's health care record the person performing hair removal, the hair removal method, time of removal, and area of hair removal.

2. Clipping of hair for ear procedures will be performed prior to surgery by the surgeon to assure site verification and marking with the patient prior to the clipping. (ENT procedures only)

PROCEDURE:

1. Assemble supplies. You will need at least 2 towels, clipper hand piece and disposable clipper head, adhesive tape, and unsterile prep gloves.

2. Prepare patient by explaining why hair is being removed and answer any questions he/she may have. Reassure the patient that he/she will be kept as warm as possible while also providing privacy.

3. Expose only the area to be clipped. Surround the area with towels or some other absorbent pad to contain the removed hair. The goal is to prevent as much hair from remaining on the gurney or bed as possible.

4. Using one hand to hold the patient's skin slightly taut, clip the hair in a direction away from this hand using short strokes against the direction of hair growth. Brush the hair away into a towel to maintain vision of the area of hair removal; for this you may wish to use a warm, moist, slightly soapy washcloth.

5. Remove towels while containing the hair in the towels. Finish up by using adhesive tape to remove any loose hair from the prepped area. If using vacuum device (ClipVac), dispose in the appropriate receptacle when clipping is complete.

6. Dispose of the clipper head in the sharps container. Decontaminate the clipper head and hand piece with a disinfectant wipe after running water and patting dry. Return hand piece to charger.

7. Document the condition of the skin both prior to and following the hair clipping.

REFERENCE:

- Association of Perioperative Registered Nurses. Guidelines. Patient Skin Antisepsis. Retrieved May 13, 2021.https://aornguidelines.org/guidelines/content?sectionid=245924616&view=book#245924800.

SUBJECT: **IDENTIFICATION OF RESIDENT**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define a process that reliably identifies the resident as the person for whom the service or treatment is being rendered: second, to match the service or treatment to that individual.

POLICY:

Two patient identifiers will be used when administering medications, blood or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures.

AFFECTED PERSONNEL/AREAS: *ALL DP/SNF STAFF, ALL HOSPITAL PERSONNEL PROVIDING SERVICES TO THE RESIDENT*

PROCEDURE:

Resident's Picture:

1. A picture will be inside the cover of every resident's chart, medication and treatment book, and in the IV administration binder.

2. Pictures will be updated annually and as needed.

Hospital Arm Band:

1. A nontransferable identification band shall be prepared and affixed to the resident during the registration/ admit process.

2. The ID band will be fixed to the bed if resident refuses to have an armband on and will be care planned.

3. The identification band shall be checked by the care provider for the following **two** identifiers to ensure that the right resident is involved:

    a. Resident's name

    b. Resident's date of birth

4. Whenever possible, staff should also verbally assess the resident to assure proper identification, asking the resident's name and date of birth and matching the verbal confirmation to the written information on the identification band.

    a. If the resident's date of birth is **not** available, the second identifier will become the resident's **medical record number.**

    b. Blood Bank (BBK) numbers will be referenced when specimens are obtained for cross match.

c. Blood Bank numbers will be referenced during the administration of blood or blood components.

4. Resident identification must be confirmed using the **two-identifier** system:

   a. No procedure shall be conducted when the resident's identity cannot be verified because the imprinted band is illegible or missing.

   b. Defective or missing bands shall be replaced immediately with new bands.

5. Each healthcare provider conducting assessments on the residents shall include a check of the identification band to assure the band is present and legible, as a routine component of the assessment process.

6. The daily nursing staff rounds shall include spot checking the residents to ensure that they are wearing identification bands and that the information is legible.

Room Identification:

As an additional customary identification measure, room assignment reflecting the patient's/resident's last name, will be placed outside by the (assigned room) door entry for each respective patient/resident immediately during admission.

Same Name Alert:

"NAME ALERT" will be documented on the front of the chart, using "NAME ALERT" labels when residents are present on the same nursing unit with the same last name.

Chart Forms:

All chart forms must have at least two resident identifiers for processing.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §70717, San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT: **INSULIN DRIP (DKA)**	SECTION: ***Medication Management (MM)*** **Page 1 of 3**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To provide guidelines for the management of patients greater than 13 years of age requiring glycemic control with the administration of insulin by intravenous infusion.

DEFINITIONS:

1. Insulin: A protein hormone secreted by the beta cells of the pancreas that is produced in response to elevated blood glucose levels.
2. Hypoglycemia: Abnormally low blood sugar
3. Hyperglycemia: Abnormally high blood sugar
4. EMR: Electronic Medical Record
5. DKA: Diabetic Ketoacidosis

POLICY:

A. It is the policy of Sierra View Medical Center to provide safe and effective glycemic control to patients with the use of insulin.

AFFECTED PERSONNEL/AREAS: *NURSING, PHARMACY*

EQUIPMENT:

- IV Pump as indicated
- Insulin Syringes as indicated
- Blood Glucose Monitor and testing supplies

PROCEDURE:

A. Intravenous Insulin Infusions

1. Physician or Allied Health Profession Responsibilities

   a. Upon DKA diagnosis confirmation, initiation of Diabetic Ketoacidosis Order Set.

2. Licensed Registered Nurse responsibilities

   a. Ensure that the patient has a patent IV with fluids infusing as ordered.

   b. Insulin is a High Alert medication that requires the electronic co-signature of a second RN before bolus or before titrations of the insulin drip.

   c. Ensure that insulin infusion, as with all medication infusions, are administered with a smart IV pump.

d. Initiate and maintain the insulin drip as per the dosing chart (see Addendum A or above order set link) and follow nursing care as per doctors' orders, (i.e., labs, finger sticks, etc).

e. Assess patient for signs of hypoglycemia which may include:

i. Change in mental status (lethargy, confusion)
ii. Tachycardia
iii. Diaphoresis
iv. Seizure
v. Urgently report signs or symptoms of hypoglycemia and treat as per MD orders
vi. Review glycemic progress with physician

REFERENCES:

- Association, A. D. (2013). Standards of medical care in diabetes-2013. Retrieved November 1, 2017 from http://care.diabetesjournals.org/content/36/Supplement_1/S1.
- Garber AJ, Moghissi ES, BuonocoreD., et al. American College of Endocrinology and American Diabetes Association consensus statement on inpatient diabetes and glycemic control. *Diabetes Care* 2006;29:1955-1962.
- Hirsch, I. (2021). Diabetic ketoacidosis and hyperosmolar hyperglycemic state in adults: Treatment. Retrieved August 25, 2021 from https://www.uptodate.com/contents/diabetic-ketoacidosis-and-hyperosmolar-hyperglycemic-state-in-adults-treatment.
- Osama, H., MD,PhD. (2017). Diabetic Ketoacidosis Treatment & Management. Retrieved November 1, 2017 from www.emedicine.medscape.com/article/118361-treatment

ADDENDUM A

GOAL BLOOD GLUCOSE = 150-200MG/dL

DKA Insulin Drip (100 units Regular Insulin in 100ml= 1 unit/ml)

Starting Rate	Dose/Route	Instructions
BG Greater Than 200 mg/ dL	0.1 Unit/Kg/Hr	Continuous Infusion
BG 150 mg/dL - 200 mg/dL	0.05 Unit/Kg/Hr	
BG 100 mg/dL -149 mg/ dL	0.025 Unit/Kg/Hr	
BG less than, equal to 99 mg/dl		Turn Off infusion
BG less than 60 mg/dL	Hypoglycemia	Stop Infusion/Call MD/ Administer Dextrose 50% per Nursing Order. Restart per MD Orders.
Resolution of DKA	Anion Gap in Normal Range	Less Than 13, Call MD

Protocol Text	Titrate to: PROTOCOL When BG is greater than 200mg/dL: Continue intravenous infusion maintenance dose of 0.1 unit/kilogram body weight/per hour. When BG is 150 mg/dL - 200 mg/dL: Adjust insulin regular human to 0.05 unit/kilogram body weight/per hour continuous intravenous infusion as maintenance dose. When BG is 100 mg/dL - 149 mg/dL: Adjust insulin regular human to 0.025 unit/kilogram body weight/per hour continuous intravenous infusion as maintenance dose. When BG is less than or equal to 99 mg/dL: Turn off insulin infusion, and resume insulin infusion when blood glucose greater than 150 mg/dL. Start insulin infusion at 0.025 unit/kilogram body weight per hour and continue hourly blood glucose checks. Once BG is greater than or equal to 150 mg/dL x one hour, continue insulin infusion per protocol (0.05 unit/kg body weight per hour). *BG less than 60 mg/dl : Discontinue insulin infusion and give D50W IV 25ml and recheck BG in 15 minutes and repeat 25 ml D50W if BG still <60 mg/dl. Resume insulin infusion per protocol once BG is greater than or equal to 150 mg/dL. Notify physician of all episodes of hypoglycemia. When Resolution of DKA is achieved, defined as Anion gap in normal range (less than 13), call MD for confirmation and for further orders. (I.e. sliding scale/Lantus and diet orders) Nursing Considerations: Blood Glucoses are to be monitored and recorded HOURLY. Fingerstick Blood Glucose Result and Insulin Infusion Rate should be documented HOURLY. Blood Glucose may decrease if nutritionaltherapy (e.g. TPN or tube feeds) are discontinued or reduced. Renal Impairment (SCr >2 or CrCl <50) may increase insulin sensitivity and decrease BG more rapidly as a result.

SUBJECT: **INTERDISCIPLINARY ASSESSMENT AND REASSESSMENT DPSNF**	SECTION: **Page 1 of 10**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define initial resident assessment and reassessment parameters, a process to prioritize resident care, and criteria that all members of the healthcare team utilize during the assessment process.

To develop a database of information regarding the resident in order to provide the necessary information to plan, coordinate, delegate, and supervise the care of the resident.

POLICY:

1. All residents entering Sierra View Medical Center (SVMC) will receive an initial assessment, which takes into account their immediate and emerging DP/SNF needs. The data gathered will be analyzed to create information needed for care decisions concerning any need for further assessments, treatment, interventions, and reassessments.

2. Each admitted resident's initial assessment is conducted within a time frame identified by the service. Reassessment occurs throughout the care process and the purposes, key reassessment points and/or time intervals are defined.

3. Assessments are performed by each discipline within its scope of practice, state licensure laws, applicable regulations, or certification.

4. A registered nurse (RN) shall assess the patient's need for nursing care in all settings where nursing care is provided.

5. Care decisions will be based upon data and information gathered in assessments and reassessments. This data will be utilized in prioritizing patient care needs and selecting appropriate interventions.

6. Prioritizing resident care will be as follows:

    a. Emergent needs

    b. Actual needs

    c. Potential needs

    d. Educational needs

AFFECTED PERSONNEL/AREAS: *NURSING, RESPIRATORY THERAPY, NUTRITIONAL SERVICES, REHAB SERVICES, DISCHARGE PLANNING, SOCIAL SERVICES, PHARMACY, ACTIVITIES, PHYSICIAN (WHEN AVAILABLE, CHAPLAIN)*

PROCEDURE:

NURSING

1. ***Initial Assessment*** – will be performed by a Registered Nurse (RN) and other members of the Interdisciplinary Team to include the following:

   a. Physical Status (medication history and allergies)

   b. Psychological Status

   c. Social Status

   d. Spiritual Status

   e. Cultural Status

   f. Risk for Injury (Fall Risk Assessment)

   g. Nutritional Status Screen

   h. Functional Screen

   i. Skin Assessment

   j. Functional/Environmental Needs

   k. Anticipated Discharge Planning Needs

   l. Initial Anticipated Educational Needs and any Barriers to Learning

   m. Pain Assessment

   n. Abuse/Neglect Screening

2. Each nursing unit/department has established a time frame for completing the admission assessment interview, taking into consideration the following factors based on the major patient population of each department:

   a. The anticipated length of stay

   b. The complexity of nursing care needs

   c. The dynamics of the resident's condition(s)

3. Family involvement in the admission process will be encouraged /facilitated by the admitting RN whenever possible.

4. The RN can delegate data gathering aspects of the admission process to licensed vocational nurses (LVNs) and certified nursing assistants (CNAs), according to their practice guidelines, but the RN must analyze the data and formulate a nursing diagnosis and plan of care in collaboration with the resident and other clinical disciplines.

5. The RN/Social Service Designee will document or delegate documentation of the disposition of resident's valuables. This is particularly important when the resident is physically or mentally unable to keep track of personal property. The problem can be partially resolved by encouraging the resident's family to take personal belongings home.

6. The admission assessment will be documented on the Admission Intervention in the electronic medical record (EMR).

7. The scope and intensity of the assessment will be determined by:

   a. Resident diagnosis

   b. Care setting to which the resident is admitted

   c. Resident desire for care and interventions

   d. Resident response to treatment, procedures, and interventions.

9. ***Reassessment***

   a. The resident will be reassessed:

      - To determine response to treatment(s)/procedure(s)
      - When there is a significant change in condition
      - When there is a change in diagnosis
      - When there is a change in the level of care
      - Any time as deemed necessary
      - Minimally every shift and at unit specified intervals related to the care setting and course of treatment

   b. Documentation of the reassessment will be located on the RN Weekly Summary Intervention in the EMR.

c. Reassessments are completed by RNs. The information for reassessment will be gathered from residents, families, other healthcare professionals and physician input.

d. Procedural reassessment is continuous during procedures in OR, Endoscopy, and Diagnostic Radiology.

RESPIRATORY CARE

1. ***Initial Assessment***

a. Initial assessment will be initiated within 15 minutes of notification of a STAT physician order or within 2 hours of notification for routine physician order and completed within 2 hours by a Respiratory Care Practitioner (RCP).

b. The resident is evaluated by:

- Diagnosis
- History
- Physical Assessment
- Clinical Data – ABGs, Pulse Oximetry, Breath Sounds, Chest X-ray
- Resident's ability to perform ordered procedures
- Necessity for teaching home care

c. The ordered therapy is initiated and an assessment made as to the effectiveness of therapy and its appropriateness to the resident's condition and abilities. Treatments and patient's response are documented on the Respiratory Therapy Record in the EMR.

2. ***Reassessment***

a. As long as the patient is receiving therapy, the therapist will reassess the resident prior to, during, and following each treatment to determine response to medication and occurrence of significant changes. The following areas will be monitored:

- Breath sounds
- Heart rate
- Respiratory rate
- Secretions

- How well treatment was tolerated
- Clinical data
- Continuing need of current therapy
- Evaluation of mode and frequency

NUTRITIONAL SERVICES

1. ***Initial Assessment***

   a. The purpose of the nutritional assessment is to evaluate the resident's nutritional status, develop a plan of nutritional care, and evaluate the efficiency of nutritional support. The need for a nutritional assessment is determined following a nutritional screening process completed by a Registered Dietitian/RN during the initial resident assessment.

   b. All inpatients are screened within 24 hours of admission, which triggers a referral to a Registered Dietitian (RD), who will assess residents in a time frame according to high, moderate or low risk identification.

   - Physician-ordered nutritional consults are completed within 24 hours of order.
   - Nursing referrals identified from the nutritional screening on nursing initial assessment form will be prioritized for nutritional risk by 48 hours.
   - All residents identified to be at high/moderate nutritional risk receive a nutritional assessment by a Registered Dietitian.

2. ***Reassessment***

   a. Residents will be reassessed by the Registered Dietitian.

   - High Risk patients, 2-3 days- TPN /PPN assessment will be completed in collaboration with lab data ordered twice weekly.

     Residents re-evaluated every 30 days or as deemed appropriate at last evaluation or Consult.

   - When ordered by a physician
   - More often as deemed necessary by the Registered Dietitian

   b. The reassessment will document the resident's response to care. At the time of reassessment, the Registered Dietitian may determine that the resident is no longer at a

certain nutritional risk level. This change of nutritional risk will be documented in the medical record.

c. All resident reassessments are documented in a narrative format on the resident's medical record in the EMR.

PHYSICAL THERAPY

1. ***Initial Assessment***

a. Residents need to be assessed by a Physical Therapist (PT) within 48 hours of receipt of physician order and may include the following:

- Resident interview
- Chart review
- Evaluation of:
  - balance/coordination
  - bed mobility
  - transfers
  - gait
  - strength
  - range of motion
  - neurological
  - posture

2. ***Reassessment***

a. Functional status and needs are reassessed with each treatment to determine the resident's response to interventions.

b. Information for reassessment will be gathered from residents, families, other healthcare professionals and physical input. Reassessment documentation will be located in the Therapy progress notes in the EMR.

OCCUPATIONAL THERAPY/With Physician Order

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1. ***Initial Assessment***

   a. All inpatients are screened for the need of further assessment within 48 hours of admission. Residents needing assessment will be assessed by an Occupational Therapist (OTR) within 24 hours of receipt of physician order and may include the following:

   - Resident interview
   - Chart review
   - Evaluation of:
     - ADLs
     - Upper Body Function
     - Transfer
     - Cognitive-Visual Perceptual Motor Skills

2. ***Reassessment***

   a. Reassessment of functional status and needs are ongoing with each treatment given to determine the resident's response to interventions.

   b. Information for reassessment will be gathered from residents, families, other healthcare professionals and physician input. Reassessment documentation will be located in the Therapy progress notes in the EMR.

SPEECH THERAPY

1. ***Initial Assessment***

   a. All residents are screened for the need of further assessment within 5 days of admission. Residents needing immediate assessment will be performed by a Speech Therapist (SLP) within 48 hours of receipt of physician order and may include the following:

   - Resident interview
   - Chart review
   - Evaluation may include:
     - Dysphasia
     - Cognition

- Communication

2. ***Reassessment***

   a. Reassessment of the functional status and needs are ongoing with each session given to determine the patient's response to interventions.

   b. Information for reassessment will be gathered from patients, families, other healthcare professionals and physician input. Reassessment documentation will be located in the Speech progress notes in the EMR.

DISCHARGE PLANNING

1. ***Initial Assessment***

   a. A Discharge Evaluation will be done by the Social Service Designee on admission, every 6 months thereafter, and on discharge from the facility.

   b. The need for Discharge Planning Service intervention is triggered following a screening process completed by nursing during the initial patient assessment.

   c. A Social Service Designee will assess residents when given notification by nursing or upon review of the patient's medical record that indicate risk factors which warrant further discharge planning activities.

   d. The resident is evaluated for:

      - Diagnosis
      - Physical ability
      - Resident's goals for discharge
      - Social setting at place of residence (i.e.; lives alone, in Board & Care/ECF, etc.)
      - Resident's ability to safely return to previous living arrangements
      - Providing availability and education of Community Resources (assisting resident/family with discharge planning that requires specific resources).

2. ***Reassessment***

   a. The Discharge Planner reviews care and progress on assigned residents as often as deemed necessary, but no less than every 3 days, and documents discharge planning progress notes on the worksheet and medical record.

b. Coordinates multi-disciplinary communication to facilitate reassessment and revision of the plan of care when necessary.

c. Information for reassessment will be gathered from patients, families, other healthcare professionals and physician input. Reassessment documentation will be located in the medical record.

SOCIAL SERVICES

1. ***Initial Assessment***

a. The need for social service intervention is triggered following a screening process completed by nursing during the initial patient assessment.

b. Intervention will be performed by a Social Worker within 1 day for high-risk patients and within 2 days for moderate risk patients, or upon request for services.

- Residents meeting high risk criteria:
  - Domestic Violence
  - Suspected abuse/neglect
- Residents meeting moderate risk criteria:
  - Newly diagnosed catastrophic illness
  - Homelessness

2. ***Reassessment***

a. Reassessment by the Social Worker occurs at least every 3 days.

b. Information for reassessment will be gathered from residents, families, other healthcare professionals and physician input. Reassessment documentation will be located in the progress notes.

PHARMACY

1. ***Initial Assessment***

a. Assessment will be performed by a Pharmacist (Pharm. D.) within 30 days.

b. Assessment will include:

- Body Stats: Height, weight, ideal body weight (IBW), age
- Pertinent labs
- Pertinent medications
- Allergies
- Goals of treatment

c. Assessment will be performed by a pharmacist for all residents receiving medications upon physician order for therapeutic appropriateness.

d. Residents receiving parenteral nutrition are assessed upon initial order.

2. ***Reassessment***

a. Reassessment by the Pharmacist is ongoing on a monthly basis to determine the resident's response to interventions.

b. Reassessment will be performed to assure designated medications are administered to achieve therapeutic drug levels.

c. Information for reassessment will be gathered from residents, families, other healthcare professionals, and physician input. Reassessment documentation will be located in the progress notes for drug dosing/monitoring protocol.

REFERENCES:

- Centers for Medicare/Medicaid Services RAI Manual (2019). Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.
- The Improving Medicare Post- Acute Care Transformation Act (IMPACT ACT) of 2014 Data Standardized Patient Assessment Data Elements, CMS.gov
- https://www.ncbi.nlm.nih.gov>pmc

SUBJECT: **INTERDISCIPLINARY PATIENT ASSESSMENT AND REASSESSMENT**	SECTION: ***Provision of Care, Treatment and Services (PC)***

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

- To define initial patient assessment and reassessment parameters, outline a process to prioritize patient care, and provide criteria all members of the healthcare team, utilized during the assessment process.
- To develop a database of information regarding the patient in order to provide the necessary information to plan, coordinate, delegate, and supervise the care of the patient.

POLICY:

1. All patients entering Sierra View Medical Center (SVMC) will receive an initial assessment, which takes into account their immediate and emerging needs. The data gathered will be analyzed utilized to make decisions concerning any need for further assessments, treatment, interventions, and reassessments.

2. Each admitted patient's initial assessment is conducted within a time frame identified by the service. Reassessment occurs throughout the care process and the purposes, key reassessment points and/or time intervals are defined.

3. Assessments are performed by each discipline within its scope of practice, state licensure laws, applicable regulations, or certification.

4. A registered nurse (RN) will assess the patient's need for nursing care in all settings where nursing care is provided.

5. Care decisions will be based upon data and information gathered in assessments and reassessments. This data will be utilized in prioritizing patient care needs and selecting appropriate interventions.

6. Patients that have home medical equipment may use their own equipment as long as staff and patient are educated on proper use, equipment is order by the physician for use here in the hospital, and equipment is check by the appropriate staff (i.e. bio med, respiratory therapy, Etc.)

7. Prioritizing patient care will be as follows:

   a. Emergent needs;

   b. Actual needs;

   c. Potential needs; and

d. Educational needs.

AFFECTED AREAS/PERSONNEL: *NURSING; RESPIRATORY THERAPY; NUTRITIONAL SERVICES; REHAB SERVICES; DISCHARGE PLANNING; SOCIAL SERVICES; PHARMACY*

PROCEDURE:

NURSING

1. ***Initial Assessment*** – will be performed by a Registered Nurse (RN) and include the following:

   a. Physical Status (Medication History and allergies);

   b. Medical History;

   c. Psychological Status;

   d. Social Status;

   e. Spiritual Status;

   f. Cultural Status;

   g. Risk for Injury (Fall Risk Assessment);

   h. Nutritional Status Screen;

   i. Functional Screen;

   j. Skin Assessment;

   k. Functional/Environmental Needs;

   l. Anticipated Discharge Planning Needs;

   m. Initial Anticipated Educational Needs and any Barriers to Learning;

   n. Pain is assessed; and

   o. Abuse/Neglect screening.

2. Each nursing unit/department has established a time frame for completing the admission assessment interview, taking into consideration the following factors based on the major patient population of each department:

   a. The anticipated length of stay.

   b. The complexity of nursing care needs.

   c. The dynamics of the patient's condition(s).

3. Family involvement in the admission process will be encouraged/facilitated by the admitting RN whenever possible.

4. The RN can delegate data gathering aspects of the admission process to LVNs and NAs, according to their practice guidelines, but the RN must analyze the data and formulate a nursing diagnosis and plan of care in collaboration with the patient and other clinical disciplines.

5. The RN will document or delegate documentation of the disposition of patient's valuables. This is particularly important when the patient is physically or mentally unable to keep track of personal property. The problem can be partially resolved by encouraging the patient's family to take personal belongings home.

6. The admission assessment will be documented on the Initial Assessment and the Interdisciplinary Patient/Family Education Record.

7. The scope and intensity of the assessment will be determined by:

   a. Patient diagnosis;

   b. Care setting to which the patient is admitted;

   c. Patient desire for care and interventions; and

   d. Patient response to treatment, procedures, and interventions.

8. Patients 13 year old and under patient assessments will include:

   a. Emotional, cognitive, communication, educational, social, and daily activity needs.

   b. Immunization status.

   c. Family's expectations for and involvement in the care and treatment of the patient.

d. Developmental age, length or height, head circumference (for patients under 3 years), and weight.

e. Effect of the family or guardian on the patient's condition and the effect of the patient's condition on the family or guardian.

9. ***Reassessment***

a. The patient will be reassessed:

- To determine response to treatment(s)/procedure(s).
- When there is a significant change in condition.
- When there is a change in diagnosis.
- When there is a change in the level of care.
- Any time as deemed necessary.
- Minimally every shift and at unit specified intervals related to the care setting and course of treatment (see attached table).

b. Documentation of the reassessment will be located on the unit specific intervention or flowsheet

c. Reassessments are completed by RNs. Data may be collected by the LVN. Abnormal data obtained by an LVN will be reviewed and assessed by an RN.

d. Procedural reassessment is continuous during procedures in OR, Endoscopy, and Diagnostic Radiology.

RESPIRATORY CARE

1. ***Initial Assessment***

a. Initial assessment will be initiated within 15 minutes of notification of a STAT physician order or within 2 hours of notification for routine physician order and completed within 2 hours, by a Respiratory Care Practitioner (RCP).

b. The patient is evaluated by:

- Diagnosis;
- History;
- Physical Assessment;
- Clinical Data – ABG's, Pulse Oximetry, Breath Sounds, Chest X-ray;
- Patient's ability to perform ordered procedures; and
- Necessity for teaching home care.

c. The ordered therapy is initiated and an assessment made as to effectiveness of therapy and its appropriateness to the patient's condition and abilities. Treatments and patient's response are documented on the Respiratory Therapy Record.

2. ***Reassessment***

a. As long as the patient is receiving therapy, the therapist will reassess the patient prior to, during, and following each treatment to determine response to medication and occurrence of significant changes. The following areas will be monitored:

- Breath sounds;
- Heart rate;
- Respiratory rate;
- Secretions;
- How well treatment was tolerated;
- Clinical data;
- Continuing need of current therapy; and
- Evaluation of mode and frequency.

NUTRITIONAL SERVICES

1. ***Initial Assessment***

a. The purpose of the nutritional assessment is to evaluate the patient's nutritional status, develop a plan of nutritional care, and evaluate the efficiency of nutritional support. The need for a nutritional assessment is determined following a Nutritional Screening Process completed by nursing during the initial patient assessment.

b. All inpatients are screened within 24 hours of admission, which triggers a referral to a Registered Dietitian (RD) who will assess patients in a time frame according to high, moderate or low risk identification.

c. Physician ordered nutritional consults are completed within 24 hours of order.

d. Nursing referrals identified from the nutritional screening on nursing initial assessment form will be prioritized for nutritional risk by 48 hours.

e. All patients identified to be at high/moderate nutritional risk receive nutritional assessment by a Registered Dietitian.

2. ***Reassessment***

a. Patients will be reassessed by the Registered Dietitian.

b. High Risk patients, 2-3 days- TPN /PPN assessment will be completed in collaboration with lab data ordered twice weekly.

c. Moderate risk patients, 4-5 days.

d. Low risk re-evaluated every 7 days or as deemed appropriate at last evaluation.

e. When ordered by a physician.

f. Or more often as deemed necessary by the Registered Dietitian.

g. The reassessment will document the patient's response to care. At the time of reassessment, the Registered Dietitian may determine that the patient is no longer at a certain nutritional risk level. This change of nutritional risk will be documented in the medical record.

h. All patient reassessments are documented in the patient's medical record.

PHYSICAL THERAPY

1. ***Initial Assessment***

a. All inpatients are screened for the need of further assessment within 24 hours of admission. Patients needing assessment will be assessed by a Physical Therapist (PT) within 24 hours of receipt of physician order and may include the following:

- Patient interview;
- Chart review;
- Evaluation of:
  - Balance/coordination
  - Bed mobility
  - Transfers
  - Gait
  - Strength
  - Range of motion
  - Neurological
  - Posture

2. ***Reassessment***

a. Functional status and needs are reassessed with each treatment to determine the patient's response to interventions.

b. Information for reassessment will be gathered from patients, families, other healthcare professionals and physical input. Reassessment documentation will be located in the Therapy Progress Notes.

OCCUPATIONAL THERAPY (if available)

1. ***Initial Assessment***

a. All inpatients are screened for the need of further assessment within 24 hours of admission. Patients needing assessment will be assessed by an Occupational Therapist (OTR) within 24 hours of receipt of physician order and may include the following:

- Patient interview
- Chart review
- Evaluation of:
  - ADLs
  - Upper Body Function
  - Transfer
  - Cognitive-Visual Perceptual Motor Skills

2. ***Reassessment***

   a. Reassessment of functional status and needs are ongoing with each treatment given to determine the patient's response to interventions.

   b. Information for reassessment will be gathered from patients, families, other healthcare professionals and physician input. Reassessment documentation will be located in the Therapy Progress Notes.

SPEECH THERAPY

1. ***Initial Assessment***

   a. All inpatients are screened for the need of further assessment within 24 hours of admission. Patients needing assessment will be performed by a Speech Therapist (SLP) within 24 hours of receipt of physician order and may include the following:

   - Patient interview
   - Chart review
   - Evaluation may include:
     - Dysphasia
     - Cognition
     - Communication

2. ***Reassessment***

   a. Reassessment of the functional status and needs are ongoing with each session given to determine the patient's response to interventions.

   b. Information for reassessment will be gathered from patients, families, other healthcare professionals and physician input. Reassessment documentation will be located in the progress notes.

DISCHARGE PLANNING

1. ***Initial Assessment***

   a. The need for Discharge Planning Service intervention is triggered following a screening process completed by nursing during the initial patient assessment.

   b. A Discharge Planner will assess patients within 2 days of notification by nursing or upon review of the patient's medical record that indicate risk factors which warrant further discharge planning activities.

   c. The patient is evaluated for:

      - Diagnosis;
      - Physical ability;
      - Social setting at place of residence (i.e.; lives alone, in Board & Care/ECF, etc.);
      - Patients ability to safely return to previous living arrangements; and
      - Providing availability and education of Community Resources (assisting patient/family with discharge planning that requires specific resources).

2. ***Reassessment***

   a. The Discharge Planner reviews care and progress on assigned patients as often as deemed necessary, but no less than every 3 days, and documents discharge planning progress notes on the worksheet and medical record.

   b. Coordinates multi-disciplinary communication to facilitate reassessment and revision of the plan of care when necessary.

c. Information for reassessment will be gathered from patients, families, other healthcare professionals and physician input. Reassessment documentation will be located in the medical record.

SOCIAL SERVICES

1. ***Initial Assessment***

a. The need for social service intervention is triggered following a screening process completed by nursing during the initial patient assessment.

b. Intervention will be performed by a Social Worker within 1 day for high-risk patients and within 2 days for moderate risk patients, or upon request for services.

- Patients meeting high risk criteria:
  - Domestic Violence
  - 5150 Psychiatric Patient
  - Adoption Planning
  - Suspected abuse/neglect
- Patients meeting moderate risk criteria:
  - Newly diagnosed catastrophic illness
  - Homeless

2. ***Reassessment***

a. Reassessment by the Social Worker occurs at least every 3 days.

b. Information for reassessment will be gathered from patients, families, other healthcare professionals and physician input. Reassessment documentation will be located in the progress notes.

PHARMACY

1. ***Initial Assessment***

a. Assessment will be performed by a Pharmacist (Pharm. D.) within 1 hour of referral to a drug dosing/monitoring protocol.

b. Assessment will include:

- Interview with patient/family as appropriate;
- Body Stats: height, weight, ideal body weight (IBW), age;
- Pertinent labs;
- Pertinent medications;
- Allergies; and
- Goals of treatment.

c. Assessment will be performed by a pharmacist for all patients receiving medications upon physician order for therapeutic appropriateness.

d. Patients receiving parenteral nutrition are assessed upon initial order.

2. ***Reassessment***

a. Reassessment by the Pharmacist is ongoing throughout protocol or parental nutrition to determine the patient's response to interventions.

b. Reassessment will be performed to assure designated medications are administered to achieve therapeutic drug levels.

c. Information for reassessment will be gathered from the medical record, patients, families, other healthcare professionals & physician input as needed by the assessing pharmacist. Reassessment documentation is completed on pharmacy department forms for pharmacist to dose requests & total parenteral nutrition (TPN) management

REFERENCES:

- The Joint Commission (2020). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **INTERDISCIPLINARY PATIENT ASSESSMENT AND REASSESSMENT**	SECTION: ***Provision of Care, Treatment and Services (PC)*** 12 16 **Page ~~13~~ of ~~17~~**

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DISCIPLINE	**ASSESSMENT TIME FRAME**	**REASSESSMENT PARAMETERS**

Nursing **RN** – analyzes data and prioritizes care. **LVN** – collects data **CNA** – collects data	**Med/Surg/Tele/Peds –** brief within 30 minutes; complete within 8 hours of Admission. **ICU/CCU**—brief immediately upon arrival; complete within 2 hours of admission. **L&D** – assessment of uterine contractions and fetal heart rate immediately; complete within 30 minutes of admission. Newborn – 1, 5, and 30 minutes of age; complete within 2 hours of admission. **Postpartum** - Within 30 minutes of arrival into the room. **GI LAB** – Upon arrival.	**Med/Surg/Tele/Peds** – Total system assessment every shift. **ICU/CCU** – q 4 hours and a full physical assessment every shift. **L&D –** ***Low risk:*** ***v.s.:*** Stage 1 = q 1 hour Stage 2 = q 30 minutes **Temp:** Intact = q 4 hours Ruptured = q 2 hours **FHT:** Stage 1 = q 30 minutes Stage 2 = q 15 minutes ***High risk:*** **v.s.** Stage 1 = q 30 minutes Stage 2 = q 15 minutes **Temp:** Intact = q 4 hours Ruptured = q 2 hours **FHT:** Stage 1 = q 15 minutes Stage 2 = q 5 minutes Postpartum recovery - q 15' X 4 then q 30' X 2, then q 1 hour X 2 Newborn – q 1 hour X 2 until stable, then q 8 hours **Postpartum** – q 4 hours. **GI LAB** – Ongoing during procedure. Post procedure, q 15'

DISCIPLINE	ASSESSMENT TIME FRAME	REASSESSMENT PARAMETERS
		X 4 then q 30' X 2, then q 1 hour until discharged.
	ER – triaged within 15 minutes of arrival then seen per triage policy; immediate via ambulance; completed within 3 hours of admission.	**ER** – q 1 hour unless otherwise indicated.
	Urgent Care – Immediately upon arrival and completed within 1 hour.	**Urgent Care** – q 1 hour until discharge.
	PACU – brief upon arrival; complete within 15 minutes of admission.	**PACU** – Q 5 minutes x3 then Q15 minutes

SUBJECT: **INTERDISCIPLINARY PATIENT ASSESSMENT AND REASSESSMENT**	SECTION: ***Provision of Care, Treatment and Services (PC)***

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

DISCIPLINE	ASSESSMENT TIME FRAME	REASSESSMENT PARAMETERS
	OR – Upon arrival. **Diagnostic Radiology** – brief immediately upon arrival and completed within 15 minutes.	**OR** – ongoing during procedure and prior to discharge to PACU. **Diagnostic Radiology --** ongoing during procedure and prior to discharge home or to Flexcare.
Respiratory Therapy RT	Within 15 minutes of notification for STAT orders and within 2 hours for routine orders; complete within 2 hours.	• With each treatment/procedure given • Changes in Condition or Diagnosis • Changes in level of care • Any time as deemed necessary
Nutritional Services RD	Within 24 hours of physician referral Within 48 hours nursing referral RD will identify high/moderate nutrition risk diagnosis and place at risk level	• High risk q 2-3 days • Moderate risk q 4-5 days • Low risk q 7 days **Or**…when ordered by the physician • Change in diagnosis or condition • Goals of nutrition therapy are not being achieved.
Physical Therapy PT	Within 24 hours of receipt of physician order	• Ongoing with each treatment • Changes in condition or diagnosis
Occupational Therapy OTR	Within 24 hours of receipt of physician order	• Ongoing with each treatment • Changes in condition or diagnosis
Speech Therapy SLP	Within 24 hours of receipt of physician order	• Ongoing with each session • Changes in condition or diagnosis
Social Worker LCSW	High risk within 1 day of referral; Moderate risk within 2 days of referral.	• Ongoing with each session and documented at least every 3 days. • Changes in condition or diagnosis • As deemed necessary

Discharge Planning RN	Within 2 days of referral.	• At least every 3 days. • Changes in condition or diagnosis • To determine patient response to treatments and progress toward discharge. • To verify discharge plan is viable
Pharmacist PharmD.	Within 1 hour of referral.	• At least daily. • Ongoing throughout protocol to evaluate efficacy and potential toxicity • Changes in condition or diagnosis when on protocol • As deemed necessary.

SUBJECT: **INITIATING DIALYSIS WITH AN AV FISTULA OR VEIN GRAFT**	SECTION: **Page 1 of 3**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To gain access to a patient's arteriovenous (AV) fistula or AV graft, minimizing the possibility of infection, occlusion, thrombosis, infiltration and other trauma.

POLICY:

- Before initiating dialysis, the Renal Services RN/Certified Hemodialysis Technician will determine the integrity of the vascular access by palpating for a thrill and auscultating for a bruit.
- The Nephrologist will be notified immediately if the bruit/thrill is not present. The absence of the bruit/thrill indicates the venous access is clotted.
- Aseptic technique will be followed when initiating dialysis.

AFFECTED AREAS/ PERSONNEL: *PHYSICIANS, DIALYSIS PERSONNEL*

EQUIPMENT:

- Clean Gloves
- Gown, Mask, Goggles/Face Shield
- Barrier
- Four (4) Alcohol Prep Pads
- Tourniquet, as needed
- Two (2) Fistula Needles
- Lab Tubes, as needed
- One (1) 10 ml - 30 ml Syringe, as needed
- Two (2) 10 ml Syringes with 10 ml Normal Saline
- Four (4) 2 x 2 in. gauze pads
- Paper tape, plastic tape and two (2) adhesive bandages

SUBJECT: **INITIATING DIALYSIS WITH AN AV FISTULA OR VEIN GRAFT**	SECTION: **Page 2 of 3**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PROCEDURE:

- Assess site for stenosis, ischemia, and signs and symptoms of infection including swelling, redness, excessive warmth, drainage or tenderness. If infection is a concern stop and contact the nephrologist for further instruction.
- Follow aseptic technique.
- Put on gown, mask and goggles. Perform hand hygiene and put on clean gloves.
- Place a barrier under the access arm.
- Select the cannulation site carefully. Consider straight areas and needle orientation. Sites should be selected in an area without aneurysm/pseudo aneurysms and with a minimum of two inches between the tips of the needles.
- Apply a tourniquet to all AV Fistulas.
- Swab the skin over the arterial and venous sites with alcohol prep pads. Allow to air dry.
- Grasping the wings of the cannulation needle, insert the fistula needle into the arterial site with the bevel up. The needle position should be concurrent with the blood flow to prevent vessel damage. Cannulate at a 25 degree angle for arteriovenous fistula (AVF) and 45 degree for arteriovenous graft (AVG).
- Release the tourniquet while stabilizing the needle. A flashback of blood indicates that the needle is in the access. Lower the angle of insertion and advance the needle into the AVF/AVG until appropriately positioned within the vessel.
- Place an adhesive bandage/ gauze over the butterfly of the needle and secure the butterfly with a chevron utilizing ½ inch plastic tape. Place a strip of paper tape over the cannulation site.
- Unclamp the needle and allow the blood to flow to the end of the tubing. Re-clamp the tubing.
- Attach one of the 10 ml syringes containing normal saline and clear the needle with normal saline.
- Reapply the tourniquet as needed. Repeat the above process for venous site cannulation.
- Release the tourniquet.
- Proceed with the initiation of dialysis.
- Document the initiation of the dialysis treatment.

NOTE:

- When selecting needle sites, avoid inflamed areas or aneurysms. Vary needle sticks to ensure longevity of the vascular access.
- Hemodialysis treatment may be terminated at the discretion of the Renal Services RN as appropriate.

REFERENCES:

- Centers for Disease Control and Prevention. (January 2024). CDC guidelines, Recommendations and Resources. Retrieved on 8/16/24. https://www.cdc.gov/dialysis-safety/hcp/recommendations-resources/index.html

SUBJECT: **MANAGEMENT OF EMPLOYEE ILLNESSES AND EXPOSURES/DUTY RESTRICTIONS**	SECTION: **Page 1 of 6**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To provide guidance for management of infectious illnesses among health care personnel (HCP) in order to ensure a safe environment for personnel, patients, volunteers and visitors.

POLICY:

Sierra View Medical Center (SVMC) shall implement measures to prevent further transmission of infectious illnesses by HCP, which sometimes warrants exclusion of personnel from work or patient contact. Employee Health Services (EHS), Infection Prevention or a designee, such as the House Supervisor, have authority to temporarily exclude personnel from duty if it is determined that there is risk of transmission to other personnel and/or patients.

AFFECTED AREAS/PERSONNEL: *ALL HCPs, VOLUNTEERS*

PROCEDURE:

1. HCP will report to EHS in person or by phone, independently or as directed by a department manager or supervisor for evaluation of any actual or suspected illness or infection. When EHS and Infection Prevention are closed, the HCP will report to the House Supervisor.

2. Determine if illness or infection is included in the Disease/Problem list. (See attachment entitled: *Guideline For Infection Control*)

3. Use criteria as identified in attachment to determine duty restriction or exclusion

4. If excluded from duty, HCP may choose to either visit the Emergency Department voluntarily, or their primary care provider to obtain clearance to return to work.

5. Refer HCP to Human Resources for guidance on obtaining primary provider clearance to return to work, as well as obtaining information regarding wages, benefits or job status during restriction.

REFERENCES:

- Bader, M. S., Brooks, A., Kelly, D. V., & Srigley, J. A. (2017). Postexposure management of infectious diseases. *Cleveland Clinic journal of medicine*, *84*(1), 65–80. DOI: https://doi.org/10.3949/ccjm.84a.15049

- Bolyard, E.A., Tablan, O.C., Williams, W.W., Pearson, M.L., Shapiro, C.N, Deitchman, S.D., The Hospital Infection Control Practices Advisory Committee (1998). Guideline for infection control in health care personnel, 1998. *AJIC, 26(3), 289-354*. DOI: https://doi.org/10.1016/S0196-6553(98)80015-1

- California Code of Regulations, Title 22. Social Security Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies Chapter 1. General

Acute Care Hospitals. AFL-20-08-Attachment-02. Title 22, Section 70723. https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-20-08-Attachment-02.pdf

GUIDELINE FOR INFECTION CONTROL (AMERICAN JOURNAL OF INFECTION CONTROL)
THIS TABLE SUMMARIZES SUGGESTED WORK RESTRICTIONS FOR HEALTHCARE PERSONNEL EXPOSED TO OR INFECTED WITH INFECTIOUS DISEASES OF IMPORTANCE IN HEALTHCARE SETTINGS, IN THE ABSENCE OF STATE AND LOCAL REGULATIONS (TAKEN FROM TABLE 3, FROM BOLYARD, *ET AL.*, MODIFIED BY THE AMERICAN JOURNAL OF INFECTION CONTROL (AJIC) FROM ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) RECOMMENDATIONS)

Disease/Problem	Work Restrictions	Duration
Conjunctivitis	Restrict from patient contact and contact with the patient's environment	Until discharge ceases
Cytomegalovirus infections	No restriction	
Diarrheal diseases		
Acute stage (diarrhea with other symptoms)	Restrict from patient contact, contact with the patient's environment, or food handling	Until symptoms resolve
Convalescent stage, *Salmonella* species	Restrict from care of high-risk patients	Until symptoms resolve; consult with local and state health authorities regarding need for negative stool cultures
Diphtheria	Exclude from duty	Until antimicrobial therapy completed and two cultures obtained ≥ 24 hours apart are negative
Enteroviral infections	Restrict from care of infants, neonates, and immuno-compromised patients and their environments	Until symptoms resolve
Hepatitis A	Restrict from patient contact, contact with patient's environment, and food handling	Until 7 days after onset of jaundice
Hepatitis B		
Personnel with acute or chronic Hepatitis B surface antigemia who do not perform exposure-prone procedures	No restriction; refer to state regulations; standard precautions should always be observed	
Personnel with acute or chronic Hepatitis B e antigenemia who perform exposure-prone procedures	Do not perform exposure-prone invasive procedures until counsel from an expert review panel has been sought; panel should review and recommend procedures the worker can perform, taking into	Until Hepatitis B e antigen is negative

Disease/Problem	Work Restrictions	Duration
	account specific procedure as well as skill and technique of worker; refer to state regulations	
Hepatitis C	No recommendation	
Herpes simplex		
Genital	No restriction	
Hands (herpetic whitlow)	Restrict from patient contact and contact with the patient's environment	Until lesions heal
Orofacial	Evaluate for need to restrict from care of high-risk patients	
Human immuno-deficiency virus	Do not perform exposure-prone invasive procedures until counsel from an expert panel has been sought; panel should review and recommend procedures the worker can perform, taking into account specific procedure as well as skill and technique of the worker. Standard Precautions should always be observed; refer to state regulations.	
Measles		
Active	Exclude from duty	Until 7 days after the rash appears
Postexposure (susceptible personnel)	Exclude from duty	From 5th day after first exposure through 21st day after last exposure and/or 4 days after rash appears
Meningococal infections	Exclude from duty	Until 24 hours after start of effective therapy
Mumps		
Active	Exclude from duty	Until 9 days after onset of parotitis
Postexposure (susceptible personnel)	Exclude from duty	From 12th day after first exposure through 26th day after last exposure or until 9 days after onset of parotitis
Pediculosis	Restrict from patient contact	Until treated and observed to be free of adult and immature lice
Pertussis		
Active	Exclude from duty	From beginning of catarrhal stage through 3rd week after onset of paroxysms or until 5 days after start of effective antimicrobial therapy
Postexposure (asymptomatic personnel)	No restriction, prophylaxis recommended	

Disease/Problem	Work Restrictions	Duration
Postexposure (symptomatic personnel)	Exclude from duty	Until 5 days after start of effective antimicrobial therapy
Rubella		
Active	Exclude from duty	Until 5 days after rash appears
Postexposure (susceptible personnel)	Exclude from duty	From 7th day after first exposure through 21st day after last exposure
Scabies	Restrict from patient contact	Until cleared by medical evaluation
Staphylococcus aureus infection		
Active, draining skin lesions	Restrict from contact with patients and patient's environment or food handling	Until lesions have resolved
Carrier state	No restriction, unless personnel are epidemiologically linked to transmission of the organism	
Streptococcal infection, group A	Restrict from patient care, contact with patient's environment, or food handling	Until 24 hours after adequate treatment started
Tuberculosis		
Active disease	Exclude from duty	Until proved noninfectious
PPD converter	No restriction	
Varicella		
Active	Exclude from duty	Until all lesions dry and crusted
Postexposure (susceptible personnel)	Exclude from duty	From 10th day after first exposure through 21st day (28th day if VZIG given) after last exposure
Zoster		
Localized, in healthy person	Cover lesions; restrict from care of high-risk patients	Until all lesions dry and crust
Generalized or localized in immunosuppressed person	Restrict from patient contact	Until all lesions dry and crust
Postexposure (Susceptible personnel)	Restrict from patient contact	From 8th day after first exposure through 21st day (28th day if VZIG given) after last exposure or, if Varicella occurs, until all lesions dry and crust

Disease/Problem	Work Restrictions	Duration
Viral respiratory infections, acute febrile	Consider excluding from the care of high-risk patients or contact with their environment during community outbreak of RSV and influenza	Until acute symptoms resolve

SUBJECT: **MANDATED ABUSE REPORTING- DP/SNF**	SECTION: **Page 1 of 8**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define the Sierra View Medical Center (SVMC) process for handling and reporting of patient/resident suspected or actual abuse by those involved in operations of the District.

POLICY:

It is the policy of SVMC's DP/SNF to comply with the Elder Justice Act (EJA) about reporting a reasonable suspicion of a crime under Section 1150B of the Social Security Act, as established by the Patient Protection and Affordable Care Act (ACA), §6703(b)(3).

The Director of DP/SNF for SVMC will be held accountable for following the established guidelines for screening, training, preventing, identifying, investigating, protecting and reporting and/or responding to all alleged events of suspected abuse.

For the purposes of this policy, the following definitions apply:

"Abuse" - Is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish to the resident. Examples may include but not be limited to: deprivation by a caretaker of goods and services that are necessary, to attain or maintain physical, mental and psychosocial well-being. This presumes that instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.

"Alleged Violation" - Is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be noncompliant with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.

"Exploitation" - As defined at 483.5 means "taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion."

"Immediately" – Reporting must be made immediately, and no later than 2 hours, this applies to ANY abuse (whether actual, alleged or potential), including abuse resulting in serious bodily injury. All other conduct must be reported no later than 24 hours.

"Injuries of unknown source" – An injury should be classified as an "injury of unknown source" when both of the following criteria are met:

- The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and
- The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.

"Misappropriation of resident property" - As defined at 483.5, means "the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent."

"Mistreatment" - As defined at 483.5, is "inappropriate treatment or exploitation of a resident".

"Neglect" - As defined at 483.5, means "the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress."

"Sexual Abuse" - Is defined at 483.5, as "non-consensual sexual contact of any type with a resident".

"Verbal Abuse" - Is the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again.

"Physical Abuse" - Includes, but is not limited to: hitting, slapping, pinching and kicking, controlling behavior through corporal punishment.

"Mental Abuse" - Includes but is not limited to: humiliation, harassment, threats of punishment or deprivation.

"Involuntary Seclusion" - Includes separation of a resident from other residents or from his/her room or confinement to his/her room (with or without roommates) against the resident's will, or the will of the resident's legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs.

"Covered Individual" - Refers to any individual (or staff) who is an owner, operator, employee, manager, agent or contractor of a long-term care facility (DP/SNF).

"Retaliation against an Employee" - Refers to when the employer discharges, demotes, suspends, threatens, harasses, or denies a promotion or any other employment-related benefit to an employee, or in

any other manner discriminates against an employee within the terms and conditions of employment because the employee has met their obligation to report a suspicion of a crime.

AFFECTED PERSONNEL/AREAS: *DP/SNF STAFF, CONTRACTORS, and MEDICAL STAFF*

PROCEDURE:

Screening of Potential Staff:

To protect the residents/patients of SVMC, all directors will coordinate in the post-employment criminal background screening with SVMC's Human Resources Department to determine eligibility for employment or assignment. *(See: "Criminal Background Screens for Employment" – Human Resource Policy & Procedure Manual)*

Staff. Resident, and Family Education/Training:

1. All staff (e.g. "covered individuals") will annually receive a copy of their obligation to comply with the law and these policies and procedures.

2. All staff who will care for or work around the DP/SNF residents, including but not limited to, EVS, Respiratory and Floats from other departments will be given an in service on the DP/SNF Abuse Policy and will be guided to the appropriate Mandated Reporting Communication Board for information and appropriate forms.

3. All new staff, as part of their New Hire Orientation to work at SVMC, shall receive a copy of their obligation to comply with the law and this policy and procedure.

4. Staff will be taught how to identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property are more likely to occur. This in-service will be given to all employees who work with or around the residents on the DP/SNF Unit on hire and every 6 months. All staff will also be taught to document their assessment of the involved resident, initially upon report of the witness, then each shift for seven (7) days from the day of the incident, in the resident's notes via the electronic medical records. All other residents will also be assessed to ensure their safety and comfort. This assessment will be entered in the EMR on the day of the incident.

5. Residents, families, and staff will be given information on how and to whom they may report concerns, incidents and grievances without the fear of retribution/retaliation; and provide feedback regarding the concerns that have been expressed.

6. *Cameras/ Cell Phones:* Staff are prohibited from taking or using photographs or recordings in any manner that would demean or humiliate a resident(s). This would include using any type of

equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep, or distribute photographs and recordings on social media.

Prevention

1. Identify, correct and intervene in situations in which abuse and /or neglect and/or Misappropriation of resident's property is more likely to occur.

Identification of Suspected Abuse:

1. Any employee who suspects abuse of a resident by SVMC staff, who identifies any suspicious bruising, repeated occurrences, patterns and trends that may constitute abuse are to report such items to their supervisor immediately, and complete an organization Occurrence Report in the PAVISSE, which will be forwarded to the unit's department director and SVMC's Risk Management Department.

The initial report (SOC 341) of suspected abuse must be completed and reported to the Ombudsman and CDPH within 24 hours of the event. During after hours, weekends or holidays, the Nursing House Supervisor will notify the DP/SNF Unit Director or designee of the event. The SOC 341 must be faxed to both the Ombudsman and CDPH. The hard copy of the SOC 341 will be mailed to CDPH within 24 hours of completing the form.

CDPH Licensing and Certification
4540 California Avenue, Suite 200
Bakersfield, CA. 93309
(O): 661-336-0543
(F): 661-336-0529

Long Term Care Ombudsman Services
1197 S. Drive
Hanford, CA. 93230
(O): 559-583-0333
(F): 559-589-0608

Porterville Police Department
350 North D. Street
Porterville, CA. 93257
(O): 559-782-7400

2. Risk Management will coordinate with the DP/SNF Unit Director and Human Resources to initiate the investigation process.

Protection of Resident:

In order to protect the resident, the employee and/or staff member under investigation will be immediately removed from the unit.

Suspension:

If abuse is suspected and/or witnessed, the Nursing House Supervisor, Unit Director and/or the Human Resources representative will immediately suspend and remove the individual from the District grounds.

Investigation:

1. SVMC's Risk Management and Human Resources Departments will conduct a thorough investigation of the incident in collaboration with the Unit Director.

2. You must also report investigation results for all allegations – within five (5) working days of the incident. This can be done by written form.

Staff Reporting Requirements:

1. The facility administrator (or designee) is to report all incidents to CDPH Licensing and Certification and the Administrative Director of Care and Quality. If the administrator is absent, reporting is required from whoever is officially acting on the administrator's behalf.

2. Reporting should be made by telephone and /or fax copy of the SOC 341.

3. Keep a copy of the fax confirmation. Also, if the report is via phone, make sure to document who was spoken to and the time of the call.

4. When staff suspects a crime has occurred against a resident of the DP/SNF, they must report the incident to the physician, facility administrator, unit director/abuse coordinator. Appropriate state agencies will also be contacted/notified as part of the mandated reporting process.

5. Staff must report a suspicion of a crime to the state survey agency and at least one local law enforcement entity within a designated time frame by e-mail, fax, or telephone. The individual does not need to determine which local law enforcement entity to report a suspicion of crime; but, must report to at least one local law enforcement entity. This will meet the individual's obligation to report.

6. Suspected abuse not resulting in serious bodily injury by a resident with a diagnosis of Dementia:

   - Report the incident to the local Ombudsman and local law enforcement agency by telephone as soon as possible.
   - A written report must follow within 24 hours to the local Ombudsman and the local law enforcement agency.

7. If the suspected abuse does not result in serious bodily injury, the mandated reporter must:

   - Report the incident by telephone within 24 hours to local law enforcement agency

- Provide a written report to the local Ombudsman, the L & C Program and the local law enforcement agency within 24 hours.

8. If suspected abuse results in serious bodily injury, then facility must do the following:

   - Report the incident immediately and no later than 2 hours by telephone to local law enforcement. Send a written report within 2 hours to the local law enforcement agency, L & C Program and the Ombudsman.

9. Staff can either report the same incident as a single complaint, or multiple individuals may file a single report that includes information about the suspected crime from each staff.

10. If, after a report is made regarding a particular incident, the original report may be supplemented by additional staff that become aware of the same incident. The supplemental information may be added to the form and must include the name of the additional staff along with the date and time of their awareness of such incident or suspension or suspicion of a crime. However, in no way will a single or multiple person report preclude an individual from reporting separately. Either an individual or joint report will meet the individual's obligation to report.

11. To ensure correction is achieved and sustained in regards to providing evidence of investigation, an assessment entry will be made in the involved patient's note for seven (7) days from the day of the incident. This will serve as evidence of all measures undertaken and of the investigation that transpired. Such process will be an included instruction in the routine abuse training for all staff.

12. Failure to report in the required time frames may result in disciplinary action, including up to termination.

13. The Compliance RN will monitor for compliance of the investigation/monitoring process, through the nurse's daily assessment notes, for each shift x seven (7) days from the day of the incident, as documented in the EMR. The result of the monitoring will be reported on QA/PI report for the specific quarter that the incident has transpired.

***There may be instances where a report is required under 42 CFR 483.12(C) [f609], but not under 42 CFR 483.129(b) (5)/Section 1150B of the Act [F608]. The following table describes the different requirements:

	F608 42 CFR 483.12(b)(5) and Section 1150B of the Act	F609 42 CFR 483.12(C)
What	Any reasonable suspicion of a crime against a resident.	1. All alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property. 2. The results of all investigations of alleged violations.
Who is required to report	Any covered individual, including the owner, operator, employee, manager, agent or contractor of the facility.	The facility.
To whom	State Agency and one or more law enforcement entities for the political subdivision in which the facility is located (i.e., police, sheriffs, detectives, public safety officers; corrections personnel; prosecutors; medical examiners; investigators; and coroners).	The facility administrator and to other officials in accordance with State law, including to the State Agency and the adult protective services where state law provides for jurisdiction in long-term care facilities.
When	Serious bodily injury – Immediately, but not later than 2 hours after forming the suspicion. No serious bodily injury – Not later than 24 hours.	All alleged violations – Immediately, but not later than: 3) 2 hours – if the alleged violation involves abuse or results in serious bodily injury. 4) 24 hours – if the alleged violation does not involve abuse and does not result in serious bodily injury. **Results of all investigations of alleged violations will be submitted within 5 working days of the incident.

*Reporting requirements under this regulation are based on real (clock) time, not business hours.

The regulations related to Abuse were written to provide protections for the health, welfare and rights of each resident residing in the facility. The facility ensures prohibition and prevention of abuse, neglect, exploitation of residents, and misappropriation of resident property. This is achieved through implementation of the following seven (7) components within this policy, to include: Screening, Training, Prevention, Identification, Investigation, Protection, and Reporting/Response.

Posting Requirements:

1. The DP/SNF unit will post in an appropriate location, a sign specifying the rights of the employees under Elder Justice Act. This sign shall include both:

   - The reporting requirements of each staff member.
   - A statement that an employee may file a complaint with the state survey agency against a long-term care facility that retaliates against an employee for filing, and information how to file such a complaint to the State Agency.

2. The sign will be posted in the same area where other required employee signs are posted.

REFERENCES:

- MedPass Inc., (2001) (Updated February 6, 2015) *Facility Guide to OBRA Regulations.* 483.12(b)(5), 483.12(c), 483.13 (b). Abuse, United States of America, MedPass Inc.
- State of California (2021). Long Term Care Ombudsman. Retrieved from https://www.aging.ca.gov/Programs_and_Services/Long-Term_Care_Ombudsman/.
- Thomson Reuters (Revised edition April 1, 1990) Barclays California Code of Regulations, San Francisco, California, Title 22.
- Help Guide, *Elder Abuse and Neglect*, Lawrence Robinson. Joanna Saisan MSW, and Jeanne Segal PhD, Updated June 2019.
- FindLaw, Elder Justice Act Reporting Requirements, Updated May 17, 2021, Thomson Reuters.

CROSS REFERENCES:

- "CRIMINAL BACKGROUND SCREENS FOR EMPLOYMENT " – Human Resources Policy & Procedure Manual

SUBJECT:	SECTION:
MRI-MANAGEMENT OF MRI PATIENTS WITH CARDIAC IMPLANTABLE ELECTRONIC DEVICES	***MRI***

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To outline process of screening and performing MRI exams on patients with Cardiac Implantable Electronic Devices (CIED) at Sierra View Medical Center (SVMC).

DEFINITIONS: Cardiac Implantable Electronic Device (CIED), Implantable cardioverter-defibrillators (ICD). Implantable cardiovascular monitors (ICM), Implantable loop recorders (ILR).

POLICY:

MRI technologists are to identify if a patient has a Cardiac Implantable Electronic Device (CIED) and if such device meets MR Conditional criteria. Patients with implanted MR Conditional devices are to be scanned according to the manufacturer's guidelines and under the direction of a Radiologist. Examples of CIEDs include: cardiac pacemakers, implantable cardioverter-defibrillators (ICD), implantable cardiovascular monitors (ICM) and implantable loop Recorders (ILR). If the CIED cannot be documented as meeting MR Conditional Criteria, the ordered exam must not be performed.

AFFECTED PERSONNEL/AREAS: *MRI SUITE/MRI TECHNOLOGISTS/SVMC NURSING PERSONNEL (RNs).*

PROCEDURE:

The MR Conditional status of the device/s must be first established. Patient product wallet identification cards, prior imaging studies performed at SVMC, operative notes, plain film lead and pulse generator identifiers, or the manufacturer's patient database may assist in the identification of MR Conditional status. Verbal histories from the patient are not acceptable as well as statements referring to prior MR studies performed at other facilities.

In addition to the device itself, the leads must be identified as being MR Conditional. The processes described in the previous paragraph are to be followed to determine MR Conditional status.

The presence of abandoned leads from previous non-labeled systems in combination with MR Conditional leads renders the system as MRI unsafe. Patients with CIEDs are to be scheduled and scanned according to the manufacturer's guidelines.

Procedural steps

1. Scheduler will inquire as to the presence of a pacemaker for outpatient exams at the time of scheduling. The MRI Technologist is responsible for determining the presence of CIED's and if the device meets MR conditional criteria. If it is determined that a CIED is present on the patient's person, the following steps must occur:

a) SVMC MRI screening form (SV014285) must be completed prior to patient entering Zone III of the MRI suite in order to ensure the patient is not contraindicated for MRI exam due to ferromagnetic implants or objects.

b) The patient's cardiologist must issue clearance for the MRI exam and submit orders for the pacemaker settings. Cardiologist must complete SVMC MR Conditional device Checklist.

c) MRI technologists must follow CIED manufacturer's recommended scanning protocols.

2. Exam will be scheduled with manufacturer representative. The manufacturer representative may program device on-site or remotely.

   If programming is performed remotely the Technologist works in conjunction with the manufacturer representative to prepare the patient for programming of the device.

   a) Ensure the CIED is MRI safe before proceeding with the exam

   b) Contact manufacturer to arrange exam time either remotely or in person

   c) Technologist is to retrieve programming device for the pacemaker in question. The programming device utilized is specific to the CIED manufacturer

   d) If performed remotely, contact the manufacturer representative. Manufacturer representative will access programming device remotely.

   e) Manufacturer representative will place CIED in MRI mode

   f) The amount of time the CIED remains in MRI safe mode is determined by the manufacturer representative based on estimated exam time.

REFERENCES:

- https://d197for5662m48.cloudfront.net/documents/publicationstatus/76918/

- Gold, M. R., Sommer, T., Schwitter, J., et al. (2015). Full-Body MRI in Patients With an Implantable Cardioverter -Defibrillator: Primary Results of a Randomized Study. *Journal of American College of Cardiolology, 65*(24), PP2581-2588.

- Shinbane, Colletti, Shellock, et al (2007). MR in Patients With Pacemakers and ICDs: Defining the Issues. *Journal of Cardiovascular Magnetic Resonance, 9*, 5-13. http://www.imrser.org/PDF/Shinbane.PACE.ICD.JCMR.2007.pdf.

SUBJECT: **NON-STERILE COMPOUNDING**	SECTION: **Page 1 of 11**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

In compliance with state and federal laws, this policy defines the process to follow any time two or more ingredients are combined to produce a medication intended for patient use, except for admixing and reconstitution of medications and preparations that are products of sterile compounding. The scope of this policy is subject to compounded non sterile products for the following dosage forms: solid oral, liquid oral, rectal, vaginal, and topical (creams, gels, ointments), nasal and sinus preps for local application, and otic (excluding perforated eardrums).

Practices not subject to the requirements of this policy:

Nonsterile radiopharmaceuticals: Compounding of nonsterile radiopharmaceuticals is subject to the requirements in *Radiopharmaceuticals—Preparation, Compounding, Dispensing, and Repackaging* ⟨825⟩. Not applicable as SVMC Pharmacy does not compound these items.

Reconstitution: Reconstitution of a conventionally manufactured nonsterile product in accordance with the directions contained in the manufacturer approved labeling

Repackaging: Repackaging of conventionally manufactured drug products

Splitting tablets: Breaking or cutting a tablet into smaller portions

Administration: Preparation of a single dose for a single patient when administration will begin within 4 h. This includes crushing atablet(s) or opening a capsule(s) to mix with food or liquids to facilitate patient dosing. SVMC Pharmacy will strive to prepare only single doses for single patients for administration within 4 hours whenever possible.

DEFINITIONS:

1. **Approved labeling-** FDA approved labeling that contains approved information for the diluent, the resultant strength, the container closure system, and storage time. By itself, this is not considered compounding.

2. **Beyond Use Date or BUD-** the date, or date and time, after which administration of a compounded non-sterile preparation (CNSP) shall not begin, the preparation shall not be dispensed, and the preparation shall not be stored.

3. **Compounding (Non-Sterile)**- the act of combining or altering ingredients by a pharmacist, or by a pharmacy technician under the direct supervision of a pharmacist, in response to a licensed practitioner's prescription, which produces a medication tailored to an individual patient's special medical needs. This definition does not include mixing or reconstituting commercial products in accordance with the manufacturer's instructions or the product's approved labeling, as these tasks are not considered compounding.

4. **Designated person** – will be the Pharmacist in Charge, and will be accountable for the performance and operation of the facility and personnel as related to non-sterile compounding

5. **Integrity**- retention of potency until the expiration date noted on the label.

6. **Potency**- active ingredient strength within +/- 10% of the labeled amount.

7. **Reconstitution**- the return, usually by adding liquid, of a drug previously altered for preservation and storage to its original state for administration to a patient.

8. **Quality**- absence of harmful contaminants, including filth, putrid, or decomposed substances, and absence of active ingredients other than those noted on the label.

9. **Strength**- amount of active ingredient per unit of a CNSP.

10. **CNSP-** compounded nonsterile product

11. **DSCSA-** Drug Supply Chain and Security Act

12. **COA-** Certificate of Authenticity

13. **SOP-** Standard Operating procedure

14. **API-** Active Pharmaceutical Ingredient

POLICY:

Sierra View Medical Center's Department of Pharmacy will follow USP 795 guidelines for non-sterile compounding outlined in this policy to produce safe and effective medications.

AFFECTED PERSONNEL/AREAS: *PHARMACY*

EQUIPMENT:

- Graduated cylinders, mortar and pestle, electronic scale, weighing paper, spatula, glass stir rod. Closed-system processing devices to reduce exposure to staff will be communicated in the master formulation & determined by the designated person.

PROCEDURE:

A. Designated Person Oversight
   a. Responsibilities include the following:
      - Overseeing a training program to ensure competency of personnel involved in compounding, handling, and preparing CNSP's (Compounded Nonsterile Product)
      - Selection of components
      - Monitoring and observing compounding activities and taking immediate corrective action if deficient practices are observed.

- Ensuring that SOPS are fully implemented & follow up is carried out if issues are identified.
- Establishing, monitoring, and documenting procedures for the handling and storage of CNSP

B. Personnel Training and Evaluation

1. The elements of knowledge and competency include the following:
   i. Hand hygiene
   ii. Garbing
   iii. Cleaning and sanitizing
   iv. Handling and transporting components of CNSPs
   v. Measuring and mixing
   vi. Proper use of equipment and devices selected to compound CNSP's
   vii. Documentation of the compounding process
2. The pharmacy will maintain written documentation sufficient to demonstrate that pharmacy personnel have the skills and training required to properly and accurately perform assigned responsibilities relating to compounding. Additional topics will address the following:
   i. Quality assurance and quality control procedures
   ii. Container closure and equipment selection
   iii. Component selection and handling
   iv. USP 795 chapter
   v. Understand and interpret safety data sheets
   vi. The procedures within this policy related to their duties.
3. All pharmacy personnel performing nonsterile compounding will complete an initial assessment and be re-evaluated at least every 12 months. The assessment will be compromised of didactic and observational reviews. Training may be performed by an assigned trainer by the designated person.
4. If a member of compounding personnel fails any aspect of training or demonstrated competency, he or she shall not be involved in compounding until after successfully passing reevaluations in the deficient area(s).
5. Designated person or their designee will notify and educate staff of any changes in process via email, meetings or written material.
6. The Designated person or their designee will check the compounding log monthly to monitor and observe any compounding activities & will take action to remedy any deficient practices observed.

B. Personnel Preparation

1. Before compounding a CNSP, the supervising pharmacist shall evaluate compounding personnel experiencing any of the following: rashes, recent tattoos or oozing sores, conjunctivitis, active respiratory infection or other medical conditions that could contaminate the CNSP or the environment. The pharmacist shall notify the designated person for evaluation of to determine whether the individual is excluded from compounding duties until condition resolved.

2. Hand Hygiene & Garbing procedures

i. Prior to entering the compounding area to compound staff must wash hands with soap and water for at least 30s, dry hands completely with disposable towels or wipers, then don gloves. Gloves are to be wiped or replaced before beginning a CNSP of different compounds. Gloves should be immediately replaced if defects such as holes are identified.

ii. Gloves are to be worn for all compounding activities. Other garb as noted in the formulation record if noted.

C. Cleaning & Sanitizing of areas

Site	Minimum Frequency
Work Surfaces, Floors, Walls, Storage and Shelving	See Table 1 at end of references.
Other devices	Before first use of the day and in accordance with manufacturer's recommendations. If no recommendation, the between compounding CNSP with different components.

D. Procurement of components.

1. Preferably, active pharmaceutical ingredients (API) that meet the USP-NF standards of strength, quality, purity and integrity and comply with FDA Good Manufacturing Practices will be used.
2. All components other than API's:
   - Should be accompanied by a certificate of analysis (COA) verifying it meets criteria in USP-NF monograph, if one exists.
   - Should be manufactured by an FDA-registered facility.
   - Purified water or better quality, e.g., Sterile Water for Irrigation, must be used for compounding nonsterile drug preparations when formulations indicate the inclusion of water.
   - Manufactured items will comply with DSCSA requirements which will keep track of receipt date, supplier name, quantities, lot numbers, and expiration data. Package insert will maintain data for testing.
3. For all ingredients used a MSDS (Master Data Safety Sheet) sheet will be readily available for management of nonhazardous spills and disposal.

E. Master Formulation and Compounding Records

a. A compounded non-sterile preparation (CNSP) shall not be compounded until the pharmacy has first prepared a written master formula. When the pharmacy does not routinely compound a particular drug preparation, the master formula may be written on the prescription itself.

b. No CNSP shall be prepared that is essentially a copy of one or more commercially available drug products, unless:

i. The drug product is a shortage item (ASHP or FDA Database), or

ii. There is a specific, documented medical need made known to the pharmacist. A copy of the documentation of the shortage or the specific

medical need shall be maintained for three years from the date of receipt.

c. NO CNSP shall be prepared with any component not intended for use in a CNSP for the intended patient population.
   i. Example: Doxycycline for pediatrics

F. Each master formulation record must contain at a minimum:
1. Name, strength or activity, and dosage form of the CNSP
2. Identities and amounts of all components; if applicable, relevant characteristics of components
3. Container closure system(s)
4. Instructions for preparing CNSP including equipment, supplies, & description of compounding steps
5. Physical description of the final CNSP
6. Beyond-use date (BUD) and storage requirements
7. Reference source to support the assigned BUD
8. If applicable, calculations for quantities and/or conc. of components &strength
9. Labeling requirements (e.g., shake well)
10. Quality control (QC) procedures (e.g., pH testing, visual inspection) and expected results
11. Other information needed to describe the compounding process and ensure repeatability

G. Assign each product or batch a unique compounding lot number or reference.

H. Record Keeping

A compounding record for each CNSP will be maintained and includes the following:

1. The master formula-document.(This shall include the instructions for compounding including equipment and physical description of final CSP, reference source for assigned BUD).
2. Name, strength, and dosage form of the compounded drug product.
3. Container closure system as needed.
4. The date and time the drug product was compounded
5. The identity of the pharmacy personnel who compounded the drug product
6. The identity of the pharmacist reviewing the final drug product
7. The quantity of each component used in compounding the drug product & any associated calculations.
8. The manufacturer or supplier, expiration date, and lot number of each component
9. The pharmacy assigned reference or lot number for the compounded drug product
10. The quantity of drug product compounded and volume or weight of each unit
11. Labeling requirements & quality procedures such as visual inspection for expected results.
12. The BUD of the final compounded drug product & any storage requirements.

The pharmacy shall maintain records of the proper acquisition, storage, and destruction of chemicals, bulk drug substances, drug products, and components used in compounding. This can be organized as an "audit trail" that includes a detailed, chronological record of all revisions and updates made by the facility's personnel.

I. Labeling

a. Each container of prepared CNSP must have the following information:

- Assigned internal ID number
- Active ingredients and amount or concentration
- Storage conditions if other than room temp
- BUD
- Dosage form
- Total amount or volume if not obvious from container
- Route of administration
- Indication that the solution was compounded
- Any special handling instructions
- Any applicable warnings
- Facility name

J. The pharmacy maintains and retains all records required in the pharmacy in a readily retrievable form for 3 years.

K. For non-sterile compounded drug preparation (s), the beyond use date shall not exceed any of the following (refer to Table 3 and 4 in USP Chapter 795):

1. The shortest expiration date or beyond use date of any ingredient in the preparation
2. The chemical stability of any one ingredient in the preparation
3. The chemical stability of the combination of all the ingredients in the preparation
4. For aqueous ($a_w \geq 0.60$) formulations, 14 days (refrigerated)
   i. Cream or gel
   ii. Lotion
   iii. Oral solutions and suspensions
5. For non-aqueous ($a_w < 0.60$) formulations
   i. Oral = 90 days (controlled room temperature or refrigerated)
   ii. Non-oral = 180 days (controlled room temperature or refrigerated)
6. A pharmacist, using his or her professional judgment, may establish an extended date if the pharmacist researches literature and applies drug-specific and general stability documentation from the literature; Documentation of the pharmacist's research and analysis supporting an extension must be maintained in a readily retrievable format as part of the master formula.
7. Shorter dating may be used if it is deemed appropriate in the professional judgment of the responsible pharmacist.

8. BUDs assigned with only a date shall expire at 11:59 pm on that date.

All non-sterile compounding will be:

i. Performed in a designated area & no other activities may be occurring in the area at the same time as compounding.
ii. Executed with gloves for all activities. They must be replaced in the event of compounding a different CNSP or noticing a soiled or compromised appearance.
iii. Prepared accurately and carefully using clean equipment in good working order, and certified if applicable.
iv. When a diluent is needed, purified water or sterile water for injection will be used. Tap water is not allowed.
v. If a closed-system processing device is used, a gown and face-mask shall be used.
vi. Non-disposable garb shall be cleaned with a germicidal detergent and sanitized with 70% isopropyl alcohol before re-use.
vii. Any garbing accommodations shall be documented and the record shall include the name of the individual that granted the accommodation, the date, and description of reasons.
viii. Before compounding begins, the pharmacist will check that starting components are correct and accurate.
ix. The final product will be accurately labeled with the pharmacy name, the generic name(s) of the principle active ingredient(s) and strength, volume and weight of each ingredient, the route of intended administration, date, expiration date, lot number and initials of person preparing and checking the product. Drug products compounded into unit-dose containers that are too small or otherwise impractical for full compliance will be labeled with at least the name(s) of the active ingredient(s), concentration of strength, volume or weight, pharmacy reference or lot number, and expiration date.
x. The container or receipt contains a statement that the drug has been compounded by the pharmacy.
xi. Appropriate auxiliary labels will be affixed.
xii. In addition to checking the final product, the pharmacist will perform quality checks throughout the compounding procedure to verify accuracy.

L. All equipment utilized to compound drug products are to be calibrated every 12 months prior to use and will be stored, used, maintained and cleaned/disinfected in accordance to manufacturer recommendations. Equipment should be cleaned/disinfected prior to compounding of any product.

1. Staff, utilizing such equipment, will receive training to verify competency.
2. Date and time of each calibration is recorded, maintained and retained in the pharmacy records.
3. Purified water, distilled water, or reverse osmosis water shall be used for rinsing equipment and utensils. Tap water is not allowed.
4. Temperature will be monitored once daily for all drug components stored for nonsterile compounding.

M. Cleaning and Sanitizing
   a. Documentation shall include a record of the identity of the person completing the cleaning and sanitizing as well as the product name of the cleaning and sanitizing agents.
   b. Frequency is determined per USP 795.

N. Drug Recalls: See Policy: SVMC DRUG RECALL POLICY

O. Compounding Quality Assurance

   1. The Designated person will verify, monitor, and review the adequacy of the compounding processes as well as documentation of review of those processes by qualified pharmacy personnel.
   2. Authorized pharmacy personnel shall perform quantitative testing as deemed appropriate by the pharmacist in charge (PIC).
      i. Potency testing
      ii. Sterility testing
   3. Any quality reports generated will be retained by the pharmacy and collated with the compounding record and master formula.
   4. When a sample yields a significant variance from labeled strength, the pharmacist in charge shall be notified. Likewise appropriate follow up, corrective action and process improvement shall commence as deemed necessary based on the findings.

Complaint & Adverse Event Handling
The Designated Person will review all complaints related to a potential quality problem with a CNSP & conduct an investigation. Corrective action will be implemented for any issues identified as part of the investigation & consideration into recalling the product and ceasing nonsterile compounding processes until underlying problems are identified and corrected.
Complaints will be handled using the error reporting software for the facility and will include a unique identifier, date of complaint, nature of complaint, and response to complaint. If CNSP reveals a quality problem likely to affect other patients, those patients and prescribers affected are to be informed.

REFERENCES:

- California Pharmacy Lawbook Online-California Code of Regulations (2023), Division 17, Title 16, Section 1735-1735.14.
- USP. USP <795> Pharmaceutical compounding—Nonsterile preparations. Second supplement to USP 40–NF 35. December 29, 2022; 675–83.

CROSS REFERENCES:

- Drug Recall Procedure Policy

Table 3. Water Activity of Common Compounded Nonsterile Dosage Forms[a]

Nonaqueous Dosage Forms: a_w < 0.6			Aqueous Dosage Forms: a_w ≥ 0.6		
Dosage Form	**Description**	**a_w**	**Dosage Form**	**Description**	**a_w**
Animal treat	Animal treat (oil flavor)	0.507	Animal treat	Animal treat with 15%–18% aqueous flavor	0.716
Capsule (oil filled)	Olive oil encapsulated	0.468	Cream	Cream vehicle (oil in water emulsion, petrolatum free)	0.968
Capsule (powder filled)	Powder base encapsulated	0.435	Cream	Emollient cream (petrolatum and mineral oil)	0.984
Gel (glycol based)	Propylene glycol, ethoxy diglycol, hydroxypropyl cellulose gel	0.056	Cream	Cream (oil in water emulsion with natural oils)	0.989
Lollipop (sorbitol based)	Sorbitol-based lollipop	0.460	Foam	Foaming surfactant solution	0.983
Ointment	Hydrophilic petrolatum	0.396	Gel (water based)	Alcohol-free aqueous gel	0.990
Ointment	Polyethylene and mineral oil gel base	0.459	Gel (water based)	Hydroxypropyl methylcellulose (HPMC) gel	1.000

Nonaqueous Dosage Forms: a_w < 0.6			Aqueous Dosage Forms: a_w ≥ 0.6		
Dosage Form	**Description**	**a_w**	**Dosage Form**	**Description**	**a_w**
Oral solution (glycol based)	20% Polyethylene glycol and 80% propylene glycol	0.009	Lotion	Lotion (oil in water emulsion)	0.986
Oral solution (oil based)	Medium chain triglycerides oil	0.338	Nasal spray	Nasal spray	0.991
Oral suspension (fixed oil)	Fixed oil with thickener	0.403	Oral solution (water based)	Low-sucrose syrup vehicle	0.906
Powder for inhalation	Encapsulated powder for inhalation	0.402	Oral solution (water based)	90% Water and 10% glycerin	0.958
Stick	Lip balm	0.181	Oral suspension (water based)	Oral suspension base	0.992
Suppository	Polyethylene glycol base	0.374	Rinse	Polymer gel with 30% water	0.960
Suppository	Fatty acid base	0.385	Shampoo	Shampoo	0.976
Tablet (compressed)	Compressed tablet	0.465	Simple syrup	Simple syrup	0.831
Tablet (triturate)	Tablet triturate (lactose and/or sucrose)	0.427	–	–	–
Troche or lozenge (gelatin based)	Gelatin troche or lozenge with NMT 3% aqueous flavor	0.332	–	–	–
Troche or lozenge (glycol based)	Polyethylene glycol troche or lozenge with NMT 3% aqueous flavor	0.571	–	–	–

Table 1. Minimum Frequency for Cleaning and Sanitizing in Nonsterile Compounding Area(s)—Surfaces

Site	Minimum Frequency
Work surfaces	• At the beginning and end of each shift on days when compounding occurs, after spills, and when surface contamination (e.g., from splashes) is known or suspected • Between compounding CNSPs with different components
Floors	• Daily on days when compounding occurs, after spills, and when surface contamination (e.g., from splashes) is known or suspected
Walls	• When visibly soiled, after spills, and when surface contamination (e.g., from splashes) is known or suspected
Ceilings	• When visibly soiled and when surface contamination (e.g., from splashes) is known or suspected
Storage shelving	• Every 3 months, after spills, and when surface contamination (e.g., from splashes) is known or suspected

SUBJECT: **NOTIFICATION AND EXERCISE OF RIGHTS AND RESPONSIBILITIES**	SECTION:

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To assure that residents are informed of his/her rights within the facility, to ensure protection in exercising rights, and to provide notification of changes in rights under federal or state law.

POLICY:

Residents will be informed both orally, using an interpreter when needed, and in writing, in a language he/she understands, of the rights and rules and regulations governing conduct and responsibilities while residing in the facility. All residents' rights information will be relayed prior to and upon admission (signed verification maintained in the medical record), periodically and when changes occur in resident rights. Residents will be encouraged and assisted in exercising his/her rights as a resident and a citizen.

AFFECTED PERSONNEL/AREAS: *SOCIAL SERVICES, ACTIVITIES, INTERDISCIPLINARY TEAM*

PROCEDURE:

1. Resident rights and responsibilities will be reviewed with each resident/responsible party upon admission, a copy of the list of rights and responsibilities will be provided to the resident, and a signed verification of sufficient understanding and receipt of rights and responsibilities will be obtained (Cross Reference Policy: Resident Admission).

2. Residents' rights and responsibilities will be reviewed periodically with resident/responsible party, taking into consideration factors such as health and cognitive status, age, culture, language and educational level (resident and family council meetings, during the Interdisciplinary Team Meetings, during exercising of rights, individual contact, etc.)

3. Residents will be informed, both orally and in writing, of any changes in federal and state rights, and of changes in facility rules and regulations affecting the excision of his/her rights within the facility.

4. Residents will be informed of the Minimum Data Set (MDS) process and transmission policy, which includes review of the Privacy Act Notification Statement at the time of admission.

5. Residents will be informed of the manner of participation and assisted in exercising his/her rights within the facility with freedom from discrimination, coercion or reprisal (e.g., how resident may voice grievances and recommend changes, how they wish to organize their day, process for participation in state elections, choices and input in care procedures and activities, informed consent, notification of changes, etc.).

6. Residents' rights and responsibilities will be posted in resident areas (consumer board, bulletin boards, etc.) and included in the admission agreement, to allow direct access to rights information.

7. Residents/responsible party will be provided information regarding how to contact state and local advocacy and protection agencies for the exercise of resident rights, including the following: Ombudsman, Department of Health Services, Mental Illness and Developmental Disabilities, Adult Protective Services, Medicare/Medicaid, etc. A listing of these agencies is a part of the admission packet and will be signed by the resident/responsible party as an acknowledgement of receipt of this information. A listing of state and local agencies will be posted in the resident area, i.e., Consumer Information Board.

REFERENCE:

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.10 United States of America, Med Pass Inc.
- California Department of Public Health (CDPH) (2017, October 6). *Nursing Home Residents' Rights.* https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/NursingHomeResidentsRights.aspx.
- California Advocates for Nursing Home Reform (CANHR) (2021, May 11). *Residents' Rights Fact Sheet: Long Term Care Justice and Advocacy*. Retrieved from http://www.canhr.org/factsheets/resrights_fs/html/fs_resrights.htm.

SUBJECT: **NURSING CARE OF VENTILATOR RESIDENTS ON THE DPSNF UNIT**	SECTION: **Page 1 of 3**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To assure safe, comprehensive quality care to residents requiring continuous ventilator assistance.

POLICY:

Residents who are ventilator-dependent will be cared for in a safe and competent manner.

AFFECTED PERSONNEL/AREAS: *RESPIRATORY THERAPISTS (RT), REGISTERED NURSES (RN), LICENSED VOCATIONAL NURSES (LVN)*

EQUIPMENT:

- Bag valve mask with adult mask at bedside at all times.
- 1 emergency trach set with ties at bedside at all times (same size or smaller). Respiratory therapist will ensure availability.
- Continuous pulse oximeter with physician order (weaning or capped).

PROCEDURE:

Licensed nurses rendering care to the ventilated resident will be competent in mechanical ventilator operations, basic lung auscultation and closed continuous tracheal suction system. The licensed nursing personnel will be aware of ventilator parameters as ordered by the physician.

Licensed nursing personnel will notify respiratory therapy (RT) personnel should ventilator alarms continue to alarm. Nursing will remove the resident from the ventilator and apply bag-valve ventilation if:

- Ventilator continues to show low pressure alarm
- Ventilator is inoperative or indicates gas pressure alarm; or
- If there is a deterioration of the resident's condition and/or status.
- Resident assessments will be done at least once every 12 hours and documented in the PCS resident's record.
- In accordance with established Respiratory Therapy Department policies and procedures, the Respiratory Therapist will regulate ventilator settings – NO EXCEPTIONS! This includes monitoring of the ventilated resident at least every 4-6 hours and maintenance of ventilator equipment and supplies.

NURSING INTERVENTIONS

1. Ensure tracheostomy tube is maintained securely.

2. Suction and clean airway apparatus as indicated to maintain patency. Suction resident every 2 hours PRN. Only suction for a 15-second period at any one time.

3. Prior to suctioning the resident, the nurse must:

   a. Instruct the resident on procedure to be performed.

   b. Comply with established suctioning policies and procedures regarding special instructions.

   c. Keep water emptied from tubing and trap. (Never turn resident without emptying first).

   d. Evaluate ventilatory pattern for rate, quality, signs of respiratory distress, or inappropriate inspiratory to expiratory ratio (should be at least 1:1). *NOTE: Resident chest movement needs to be equal for both sides of the chest. Be aware if resident has any spontaneous respirations.*

   e. Monitor resident for signs of fighting the ventilator, which indicates that the resident's respiratory cycle is inconsistent with the mechanical cycle; may be due to pain, hypoxia, secretions, fear or anxiety.

   f. Ensure that the alarms are always turned on.

   g. Carefully check all connections of the ventilator tubing to assure that they are tightly secured.

   h. Notify the RT department if alarms continue to be set off. If RT is unable to respond immediately or if any concerns arise as to the effectiveness or operations of the ventilator, remove the resident from the ventilator and manually ventilate the resident with resuscitation bag.

   i. Assure that the ventilator is plugged in at all times when stationary.

   j. Position resident so that all lobes of the lungs are adequately ventilated and perfused.

   k. Reposition resident every two (2) hours.

   l. Monitor breath sounds for presence and quality. Assess resident's lung fields for rales, rhonchi, wheezing, and notify physician of the changes.

m. Assure resident that he/she is not alone. Let the resident know that people are near and if they need assistance, nurses will respond rapidly. Provide a call bell for immediate access and provide a means for the resident to communicate as appropriate.

n. Assure resident that adequate ventilation is being provided.

PATIENT EDUCATION

- Explain all procedures to the resident
- Answer their questions
- Involve family when applicable

DOCUMENTATION

Nursing notes to include the following elements in the resident's record:

- Problems identified and interventions provided
- Evaluation of treatment(s)
- Document respiratory assessment and characteristics of sputum

REFERENCES:

- Paul Martin, BSN, R.N., Updated April 30, 2024, 11 Mechanical Ventilation & Endotracheal Intubation Nursing Care Plans and Management. American Medical Association

- Mora Carpio, Andres L., Mora, Jorge I, Updated 2021, May 7; Ventilator Management, In: StatPearls{Internet] Treasure Island (FL) StatPearls Publishing; Retrieved from: ncbi.nlm.nih.gov

- Lippincott Nursing Center, September 2021, Caring for the Mechanically Ventilated Patient, retrieved from: www.nursingcenter.com

SUBJECT:	SECTION:
NUTRITION ASSESSMENT, CARE PLANS, MINIMUM DATA SET AND DOCUMENTATION - DP/SNF	**Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To establish the procedure for providing comprehensive nutritional care.

POLICY:

The Registered Dietitian is responsible for providing a nutritional assessment/reassessment for comprehensive nutritional care in a timely, effective and efficient manner.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICES, DP/SNF*

PROCEDURE:

1. All residents will receive an initial comprehensive nutritional assessment by the Registered Dietitian. Assessments will be initiated within 24 hours from admission, and completed within 48 hours of admission.

2. The comprehensive medical nutritional therapy assessment shall include the following:

    a. Interview and observation to determine food tolerances, likes, dislikes and allergies as appropriate.

    b. Determination of eating ability including chewing or swallowing ability, need for self-help adaptive devices, mobility problems, etc. with observation at meal time if appropriate.

    c. Review of medical history from the resident's medical record to include laboratory tests, anthropometric measures, and clinical findings.

    d. Review of medications and food medication interactions if relevant to diet therapy or nutritional status.

    e. Review of physiological, sociological, behavioral and environmental data, which may affect nutritional status.

    f. Summary of findings including nutritional problems, assessment of estimated nutritional needs, recommendations and/or plan of care.

3. Nutritional assessment/review will be completed bi-monthly for the first month, monthly thereafter, and more often if clinically necessary.

4. Nutritional problems will be entered into the resident's interdisciplinary care plan.

5. Resident conditions requiring a weight loss/gain regimen will be presented at the DP/SNF team meeting. If the team agrees with the recommendations, the physician will write an order for the weight loss/gain regimen and the Registered Dietitian will secure a signed consent for weight loss/gain from the patient or patient family member prior to initiating the weight loss/gain regimen.

6. The facility will utilize an assessment form recommended by the Registered Dietitian.

7. The Registered Dietitian will complete the MDS nutrition section after admission within the appropriate timeframe. Information from the MDS observation period shall be used to complete the assessment.

REFERENCES:

- Centers for Medicare and Medicaid Services, Conditions of Participation (2024). Retrieved from https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html.

- Med Pass, Inc. (Updated February 6, 2015) Facility guide to OBRA Regulations, 483.25 (i). 483.20 (b)(1), 483.20(k), 483.75 (0).

SUBJECT: **ORAL CARE FOR THE RESIDENT WITH SPECIAL NEEDS**	SECTION:

PURPOSE:

To promote oral and dental health.

POLICY:

It is the policy of this facility to provide oral care for residents with special needs every shift and as needed. These residents include those who are unable to care for themselves, those who have tracheostomy tubes, and those with other special needs.

AFFECTED PERSONNEL/AREAS: *RN, LVN, CNA*

EQUIPMENT:

- Gloves
- Lemon glycerin swabs or toothettes
- Warm water
- Mouthwash
- Tongue blade
- Emesis basin
- Towel or disposable washcloths
- Placvac, Evacu toothbrush, or other oral evacuation tool such as a Yaunker.
- Regular toothbrush, if not using special brush as described above
- Toothpaste
- Clean 4x4 gauze sponges
- Lubricant for lips

PROCEDURE:

1. Arrange equipment within reach on the overbed table.
2. Wash hands and don gloves.
3. Explain the procedure to the resident.

4. Elevate the head of the bed at least 45 degrees.

5. Spread towel or disposable washcloth across patient's chest, taking care not to obstruct the tracheostomy tube if present.

6. Attach the Placvac, Evacu toothbrush, or oral evacuation tool to the extension tubing and activate the suction.

7. Brush the resident's teeth using a brush moistened with water and toothpaste, holding the brush at a 45 degree angle to the gum and using a circular motion.

8. Brush all teeth thoroughly using gentle pressure for at least several minutes.

9. Gently brush the tongue, if able.

10. If using a regular toothbrush, use the Yaunker continually on the residents with a vent or have dysphagia to prevent the resident from swallowing or choking on the water and toothpaste (to be done by licensed staff only).

11. Cleanse the entire mouth after brushing with toothettes or a gauze wrapped tongue blade moistened with diluted mouthwash, following brushing. Use oral evacuation tool continually to prevent the resident from swallowing or choking on any accumulated liquid in the oral cavity.

12. Moisten the mouth with lemon glycerin swabs following cleansing, and as needed.

13. Apply lubricant to lips as needed.

14. Discard waste, wash utensils, and return equipment to proper storage.

15. Wash hands.

DOCUMENTATION:

Document oral care provided in the resident record on the CNA Activities of Daily Living (ADL) record in the electronic medical record (EMR). Document and report any unusual conditions or problems of the mouth to the licensed nurse.

REFERENCE:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72315 (d), San Francisco, California, Title 22.

- Nita Singh DDS, Aug 2019, Providing Care to Patients with Special Needs, Journal of Dimensions for Dental Hygiene, updated from https://dimensionsofdentalhygiene.com

SUBJECT: **OXYGEN PROTOCOL FOR RESIDENT TRANSPORT**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define a process to ensure that supplemental oxygen is administered appropriately according to the patient's condition and status while in transport.

POLICY:

The oxygen therapy protocol will be instituted by a physician order, which indicates:

- Initial flow rate
- Type of delivery appliance
- Target $Sp0_2$ [if other than 92%] or target $Pa0_2$ [if other than 60 mmhg]

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSE (RN), LICENSED VOCATIONAL NURSE (LVN), RESPIRATORY THERAPISTS (RT)*

PROCEDURE:

1. Oxygen therapy will be titrated as appropriate whenever residents are in transport to the Activity Room, shower, or off the unit to another department.

    a. Cardiopulmonary stability including vital signs and respiratory pattern.

    b. Adequate tissue perfusion based upon clinical assessment which includes, but is not limited to:

        - Level of consciousness or neurological changes
        - Respiratory rate and pattern
        - SpO_2 monitoring as indicated

2. For COPD residents with documented $C0_2$ retention, oxygen will be titrated from 0-2 LPM via nasal cannula or <28% via venti-mask, or via venturi device via trach to maintain a $SP0_2$ between 88-92%, unless the physician specifies a different target $SP0_2$.

3. For all residents on a blow-by mist via trach, oxygen will be titrated <40% via venturi device to maintain an $SP0_2$ > 92% =>60 mmhg, unless the physician specifies a different target $SP0_2$ or $Pa0_2$.

    a. If a resident is on oxygen of 28% or less, prior to transport, take off O_2 for five minutes and then check O_2 saturation on room air. If the O_2 saturation is 88% and above on room air, and resident is clinically stable (vital signs, temp), resident may be transported to the shower or activities without O_2 supplement.

4. All residents on a mechanical ventilator will be oxygenized via ambu-bag by a licensed nurse (RN, LVN, RT) while being transported and taken off the ventilator for any length of time.

5. The physician will be notified immediately for any patient who cannot maintain an adequate $SP0_2$ or $Pa0_2$ based upon this protocol.

6. All residents scheduled for transport (internally and externally) will be evaluated by Respiratory Therapy Staff and/or Licensed Nursing Staff for the following:

   a. Stable vital signs

   b. Type of delivery appliance

   c. Initial flow rate

   d. Adequate oxygen source for transport

Special Note: When resident on a ventilator/oxygen is being transported, they will have a licensed staff member in attendance.

REFERENCES:

- CMS Department of Health and Human Services, Dec 10, 2018, *Updated Guide for Long Term Care Participation: Oxygen Therapy Guidelines*. Retrieved from https://www.cms.gov.
- American Association for Respiratory Care, 2021, Oxygen Protocol. Retrieved from www.aarc.org.

CROSS REFERENCES:

- Respiratory Care Services Policy: "Oxygen Protocol"
- Respiratory Care Services Policy: "PULSE OXIMETRY"

SUBJECT: **PACEMAKER- PERMANENT CARE OF**	SECTION: **Page 1 of 1**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To have a system of monitoring residents with permanent pacemakers.

POLICY:

It is the policy of this facility that residents with permanent pacemakers will be checked on a periodic basis to ensure that implanted pacemaker is functioning properly.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSE (RN), LICENSED VOCATIONAL NURSE (LVN), UNIT CLERK*

PROCEDURE:

1. Shape all routines around the physician's orders.
2. Pacemaker will be checked every 3-6 months per company policy using the telephone and the appropriate device.
3. Include an entry for pacemaker on the resident care plan.
4. Enter on resident care plan the type of pacemaker, date of insertion, rate, and pacemaker check lab and phone number (or keep info packet in the chart).
5. Report to physician any rate change of more than five impulses per minute, missed beats or any unaccustomed sensations associated with the pacemaker.
6. Advise resident to report signs/symptoms of dizziness or weakness.
7. Observe for pain, swelling or discoloration at pacemaker site.
8. If pacemaker does not need to be checked, identify that on the resident care plan.
9. Do not use any electrical appliances (i.e., electric razors) that come in contact with the resident's skin.
10. Monitor electrical appliances close to the resident (i.e., microwave ovens) for signs of electrical interference and leakage.
11. Obtain plastic card that comes with the pacemaker and affix to the inside of the resident's chart cover.

REFERENCE:

- National Heart, Lung, and Blood Institute (NHLBI) (n.d.). *Pacemakers*. Retrieved from https://www.nhlbi.nih.gov/health-topics/pacemakers.

SUBJECT: **PATIENT'S OWN MEDICATIONS**	SECTION: **Page 1 of 5**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define conditions under which patient's medications may be brought into the facility.

POLICY:

Patients are discouraged from bringing their own medications into Sierra View Medical Center (SVMC). Under limited and unusual circumstances, the patient may use their own medication (s) under the following circumstances:

1. Pharmacy cannot supply the medication.

2. When the patient insists.

Patient's own herbal remedies may not be used at Sierra View Medical Center due to the following reasons:

1. Herbal medications are categorized as a food (dietary supplement) under the Dietary Supplement Health and Education Act of 1994 by the Food and Drug Administration and are not held to the standards for the manufacturer of drugs.

2. These dietary supplements are not marked or identified with a stamp or number which does not satisfy the requirements for "positive identification" as stipulated in Title 22 § 70263 (m)(3).

Sierra View Medical Center shall permit patient use of medical cannabis for terminally ill patient's (prognosis of life of one year or less, if the disease follows it's natural course) and shall do all of the following:

1. Prohibit smoking or vaping as methods to use medicinal cannabis
2. Include the use of medicinal cannabis within the patient's medical record. This will be done by following the process outlined in Patient's Own Medication policy & in adherence to the Controlled Substances Policy.
3. Patient is required to provide a copy of their medical marijuana card or written documentation that the use of medicinal cannabis is recommended by a physician prior to its use. This must be documented in the medical record. Patient's qualifying status as terminally ill by provider must also be documented into the medical record.
4. Require a patient or a primary caregiver, as defined in Section 11362.7, to be responsible for acquiring, retrieving, administering, and removing medicinal cannabis.
5. Medicinal cannabis is to be stored securely at all times in a locked container & with the patient's primary caregiver. Sierra View Medical Center also prohibits health care professionals and facility staff, including but not limited to physicians, nurses, and pharmacists from administering medicinal cannabis or retrieving medicinal cannabis from storage.

6. Use is not permitted by a patient receiving emergency services and care, as defined in Section 1317.1, or to the emergency department of a health care facility, as specified in subdivision (a) of Section 1250, while the patient is receiving emergency services and care.
7. Medicinal cannabis will not be supplied by Sierra View Medical center.
8. Medicinal cannabis will be allowed to be brought in by the patient or by someone on the patient's behalf, for the patient's exclusive use. It is the personal property of the patient.
9. Only oral and topical forms of medical cannabis may be brought into Sierra View Medical Center for use under this policy.
10. Upon discharge, all remaining medicinal cannabis shall be removed by the patient or patient's primary caregiver. If a patient cannot remove the medicinal cannabis and does not have a primary caregiver that is available to remove the medicinal cannabis the product shall be disposed of in accordance with health facility policy and procedure for controlled substances.

Sierra View Medical Center will not prohibit patient use of medicinal cannabis due soley to that fact cannabis is a schedule I drug in the federal Uniform Controlled Substances Act, or other federal constraints on the use of medicinal cannabis that were in existence prior to January 1, 2022. Sierra View Medical center reserves the right to suspend patient use of medicinal cannabis if a federal regulatory agency, the United States Department of Justice, or CMS does one of the following:

Initiates enforcement action against Sierra View Medical center related to the facility's compliance with the state-regulated mandate.

Issues a rule or otherwise provides the facility with notification that prohibits the use of medical marijuana in health care facilities or otherwise prohibits compliance with the state-regulated medical marijuana program.

Home Medications not including Medicinal Cannabis

Medications meeting the conditions below, may be brought into the hospital under the following conditions:

1. Drugs have been ordered by a person lawfully authorized to give such an order, and the order is entered in the patient medical record.

   Orders shall meet the requirements of Medication Ordering Policy.

2. The medication container is clearly and properly labeled.

3. The contents of the containers have been examined and positively identified by the hospital's pharmacist.

   a. The pharmacist will log the medication into the "Patient Own Medication Log Sheet." For medications which the pharmacy cannot supply or when the patient insists, the

pharmacist will take appropriate measures to ensure provided medications match the ordered medication. They will use a pill identifier via Clinical Pharmacology or other drug identifier database, at minimum, to confirm the contents of patient's bottles/bags, etc. Once confirmation is achieved, the pharmacist will enter the order for Patient's Own Medication. The patient's pill bottle will then be sent to the patient's unit with a label from Pharmacy for scanning/administration to patient. The pharmacist will initial this label to show confirmation that the order was checked by pharmacy. Upon dispensing, the pharmacy will label the container stating "Return Patient's Own Medications To Patient Upon Discharge."

b. The pharmacist or pharmacy technician will then deliver Patient's Own Medications to the appropriate patient care area.

Drugs that are not to be used during the patient's stay at the hospital will be given to the patient's family to take home.

In the event that the medications cannot be sent home, the medications will be sent to the pharmacy. The pharmacist (or nursing supervisor, after normal pharmacy hours), will place the labeled bag of medications in a separate drawer/cabinet marked "patients own medications" away from all other pharmacy stock. Receipt of the medication will be documented on the "patient's medication log" to include the name of the patient, the date received and the disposition of the medications (i.e. date returned to the patient upon discharge or date destroyed as applicable).

AFFECTED AREAS/PERSONNEL: *PHARMACY, NURSING*

PROCEDURE:

A patient may utilize his/her medication if ordered by the attending physician when all of the following conditions are met:

1. Medications are ordered by the patient's physician and the order is entered on the patient's medication profile indicating:

   a. Patient's own medication may be used

Name, strength, route, and dose schedule

2. Medications have been examined by the pharmacist for positive identification and are clearly and correctly labeled.

In the event that a patient has an attached medication delivery device, (e.g., pump , etc.), the nurse will contact the pharmacist to come to the patient's bedside for a visual inspection of the device.

MEDICATION INFUSION DEVICES

1. The pharmacist will contact the pharmacy that provided the pump and determine concentration, original volume, expiration of the drug and any other pertinent information deemed necessary at the time and enter that information into the medical record.

2. The pharmacist will also contact the prescriber to validate dose and delivery rate of the medication being infused as well as any parameters under which the infusion should be slowed or stopped and enter that information into the medication profile.

3. Instructions on how to stop the pump or change the rate will be obtained from the original prescriber or manufacturer and kept at the nursing station.

STORAGE AND DESTRUCTION OF PATIENT'S OWN MEDICATION:

1. Patient's own medication should be returned to the patient's family upon admission.

2. If the medication is unable to be returned to the family, it is to be sent to the pharmacy for storage.

3. If the medications are not claimed 30 days after discharge, they will be destroyed in the following manner:

   a. Drugs listed in Schedule II, III, or IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended, shall be destroyed in the presence of two pharmacists employed by the hospital. The name of the patient, the name and strength of the drug, the prescription number, the amount destroyed, the date of destruction and the signatures of the required witnesses shall be recorded in a separate log. Such a log shall be retained for at least 3 years. Medications may be sent to DEA disposal unit as required by DEA office.

   b. Drugs not listed under Schedule II, III, IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended, shall be destroyed in the presence of a pharmacist.

REFERENCES:

- The Joint Commission (2024). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Statutory Changes in Pharmacy Law. https://www.pharmacy.ca.gov/laws_regs/new_laws.pdf Accessed 1/10/2023.
- Pharmacy Law: California Edition.(2024) San Clemente, California: Law Tech Publishing Group.

- Title 22 (n.d.).Retrieved on September 20, 2019, from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.
- SB 311, Hueso. Retrieved on February 9th, 2022. https://leginfo.legislature.ca.gov/faces/billTextClinet.xhtml?bill id=202120220SB311

SUBJECT: **PCI PATIENT SELECTION AND EXCLUSION GUIDELINES**	SECTION: **Cardiac Cath Lab** **Page 1 of 3**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To ensure appropriate guidelines on the selection and exclusion of patients undergoing Percutaneous Coronary Intervention (PCI).

POLICY:

PCI patient selection and exclusion guidelines.

AFFECTED PERSONNEL/AREAS: *CARDIAC CATH LAB*

EQUIPMENT:

Refer to (Inventory and maintenance of catheterization lab supplies).

PROCEDURE: Case Selection

A. Under direct guidelines from Cath Lab Medical Director patients selected for PCI must meet one or more of the following criteria.

- Non-ST-elevation acute coronary syndrome (NSTE-ACS).
- Unstable angina
- Anginal equivalent (eg, dyspnea, arrhythmia, or dizziness or syncope).
- High risk stress test findings.
- Extent and degree of ischemia suggested by noninvasive testing before coronary angiography.
- Adequacy of medical therapy.
- Extent of anatomic CAD.

B. Patients will be excluded from PCI if the following are present.

- Arteries <1.5mm in diameter.
- Diffusely diseased saphenous vein grafts.
- Other coronary anatomy not amenable to PCI.
- Significant comorbid conditions that severely limit the lifespan of the patient.
- >50% diameter stenosis of left main artery proximal to infarct-related lesion, especially if the area in jeopardy is relatively small and overall LV function is not severely impaired.
- Long, calcified, or severely angulated target lesions at high risk for PCI failure with TIMI flow grade 3 present during initial diagnostic angiography.
- Lesions with TIMI flow grade 3 in patients with left main or three-vessel disease where bypass surgery is likely a superior revascularization strategy compared with PCI.
- Culprit lesions in more distal branches that jeopardize only a modest amount of myocardium when there is more proximal disease that could be worsened by attempted intervention.
- Chronic total occlusion.
- Emergency transfer for coronary bypass surgery patients with:

1. High-grade left main or three-vessel coronary disease with clinical or hemodynamic instability after successful or unsuccessful PCI of an occluded vessel and preferably with IABP support.

2. Failed or unstable PCI result and ongoing ischemia, with IABP support during transfer.

3. Patient and Lesion characteristics that could be unsuitable for non-emergency procedures at facilities without on-site cardiac surgery:

High-risk patients

- Decompensated congestive heart failure [Killip Class 3] without evidence for active ischemia.
- Recent [<8 weeks] cerebrovascular accident.
- Advanced malignancy.
- Known clotting disorders.
- LVEF < or =30%.
- Chronic kidney disease [creatinine clearance <60mL/min] if patient not already on dialysis.
- Serious ongoing ventricular arrhythmias.
- Patients with left main stenosis [>50% diameter] or three-vessel disease unprotected by prior bypass surgery [>70% stenosis in the proximal or mid segments of all major epicardial coronary arteries], treatment of any or all stenosis. Scoring systems, such as SYNTAX may be useful in defining the extent of disease and type of revascularization procedure.
- Patients with a single-target lesion that jeopardizes an extensive amount of myocardium.
- Patients undergoing intervention on the last remaining conduit to the heart.

High-risk Lesions

- Unprotected left main stenosis.
- Diffuse disease [>20mm in length].
- Extremely angulated segment [>90%] or excessive proximal or in-lesion tortuosity.
- More than moderate calcification of a stenosis or proximal segment.
- Inability to protect major side branches.
- Degenerated older vein grafts with friable lesions.
- Substantial thrombus in the vessel or at the lesion site.
- Any other feature that could, in the operator's judgment, impede successful stent deployment.
- Anticipated need for rotational or other atherectomy device, cutting balloon or laser.
- The characteristics listed above identify high-risk patient and lesion feature but are not absolute contraindications to performing PCI at a facility without on-site surgery. For example, an elevated creatinine levels increases the procedure risk for the patient, but this is not unique to facilities without on-site surgery and treatments to mitigate this complication can be used at all facilities. Ultimately, the operator should consider all factors and make a decision about the suitability of the patient for PCI at the facility.
- Strategy for surgical backup based on lesion and patient risk:
- High-risk patients with high-risk lesions should not undergo nonemergency PCI at a facility without on-site surgery.

- High-risk patients with non-high-risk lesions: Nonemergency patients with this profile may undergo PCI, but confirmation that a cardiac surgeon and operating room are immediately available is necessary.
- Non-high-risk patients with high-risk lesions require no additional precautions.
- Non-high-risk patients with non-high-risk lesions require no additional precautions.

REFERENCES:

- **C.L. Grines, et al. (2023, Feb) SCAI Expert Consensus Statement on Percutaneous Coronary Intervention Without On-Site Surgical Backup. Retrieved from Journal of the Society for Cardiovascular angiography & Interventions 2 (2023)**
- **Nettina, S.M. (2024). Lippincott Manual of Nursing Practice 12th edition. Philadelphia: Wolters Kluwer Health.**

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CROSS REFERENCES:

- INVENTORY AND STOCKING AUDIT

SUBJECT: **PERITONEAL DIALYSATE CULTURE**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To appropriately evaluate the peritoneal dialysate effluent for potential infection.

POLICY:

- The patient will be assessed for signs and symptoms of peritonitis during each peritoneal dialysis exchange procedure and as indicated.

AFFECTED AREAS/ PERSONNEL: *NURSING PERSONNEL*

KEY POINTS:

- The attending nephrologist will order lab work on the dialysate.
- When the patient has signs and symptoms of peritonitis and/or the effluent is cloudy, notify the attending nephrologist immediately.
- Ice the cloudy bag if it is delayed in transit to the Laboratory. Icing will reduce bacterial growth, and provide for more accurate results.

Send the entire bag to the Laboratory. Do not open the clamps and obtain a sample.

EQUIPMENT:

- Non-sterile Gloves
- Gown, Mask, Goggles, or Face Shield, as necessary
- One (1) 4 x 4 in. gauze pad
- Tape
- Two (2)- liter Pathology Container
- Large Plastic Bag

PROCEDURE:

- When the peritoneal dialysis exchange is completed, put on gown, mask, gloves and goggles.
- Wrap the dialysate tubing port with a sterile 4 x 4 in. gauze pad and tape securely to prevent potential contamination.

- Place the dialysate bag in 2-liter pathology container. Place the container in a large plastic bag to guard against leakage.
- Place laboratory label on the pathology container and dialysate bag.
- Send the container to the Laboratory. Ice the container if it is not taken to the Laboratory immediately.

REFERENCES:

BC Renal Provincial PD Nursing Group, BC Renal PD Medical Director, & BC Renal PD Nursing Group. (2023). Peritoneal Dialysate effluent collection. In *BC Renal*. http://www.bcrenal.ca/resource-gallery/Documents/PD_Procedures-PD_Effluent_Collection.pdf

SUBJECT: **PHYSICAL EXAMINATIONS POSITIONING AND DRAPING**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

The purpose is to allow adequate expose while preserving the resident's modesty and comfort during an examination by a physician.

POLICY:

It is the policy of this facility to ensure the resident's privacy will be protected by being well draped for any examination. A nurse should be present during internal examination of a female resident.

AFFECTED PERSONNEL/AREAS:

RN, LVN

PROCEDURE:

1. HORIZONTAL RECUMBENT OR SUPINE POSITION (ADMISSION AND GENERAL EXAMINATIONS):
   a. Explain procedure to resident.
   b. Position resident flat on back with legs extended or slightly flexed.
   c. Replace top bedding with bath blanket, and fan fold bedding at bottom of bed.
2. DORSAL RECUMBENT POSITION (VAGINAL AND PERINEAL EXAMINATIONS):
   a. Explain procedure to resident.
   b. Position resident flat on back with knees flexed and relaxed out to side.
3. SIMS' POSITION (RECTAL OR VAGINAL EXAMINATION):
   a. Explain procedure to resident.
   b. Place resident on left side with back close to edge of bed.
   c. Place bath blanket folded lengthwise over resident.
   d. Draw both knees up slightly. Help resident flex right knee and thigh to acute angle so both knees are resting on bed.
4. STANDING OR ERECT POSITION (SPINE OR BACK EXAMINATION):
   a. Explain procedure to resident.

b. Provide bath towel or mat for resident to stand on.

c. Loosen gown to expose entire spine.

d. A bath blanket may be pinned to gown and draped over shoulders.

5. DOCUMENTATION:

a. Record type of examination, physician performing and resident's tolerance in the Nurse's Notes in the electronic medical record (EMR).

REFERENCE:

- Davis, F.A. (2019). *Draping for Minimum Exposure and Maximum Dignity*, Chapter 6. Retrieved from: https://fadavispt.mhmedical.com

SUBJECT:	SECTION:
PHYSICIAN'S ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)	**Page 1 of 3**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To ensure the process for the resident/responsible party to determine the level/intensity of care and treatment options preferred while residing in the facility.

POLICY:

The resident or responsible party/surrogate decision-maker will exercise the right of self-determination in making informed decisions regarding medical treatments to be provided. The facility will acknowledge the resident's advanced directive, which designates the resident's wishes and/or alternate decision-maker. The facility will utilize the Physicians Orders for Life-Sustaining Treatment (POLST) form to document the review of treatment options with the resident/responsible party and the intensity of care electives for medical treatments.

AFFECTED PERSONNEL/AREAS: *PHYSICIAN, SOCIAL SERVICES, NURSING, INTERDISCIPLINARY TEAM (IDT)*

PROCEDURE:

1. At the time of admission, the Social Worker or designee will inform the resident or surrogate decision-maker of the options available in determining the level of care, withholding treatment, limiting treatment, or consenting to available treatments.

2. The physician will determine and document the mental capacity of the resident to understand the nature and consequences of the diagnosis, prognosis, and treatment options.

3. The physician will discuss the treatment plan with the health care team and the resident or the surrogate if the resident is determined to lack the mental capacity to understand the nature and consequences of the diagnosis, prognosis, and treatment options.

    a. If the physician determines that the resident lacks the mental capacity to make healthcare decisions and the resident does not have an advance directive or legal representative/surrogate, the physician, in consultation with the resident's family members or involved parties, will identify the person who will assume the responsibility of surrogate decision-maker.

    b. If there is no family, friend, or involved party who is willing to assume responsibility for the medical decision-making, the physician will utilize the facility's Interdisciplinary Team and/or the Hospital Bioethics committee to provide consultation for healthcare decision-making.

    c. The resident will be given the opportunity to participate in his/her health care decisions and intensity of care electives to the extent possible.

4. The Social Worker or designee will assist the resident or surrogate decision-maker in the following:

   a. Ensuring that a copy of the advanced directive is obtained and the Interdisciplinary Team is informed of the resident's wishes.

   b. Completing the facility's Physicians Orders for Life-Sustaining Treatment (POLST) form, which documents the intensity of care elected while residing in the unit.

   c. Informing nursing staff of treatment preferences elected by the resident or surrogate, obtaining nursing assistance as needed to provide additional clinical information and counsel regarding treatment options, and seeking nursing follow-up with physician to obtain consultation and orders for the intensity of treatments to be provided.

   d. Ensuring physician discussion of the diagnosis, prognosis, and treatment options with the resident or surrogate decision-maker, and completion of the Physicians Orders for Life-Sustaining Treatment (POLST) Form.

   e. Assisting in the establishment of surrogate decision maker.

   f. Assisting in the resolution of disagreements between the resident, surrogate and/or physician regarding intensity of treatment decisions, including advisement and/or assisting referrals to Bio Ethics Committee, public guardian, Ombudsman, legal services, advocacy groups, change of physician, and change of facility.

5. The physician and IDT will periodically do the following with the resident or surrogate decision-maker:

   a. Inform of any changes in medical condition and prognosis.

   b. Assist in determining any changes in treatment options or level of care provided.

   c. Assist in determining the resident's ongoing capacity to make informed decisions about intensity of medical treatments.

   d. Ensure the designation of a decision-maker.

   e. Ensure that decisions made on behalf of the resident are in his/her best interest or well-being.

   f. Review and revise the advance directive and intensity of care preferences as requested for change of condition or annually at Interdisciplinary Team Meeting.

   g. Review and update all care plans.

6. The Social Worker or designee and nursing staff will monitor to ensure the Intensity of Care Form is completed correctly by the physician and the treatment electives are consistently documented by relevant disciplines throughout the resident's medical record (i.e., Physicians Orders for Life-Sustaining Treatment (POLST) form, orders, Minimum Data Set, care plan, Interdisciplinary Team Meeting form and notes, etc.).

7. Nursing staff will ensure the resident's code status is clearly delineated in the medical record and will readily identify residents who are "NO CODE/Do Not Resuscitate" status on charts.

8. The physician and nursing staff will also notify the Social Worker or designee when there is a change in the resident's intensity of care preferences in order for the Social Worker or designee to ensure that a new Physicians Orders for Life-Sustaining Treatment (POLST) Form is completed which reflects the changes.

9. When the resident is transferred or discharged from the unit, nursing staff will ensure that the resident's advance directive and/or intensity of care preferences are forwarded to the receiving facility.

REFERENCES:

- California Code of Regulations (2019). Title 22, 483.10 (8), §72528. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

CROSS REFERENCES:

- Physicians Orders for Life-Sustaining Treatment Form (POLST)
- SVMC Policy and Procedure: RESIDENT SELF-DETERMINATION IN MEDICAL DECISION MAKING (PSDA)
- SVMC Policy and Procedure: SURROGATE DECISION MAKER, SELECTION OF

SUBJECT: **PRESSURE ULCER PREVENTION PLAN DPSNF**	SECTION: **Page 1 of 9**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define the facility's Pressure Injury Prevention and Wound Care Program. Sierra View Medical Center Distinct Part/ Skilled Nursing Facility (DP/SNF) will provide care, treatment, and services to promote the prevention of wound development including pressure injury development and to promote the healing wounds including pressure injuries.

This Pressure Injury Prevention Plan will include:

1. The process of identifying residents at risk for pressure injury development.
2. To identify residents at risk for developing pressure injuries who would benefit from preventative interventions and the specific factors placing them at risk.
3. To maintain and improve tissue tolerance to pressure in order to prevent injury.
4. To protect against the adverse effects of pressure, friction, shear and moisture.
5. To reduce the incidence of pressure injuries.
6. To effectively treat existing pressure injuries through the use of a comprehensive and research-based pressure injury management program.
7. To provide staff guidelines for documenting, assessing, and preventing pressure injuries.
8. To provide general procedures for skin care, pressure injuries, and wound management.

POLICY:

It is the policy of Sierra View Medical Center DP/SNF that all residents admitted to the unit shall receive a complete head-to-toe assessment, at which time a thorough examination of the skin will be done. The following steps will be taken:

1. The "Braden Scale" will be utilized for predicting skin breakdown/pressure ulcer risk and will be used to evaluate all residents for risk of skin breakdown. This will be performed on admit, weekly thereafter for four weeks, and quarterly by the MDS nurse. If the resident is identified at risk for skin breakdown with a Braden score of 18 or below, implement the pressure injury prevention plan.
2. Consult the Wound Care Specialist as indicated.
3. Complete nutritional screening by RN/LVN with appropriate referral if indicated.
4. Complete a nutritional assessment by Registered Dietitian so that the nutritional needs of the patient are met.

5. Implementing individualized, comprehensive plan of care (interventions) to attempt to stabilize, reduce, or remove underlying risk factors.

6. Maintaining and improving tissue tolerance to pressure, in order to prevent injury.

7. Protecting against the adverse effects of external mechanical forces.

8. Monitoring the effectiveness of interventions.

9. Modifying the interventions as appropriate.

10. Education will be provided to the patients and their families.

11. Staff will be provided with educational in-services regarding the prevention and treatment of pressure ulcers.

12. The assessment of care and treatment needs of the resident will be ongoing throughout the stay.

AFFECTED PERSONNEL/AREAS:

RN, LVN, CNA

DEFINITION:

1. The National Pressure Injury Advisory Panel (NPIAP) defines a pressure ulcer as, "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue."

2. Pressure injuries can occur whenever pressure has impaired circulation to tissue. Pressure injuries develop when soft tissues are compressed between a bony prominence and the surface of an object, i.e. mattress, seat of a chair, catheter compressed between patient's thighs.

3. Pressure injuries are usually located over a bony prominence, such as a sacrum, heel, the greater trochanter, fibular head, scapula, and ankle.

4. Pressure injuries and non-pressure related wounds are described as:

   Stage I:

   a. **Non-blanchable erythema of intact skin.** Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may

indicate deep tissue pressure injury. These indicators will be evident after the pressure on the area has been removed for 30-45 minutes.

b. Dark pigmented skin may not have visible blanching; the color may be different from the surrounding area.

c. The area may be firm, soft, painful, warmer or cooler than the adjacent tissue.

Stage II or partial thickness skin loss:

a. **Partial-thickness skin loss with exposed dermis**. Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel.

b. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

Stage III or full thickness skin loss:

a. **Full-thickness skin loss**. Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epiboly (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Stage IV or full thickness skin loss with exposed structures:

a. **Full-thickness skin and tissue loss**. Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury

Deep Tissue Injury:

a. **Persistent non-blanchable deep red, maroon or purple discoloration**. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister.

Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss.

b. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

c. Deep tissue injury may be difficult to detect in patients with dark skin tones. Evolution of the injury may include a thin blister over a dark wound bed. The wound may evolve further and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

Un-stageable:

a. **Obscured full-thickness skin and tissue loss.** Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar.

b. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed.

c. Stable eschar (i.e. dry, adherent, and intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

Additional Pressure Injury Definitions: **This describes an etiology.**

a. **Medical device related pressure injuries** result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.

b. **Mucosal Membrane Pressure Injury**: Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these ulcers cannot be staged.

PROCEDURE:

1. Assessments: All bony prominences of at-risk residents will be assessed once a day (i.e. occiput, sacrum, heels, ischial tuberosity's, coccyx, and trochanter).

2. Changes in skin condition: Staff will remain alert to potential changes in resident's skin condition and will evaluate and document identified changes. Changes in the resident's skin condition will be reported to the attending physician when applicable.

3. Nutritional screening: Shall be done by the RN/LVN on every admission. Residents with pressure ulcers will need a referral to the dietitian.

4. Nutritional assessment: Shall be completed by a Registered Dietitian and may include, among other recommendations, an estimation of calorie, protein and fluid needs, the need for supplementation with vitamin/minerals, and/or the need for oral, enteral or parenteral feeding.

5. Interventions will be incorporated into the resident's plan of care, evaluated and revised as the condition of the resident indicates.

6. Prevention: Prevention of pressure injuries is primarily a nursing responsibility. The most effective means of preventing skin breakdown are relief of pressure on the skin, maintenance of adequate circulation, hydration and an adequate diet.

    a. Staff will continue preventative measures when a resident has a pressure injury to prevent the development of additional pressure injuries.

    b. Residents who are dependent on the staff for repositioning will need to be repositioned every 2 hours and as needed, depending on the resident's condition. Turning will be documented on the CNA flow sheet. CAUTION: Do not drag the resident across the sheets as this reduces shear forces.

7. Preventative interventions for all residents at risk:

    a. Use of pressure reduction surfaces, wheelchair/Geri-chair cushions, zero pressure boots or pillows (to off load heels) when appropriate. **Do not use donut type devices.**

    b. Place a pillow(s) under the resident's lower leg(s), suspending the heel(s), to decrease the pressure placed on the resident's heels.

    c. Apply skin protectant cream to the resident's dry skin after each bath to decrease friction. Apply protectant/barrier cream to the buttocks, perineal area of incontinent resident's skin to prevent incontinent associated dermatitis. Do not massage vigorously over bony prominences.

    d. Try to prevent moisture, diarrhea, urinary incontinence and sweating from accumulating because this may cause skin maceration and eventual breakdown

    e. Keep linen wrinkle-free to prevent uneven pressure redistribution. Limit the number of layers between the resident and the bed to a sheet, draw sheet, and pad

f. Observe the resident for reddened or blanched areas, especially at rims of ears and bony prominences that suggest decreased circulation. If any redness is detected, remove the causative factor(s).

8. **Management of Pressure Injury/Partial thickness/full thickness wounds**: Pressure Injury's/other wounds present at the time of admission or developed after admission will be identified. It is important to be aware of factors that lead to the development of a Pressure injury/other types of wounds so that appropriate interventions can be initiated.

a. Nursing staff will take pictures and measure pressure injuries:

- On admission if present or as discovered after admission.
- Every week thereafter, until healed, on a designated day.
- PRN changes (i.e. surgical debridement).
- When healed, transferred to a higher level of care or discharged.

b. The weekly wound trending record will be completed weekly by the RN/LVN on admission if present or as discovered after admission and every week thereafter, until healed. The trending record should be updated when changes are noted such as following a surgical debridement, when the injury is healed, or when the patient is transferred to a higher level of care or discharged.

c. The wound trending form will contain the following elements:

- Date
- Location of ulcer and stage, if applicable
- Length, Width and Depth in centimeters
- Presence, location and extent of undermining or tunneling/sinus tract
- Presence of drainage/odor
- Color content of wound bed
- Pain

d. When to call the physician: The physician should be notified when a change in the skin condition or pressure injury requires a change in treatment.

e. When to call the Wound Specialist: The Wound Specialist is available for assistance Monday through Friday, 0800 – 1630.

f. Nursing staff will assess, reassess and document the injury's characteristics and observe for infection. This includes, but is not limited to:

- Signs/symptoms of infection
- Purulent exudates
- Peri-wound warmth
- Swelling
- Induration
- Erythema
- Increased pain or tenderness around the site
- Delayed wound healing

g. Follow physician's orders for treatment of the pressure injury, including cleansing and dressing.

h. Avoid positioning residents on a pressure injury.

i. Daily monitoring of Pressure Injury includes:

- Evaluating the injury even when no dressing is present.
- Evaluate the dressing if present; dressing intact, drainage present
- Evaluate the area surrounding the pressure injury.
- Observe the wound for signs of increasing ulceration, soft tissue infection around the wound, or drainage.
- Pain assessment and management.
- Notify the Wound Specialist and/or physician if pressure injury is not healing.

8. Plan of Care: Based upon the assessment and resident's clinical condition and identified needs, the resident's plan of care will include interventions to:

a. Redistribute pressure.

b. Minimize the resident's skin exposure to moisture

c. Keep the skin clean.

d. Provide appropriate pressure redistribution support surface if indicated (i.e. Stage III or IV on the trunk).

e. Maintain or improve nutrition and hydration status if feasible.

DEVICES:

A. **Pressure Redistribution Mattress**: Identify the need for a pressure redistribution mattress per following guidelines:

1. Stage III or IV on the trunk

2. Stage III or IV must be greater than 2 x 2cm on the trunk, or there must be multiple stage III or IV sites on different turning surfaces.

3. CBC, Total Protein and Albumin or Prealbumin monthly until wound(s) is healed.

4. Dietitian involvement monthly.

5. Wound healing supplements per dietitian.

B. **Mechanical loading, Support Surfaces and Repositioning devices.**

1. Place the resident in a 30-degree lateral position to decrease pressure on the trochanter.

2. The head of the bed is not to be elevated more than 30-degrees unless the resident's medical condition warrants it.

3. Elevating the head of the bed or back of a reclining chair to greater than or equal to 30-degrees creates pressures comparable to that exerted while sitting.

DOCUMENTATION:

1. Document Braden scale on admit and weekly for 4 weeks, then every quarter thereafter.

2. Document nutritional screening on admission and implement a referral as necessary.

3. Document interventions used to prevent the development of pressure injury on the plan of care.

1. Record nutrition and fluid intake.

2. Document wound assessment in PCS upon admission, on designated day weekly and PRN when applicable.

3. Document wound dressing changes as ordered in PCS, if applicable.

REFERENCES:

- Prevention and Treatment of Pressure Ulcers/Injuries: Quick Reference Guide. (2019). Emily Hasler [Ed.] EPUAP/NPIA/PPPIA.
- Wound, Ostomy and Continence Nurse Society. (2018). *Advancing the practice and guiding the delivery of expert health care to patients.* Retrieved from https://www.wocn.org/
- Quick Safety 25: Preventing pressure injuries, The Joint Commission, Updated March 2022, retrieved from https://www.jointcommission.org
- Advances in Skin and Wound Care, Lippincott, Oct 2020, Preventing Pressure Injuries in Nursing Home Residents, 33(10):p 533-539, retrieved from https://journals.lww.com

SUBJECT: **PROCEDURE FOR MOUTH CARE OF THE TUBE FED RESIDENT**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

The purpose is to prevent dryness of mouth and lips, and also increase resident comfort and dignity.

POLICY:

Mouth care will be given every shift and PRN to the tube fed resident.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSE (RN), LICENSED VOCATIONAL NURSE (LVN), CERTIFIED NURSING ASSISTANT (CNA)*

EQUIPMENT:

- Water
- Emesis basin
- Towel or linen saver pad
- Toothbrush and toothpaste
- Disposable gloves
- Mouthwash
- Toothettes swab or lemon-glycerin swab
- Water soluble lubricant

Edentulous resident:

- Denture cup
- Denture cleaner
- Denture brush

Comatose or debilitated resident:

- Cotton tipped swabs
- Evacu-toothbrush or oral suction handle
- Gauze sponges

SUBJECT: **PROCEDURE FOR MOUTH CARE OF THE TUBE FED RESIDENT**	SECTION: **Page 2 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PROCEDURE:

1. Assemble equipment pertinent to individual resident needs.
2. Provide privacy.
3. Wash hands thoroughly, put on gloves.
4. Elevate head of bed (semi-Fowlers position).
5. Drape towel or pad under resident's chin.
6. Gently brush resident's teeth and gums with small amount of toothpaste or diluted mouthwash and toothbrush.
7. For the edentulous resident, cotton tipped applicators, 2x2 gauze sponges, or toothettes dipped in half mouthwash and water may be used to clean the mouth.
8. Hold emesis basis under the resident's chin.
9. Rinse and swab mouth (including tongue, palate and gums with toothettes dipped in warm water).
10. Observe the residents mouth for cleanliness, tooth and tissue condition.
11. For the comatose resident, oral suctioning may be required for excess fluid in the mouth.
12. Apply water soluble lubricant to the resident's lips.
13. Dentures should be soaked in warm water with a denture cleanser, then brushed with a denture brush and rinsed.

RECORDING:

1. Mouth care is recorded on the activities of daily living (ADL) section in the EMR.
2. Record any unusual conditions such as bleeding, edema, mouth odor, excessive secretions or encrusted membranes on the nurses' notes in the EMR. Record interventions.

REFERENCES:

- O'Brian, Sara MS, RDN, Dietitians on Demand, Oct 2020, Making Oral Health a Priority for NPO Patients, retrieved from: https://dietitiansondemand.com
- Shepherd Center (2020). *Tube Feeding Guide*: *About Tube Feeding*. Shepherd Center. https://www.myshepherdconnection.org/tube-feeding-guide.

SUBJECT:	SECTION:
PROVISION OF 24 HOUR NURSING ACCESSIBILITY GUIDELINES	***DP/SNF STAFFING REQUIREMENTS*** **Page 1 of 4**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To ensure that quality medical care is being provided to the Residents through the accessibility of nurses 24 hours a day.

POLICY:

The facility will provide 24 hour nursing care for residents, per Centers for Medicare and Medicaid Services (CMS), California Department of Public Health (CDPH) requirements for the sub-acute program and the criteria as described in facility nursing standards.

AFFECTED PERSONNEL/AREAS:

CLINICAL DIRECTOR, MANAGER, REGISTERED NURSE (RN), LICENSED VOCATIONAL NURSE (LVN), CERTIFIED NURSING ASSISTANT (CNA), RESTORATIVE NURSING ASSISTANT (RNA), UNIT CLERK

PROCEDURE:

The facility will utilize the following staffing and skill mix for the sub-acute unit.

Skill Mix

- Clinical Nurse, Director/Manager, Registered Nurses, Licensed Vocational Nurses, Certified Nursing Assistants, Staff Developer and MDS Coordinator, Activity Director, Social Worker Designee, Unit Clerk and Restorative Nursing Assistant.

Augmentation to Core Staffing

- Core Staffing may be augmented as census increases.

DISTINCT PART SUBACUTE STAFFING REQUIREMENTS PER DEPARTMENT OF HEALTH CARE SERVICES

The Monthly Sub Acute Staffing Report must be completed and submitted to the Department of Health Care Services **by the 16th of the month**, for the previous month.

Daily Minimum Requirements:

- RN and LVN Daily Minimum Requirement hours per patient day for Distinct Part Adult Subacute Unit (Staffing Factor) is 4.0

- CNA Daily Minimum Requirement hours per patient day for Distinct Part Adult Subacute Unit (Staffing Factor) is 2.0

Additional Requirements:

- Each subacute unit ***must*** have a minimum of one RN assigned to the subacute unit per shift.
- Nursing staff assigned to the sub-acute unit shall ***not*** be assigned other duties outside the sub-acute unit during any given shift.

Cautionary notes:

- The required hours are to be met on a daily basis. Therefore, "excess" RN/LVN and CNA hours cannot be carried over to the next day. These hours ***cannot*** be averaged over a week or month.
- CNA hours ***cannot*** be used to supplement RN/LVN hours.

Included/Excluded Staffing Hours:

The following information identifies subacute staffing hours that will either be included or excluded from the ***Monthly Subacute Staffing Report*** for the adult subacute program.

Action	Who
Include staffing hours for:	-RNs, LVNs who provide actual subacute patient care -CNAs who provide actual subacute care -Director of Nurses, Nurse Supervisors, Clinical Directors when providing actual subacute patient care. -Registry Nurses who provide actual subacute patient care -Minimum Data Set (MDS) Nurses – who perform assessments for subacute patients (*not including data entry functions*) -Wound care and follow-up wound care
Exclude staffing hours for:	-Director of Nurses, Nurse Supervisors, Clinical Directors when ***not*** providing actual subacute patient care -Director of Staff Development (DSD) Nurses when performing the duties of this position as specified in California Code of Regulations, Title 22, Section 71829 -Respiratory Therapists (RTs) -Special duty nurses or nurse assistants who are privately funded -RNs, LVNs, and CNAs who are in training or on meal breaks -Staff time spent in non-nursing functions such as administration, maintenance of health records, laundry, kitchen, etc. -Staff time spent on patient care outside of the subacute unit -RNs, LVNs and CNAs on vacation/sick leave -Activity Directors

	-Technicians or other therapists -Qualified Mental Retardation Professionals (QMRP)

Information Needed Prior to Completing the *Monthly Subacute Staffing* Report Information to collect: Follow the table below prior to completing the ***Monthly Subacute Staffing*** Report form.

Who	What	Source
Staff Person assigned to complete the Monthly Subacute Staffing Report	Staff hours	Applicable information needed to substantiate actual daily subacute staff hours for each RN, LVN and CNA for the entire month can be taken from documentation such as: Daily staffing schedules/assignment sheets Daily sign-in sheets MDS nurse documentation substantiating time spent on subacute patients Nurse Registry sign-in sheets Payroll registers Punch detail printouts Time cards (hand-written or electronically stamped) ***Note***: If discrepancies are identified, compare documents, reconcile, and verify information for accuracy.
	Patient census	A list of <u>all</u> patients who receive daily care from designated subacute staff for the entire month. **Note**: Exclude subacute patients on "**bed-hold**" status from the daily patient census.

REFERENCES:

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.30, United States of America, Med Pass Inc.

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §71829, §72082, §72319, San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I

SUBJECT: **PROVISION OF 24 HOUR NURSING ACCESSIBILITY GUIDELINES**	SECTION: ***DP/SNF STAFFING REQUIREMENTS*** **Page 4 of 4**

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SUBJECT:	SECTION:
PYXIS MEDICATION OVERRIDES AND DISCREPANCY	***Medication Management (MM)*** **Page 1 of 9**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define the use of the override function in the PYXIS automated dispensing cabinets and identify the best practices associated with its use.

POLICY:

Medications available via the override function shall be limited to those drugs which may result in patient harm due to a delay in administration. The override list shall be reviewed and approved annually by the Pharmacy and Therapeutics Committee.

AFFECTED AREAS/PERSONNEL: *PHARMACY; NURSING*

PROCEDURES:

A. The override groups will include the following categories:

1. **Basic**- Includes controlled substances, over the counter (OTC) medications, respiratory medications.
2. **Emergent-** Includes the Basic group, plus those medications that require special training beyond the scope of the floor nurse to administer.
3. **Nursing House Supervisors**- Access to all medications house wide.
4. **OB Group**- Obstetric and Gynecological-related medications.
5. **RT Group**- Only access to respiratory medications.

B. Pharmacist Review of Override Medications

1. All medications removed via the override function shall be reviewed by the pharmacist the following day. Such review shall include:
   a. Verifying that there was a physician order for the over-ridden medication.
   b. Verifying that the nurse did not remove the medication on override after the order had been entered by a pharmacist.
   c. Verifying that the nurse did not override a medication using one route of administration, while the order was actually for another route.
   d. Verifying that the medication was not withdrawn on override after it had been discontinued or had expired.

e. Verifying proper dose, allergy status, and that interactions with other medications have not occurred.

2. Problems or issues with inappropriate use of the override function shall be documented in the hospital's medication event database and sent to the Nurse Managers for investigation, review and action.

3. Unresolved discrepancies shall be investigated by the Nurse Manager and the Pharmacy Manager, as appropriate, and reported via the hospital medication event database and notification of the Chief Nursing Officer, as warranted.

4. For unresolved discrepancies involving controlled substances, refer to the procedures outlined in the Controlled Substances Procurement, Administration and Documentation policy.

Override Group Name	Generic Name	Trade Name
Basics	ACETAMINOPHEN	Tylenol Supp
Basics	ACETAMINOPHEN	Tylenol
Basics	ACETAMINOPHEN	Tylenol Soln
Basics	ACETAMINOPHEN	Tylenol Supp
Basics	ACETAMINOPHEN	Tylenol Es
Basics	ACETAMINOPHEN DROPS	Tylenol Drops
Basics	ACETAMINOPHEN INJ	Ofirmev Inj
Basics	ACETAMINOPHEN W/COD 300-30	Tylenol W/Cod #3
Basics	ACETAMINOPHEN W/COD ELIX	Tylenol w/Cod Elix
Basic	Activated Charcoal	Actidose
Basics	ANAPHYLAXIS KIT	Anaphylaxis Kit
Basics	ATROPINE SULF INJ	Atropine Inj
Basics	CALCIUM CHLORIDE 10% INJ	Calcium Chloride 10% Abboject
Basics	DEXAMETHASONE SOD PHOS INJ	Decadron Inj
Basics	Dextrose 25%-water inj	D25w inj abboject

Basics	DEXTROSE 50%-WATER INJ	D50w Inj Abbojject
Basics	DIAZEPAM	Valium Inj
Basics	DIGOXIN ELIX	Lanoxin Elix
Basics	DiphenhydrAMINE INJ	Benadryl Inj
Basics	EPINEPHRINE INJ	Epinephrine Inj
Basics	ETOMIDATE INJ	Amidate Inj
Basics	FENTANYL CIT INJ	Sublimaze Inj
Basics	FENTANYL PCA	Sublimaze PCA
Basics	FLUMAZENIL INJ	Romazicon Inj
Basics	FOSPHENYTOIN SOD INJ	Cerebyx Inj
Basics	FUROSEMIDE INJ	Lasix Inj
Basics	GUAIFENESIN SYRUP	Robitussin Syrup
Basics	GUAIFENESIN/CODEINE PHOSPHATE	Robitussin Ac Syrup
Basics	HALOPERIDOL LACT INJ	Haldol Inj
Basics	HEPARIN in D5W	Heparin in D5w Ivpb
Basics	HEPARIN SOD INJ	Heparin Inj
Basics	HydrALAzine INJ	Apresoline Inj
Basics	HYDROCOD BIT/APAP ELIX 10/300	LORTAB ELIX (10/300)
Basics	HYDROCORTISONE SOD SUCC INJ	Solu-Cortef Inj
Basics	HYDROMORPHONE HCL	Dilaudid Inj
Basics	HYDROMORPHONE-HP INJ	Dilaudid Pca
Basics	INSULIN 75/25 NPL/LISP	HUMALOG 75/25 INSULIN
Basics	INSULIN ASPART	NovoLOG INSULIN
Basics	INSULIN GLARGINE INJ	Lantus Inj
Basics	INSULIN HUMAN REGULAR PER UNIT	Novolin-R U-100 (Billed Per Un
Basics	INSULIN LISPRO	HUMALOG INSULIN
Basics	KETOROLAC INJ	Toradol Inj

Basics	LIDOCAINE HCL 2% - MPF	Xylocaine 2% - MPF Inj
Basics	LIDOCAINE INJ 2%	Xylocaine Inj 2% Abboject
Basics	LIDOCAINE PF 1%	Xylocaine-Mpf Inj 1%
Basics	LORAZEPAM	Ativan Inj
Basics	MAGNESIUM SULF	Magnesium Sulf
Basics	MAGNESIUM SULFATE IVPB	MAGNESIUM IVPB
Basics	MEPERIDINE INJ	Demerol Inj
Basics	MethylPREDNISolone SOD SUC-CL	Solu-Medrol Inj
Basics	METOCLOPRAMIDE INJ	Reglan Inj
Basics	MG HYD/AL HYD/SIM ES SUSP	Maalox Es Susp
Basics	MIDAZOLAM INJ	Versed Inj
Basics	MORPHINE SULF INJ	Morphine Sulfate Inj
Basics	MORPHINE SULF LIQD	Morphine Sulf Liqd
Basics	MORPHINE SULF PCA	Morphine Sulf Pca
Basics	NALOXONE INJ	Narcan Inj
Basics	NIFEdipine	Procardia
Basics	NITROGLYCERIN	Nitrostat 1/150
Basics	NITROGLYCERIN INJ	Nitroglycerin Inj.
Basics	NITROGLYCERIN OINT 2%	Nitro-paste Oint 2%
Basics	ONDANSETRON INJ	Zofran Inj
Basics	PHENOBARBITAL INJ	Phenobarbital Inj
Basics	PROMETHAZINE INJ	Phenergan Inj
Basics	SOD POLYSTYRENE SULFON SUSP	Kayexalate Susp
Basics	Sodium Bicarb inj 4.2%	Sodium Bicarb inj 4.2%
Basics	SODIUM BICARB INJ 8.4%	Sodium Bicarbonate Inj 8.4%

Basics	SODIUM CHLOR, BACTERIOSTATIC	NaCl Bacterostatic Inj
Basics	STERILE WATER	Sterile Water
Basics	THIAMINE INJ	Vitamin B-1 Inj
Basics	TICAGRELOR	Brilinta
Basics	WATER FOR IRRIGATION,STERILE	Sterile Water Irrig
Emergent	ACETYLCYSTEINE RT SOL 10%	Mucomyst Rt Sol 10%
Emergent	ACETYLCYSTEINE RT SOL 20%	Mucomyst Rt Sol 20%
Emergent	ADENOSINE INJ	Adenocard Inj
Emergent	ALBUMIN HUMAN 25%	Albuminar-25 Ivpb
Emergent	Alprostadil inj	Prostin vr Inj
Emergent	Alteplase 100mg Vial	Activase
Emergent	AMIODARONE HCL/DEXTROSE	Nexterone IVPB
Emergent	AMIODARONE INJ	Cordarone Inj
Emergent	ANTIVENIN, CROTALIDAE	Crofab Inj
Emergent	ANTIVENIN, CROTALIDAE (EQUINE)	Anavip Inj
Emergent	ASPIRIN	Aspirin Chew
Emergent	ASPIRIN EC	Ecotrin
Emergent	BENZOCAINE Spray 20% (Topex)	Topex Spray
Emergent	BUMETANIDE INJ	Bumex Inj
Emergent	Caffeine Citrate inj	Caffeine cit inj
Emergent	CLOPIDOGREL	CLOPIDOGREL
Emergent	COCAINE HCL TOP SOL 4%	Cocaine Topical 4%
Emergent	Desmopressin acetate inj	DDVAP inj
Emergent	DEXMEDETOMIDINE/D5W 400MCG IV	PRECEDEX 400MCG/100ML
Emergent	DEXTROSE 5%-WATER (AVIVA)	D5w (Aviva)

Emergent	Digoxin immune FAB	Digifab
Emergent	DILTIAZEM INJ	Cardizem Inj
Emergent	DOBUTamine INJ	Dobutrex Inj
Emergent	DOPamine in D5W IVPB	Intropin in D5w Ivpb
Emergent	DOPamine INJ	Intropin Inj
Emergent	ENALAPRILAT INJ	Vasotec Inj
Emergent	ENOXAPARIN SOD INJ	Lovenox Inj
Emergent	EPTIFIBATIDE INJ	Integrilin Inj
Emergent	EPTIFIBATIDE IVPB	Integrilin Ivpb
Emergent	ESMOLOL INJ	Brevibloc Inj
Emergent	ESOMEPRAZOLE INJ (NON-FORM)	Nexium Inj
Emergent	FAT EMULSIONS 20% IV	Liposyn II 20% Iv
Emergent	FENTANYL in NS (Premix)	Sublimaze in NS Premix
Emergent	FLUORESCEIN/PROPARACAINE OPTH	Flucaine Op Sol
Emergent	Glucagon Inj	Glucagen
Emergent	GLYCOPYRROLATE INJ	Robinul Inj
Emergent	INSULIN REG 100 UNITS / 100 ML	Myxredlin premixed
Emergent	KETAMINE HCL INJ	Ketamine Inj
Emergent	KETAMINE HCL INJ SYRINGE	Ketamine HCl Inj Syringe
Emergent	LABETALOL INJ	Trandate Inj
Emergent	LACOSAMIDE	Vimpat
Emergent	Levetiracetam inj	Keppra inj
Emergent	LIDOCAINE in D5W IVPB	Xylocaine in D5w Ivpb
Emergent	MAGNESIUM SULF INJ 50%	Magnesium Sulfate 50% Inj
Emergent	MANNITOL INJ 20%	Mannitol Inj 20%
Emergent	METOPROLOL TARTRATE INJ	Lopressor Inj
Emergent	MIDAZOLAM in NS (Premix)	Versed in NS Premix

Emergent	MIDAZOLAM SYRUP	Versed Syrup
Emergent	Midodrine tab	Proamatine
Emergent	Nalbuphine inj	Nubain inj
Emergent	NITROGLYCERIN in D5W	Nitroglycerin in D5w Ivpb
Emergent	NITROPRUSSIDE SOD INJ	Nitropress Inj
Emergent	NOREPINEPHRINE IN D5W INJ	Levophed in D5W Inj
Emergent	NOREPINEPHRINE IN NS	Levophed in NS
Emergent	OCTREOTIDE ACET INJ	SandoSTATIN Inj
Emergent	Olanzapine inj	Zyprexa inj
Emergent	PANTOPRAZOLE INJ	Protonix Inj
Emergent	PHENOBARBITAL ELIX	Phenobarbital Elix
Emergent	Phentolamine inj	Regitine inj
Emergent	PHENYLEPHRINE INJ	Neo-synephrine Inj
Emergent	Phenytoin Inj	Dilantin inj
Emergent	Protamine inj	Protamine inj
Emergent	Phytonadione inj	Vitamin k inj
Emergent	Pyridostigmine inj	Regonol inj
Emergent	POTASSIUM CHLOR IVPB	Kcl Ivpb
Emergent	POTASSIUM PHOSPHATE IVPB	Potassium Phosphate IVPB
Emergent	PROCAINAMIDE 100MG/ML 10ML	PROCAINAMIDE 100MG/ML 10ML
Emergent	Propanolol inj	Inderal Inj
Emergent	PROPOFOL INJ	Diprivan Inj
Emergent	PROPOFOL INJ	Diprivan Ivpb
Emergent	PROTHROMBIN CMPLX CONC (HUMAN)	Kcentra Kit - 1000 units/kit
Emergent	Rabies Immune Globulin inj	Kedrab inj

Emergent	RIVAROXABAN	Xarelto
Emergent	ROCURONIUM INJ	Zemuron Inj
Emergent	SODIUM BICARB INJ 8.4%	Sodium Bicarbonate Inj 8.4%
Emergent	SODIUM BICARBONATE 4.2%	Sodium Bicarbonate 4.2%
Emergent	SUCCINYLCHOLINE INJ	Anectine Inj
Emergent	TENECTEPLASE INJ	Tnkase Inj
Emergent	Terbutaline Inj	Brethine inj
Emergent	TRANEXAMIC ACID INJ	Tranexamic Acid
Emergent	TRANEXAMIC ACID IVPB	Tranexamic Acid IVPB
Emergent	VASOPRESSIN INJ	Pitressin Inj
Emergent	Valproic Acid inj/syrup	Depakene inj/syr
Emergent	VECURONIUM INJ	Norcuron Inj
Emergent	VERAPAMIL INJ	Calan Inj
OB	AMPICILLIN INJ	Ampicillin Inj
OB	BETAMETHASONE (CELESTONE) INJ	Celestone Inj
OB	CARBOPROST TROMETH INJ	Hemabate Inj
OB	CEFAZOLIN in DEXTROSE	Ancef/Dextrose Ivpb
OB	CEFOXITIN SOD INJ	Mefoxin Inj
OB	CITRIC ACID/SODIUM CITR	Bicitra Soln
OB	CLINDAMYCIN PHOS INJ	Cleocin Inj
OB	CLINDAMYCIN PHOS/D5W	Cleocin/D5w Ivpb
OB	EPHEDRINE SULF INJ	Ephedrine Sulfate Inj
OB	FAMOTIDINE INJ	Pepcid Inj
OB	GENTAMICIN INJ	Gentamicin Inj Ped
OB	KETOROLAC INJ	Toradol Inj
OB	MAGNESIUM SULF IVPB	Magnesium Sulfate Ivpb
OB	METHYLERGONOVINE INJ	Methergine Inj
OB	MISOPROSTOL	Cytotec

OB	MORPHINE SULF PF INJ	Duramorph-Pf Inj
OB	MORPHINE SULFATE PF	Duramorph-PF Inj
OB	Oxytocin 20 Units in LR	Pitocin in LR
OB	Oxytocin 30 Units in LR	Pitocin in LR
OB	OXYTOCIN INJ	Pitocin Inj
OB	PHYTONADIONE	Vitamin K Inj
OB	PORACTANT ALFA INHALANT	Curosurf
OB	RANITIDINE HCL	Zantac Inj (Ped)
OB	RANITIDINE INJ	Zantac Inj
OB	TERBUTALINE SULF INJ	Brethine Inj
RT	ALBUTEROL RT	Proventil Rt Sol
RT	ALBUTEROL/IPRATROP RT 3ML NEBU	Duoneb RT 3ML NEBU
RT	EPINEPHRINE RT SOL 2.25%	RACEPINEPHRINE 2.25%
RT	LEVALBUTEROL RT	Xopenex Rt Sol
RT	SODIUM CHLORIDE 3% RT SOL	Sodium Chloride 3% RT Sol
RT	SODIUM CL RT SOL 0.9%	Normal Saline Rt Sol

REFERENCE:

Hospital Accreditation Standards. (2023). Oak Brook, IL: Joint Commission Resources, Inc.
MM.08.01.01, EP 16

SUBJECT: **RANGE OF MOTION**	SECTION: *Physical Therapy* **Page 1 of 8**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

- To maintain muscle strength and tone.
- To improve muscle strength and tone.
- To prevent progression of contractures.
- To maintain circulatory integrity of the limbs.
- To enhance the utilization of a body part in physical activity.
- To prevent complications and disability attendant upon other physical/emotional dysfunctions and adverse states of well-being.

POLICY:

All residents will receive active and/or passive range of motion once daily, 6 days a week if indicated by the physical therapists/doctors' orders.

DEFINITION:

- Range of Motion (ROM) – The extent to which a particular joint is capable of being moved.
- Active range of motion – The resident independently moves his/her joints, or actively assists with the movement of joints.
- Passive range of motion – The staff performs the movement of the resident's joints.

HIGH-RISK RESIDENTS:

- Unconscious
- Acutely ill
- Unable to move head or extremities
- In severe pain and remaining immobilized
- In cast, brace or other limiting devices
- Paralyzed or having nerve weakness
- Incorrectly positioned or supported

CONTRAINDICATIONS for treatment of residents with contractures:

- Imminent death
- Ankyloses- immobility of joint
- Cancer of bone
- Osteoporosis
- Congenital anomaly
- Joint inflammation

RANGE OF MOTION EXERCISES:

TYPES OF ROM:

- Passive: For parts of the body (i.e., limbs, trunk, digits) the person cannot move for himself /herself; ROM is done for and to the person.
- Active Assisted: When the person can perform a motion with the help of an assistant or a device.
- Active: For the person who can do the motion himself /herself.

NOTE: Physician order is not required for active or passive ROM.

BODY POSITION:

- Supine: Back lying
- Lateral: Side lying

JOINT POSITIONS: (Also known as body positions)

- Extension: Straightening a flexed or bent joint.
- Flexion: Bending a joint to form an acute angle.
- Adduction: Moving arm, leg or finger toward normal resting position (i.e., normal for the patient).
- Abduction: Moving arm, leg or finger away from normal positions

AFFECTED PERSONNEL/AREAS:

RN, LVN, RNA, CNA

PROCEDURE:

1. Physiotherapy is to be called for initial evaluation, if necessary. ROM is a nursing measure; therefore, it may be instituted without physiotherapy evaluation and/or physicians' order.

2. ROM is frequently used in collaboration with other nursing and rehabilitative interventions, e.g., strengthening, gait training, ambulation, etc.

3. ROM exercise does not take the place of position change and support for dependent parts.

4. Explain each step before you do ROM and as you are doing it.

5. Gentle but firm pressure is to be applied during ROM.

6. Do not bring the joint/limb motion to the point of pain.

7. Observe the resident who is unable to communicate for signs and symptoms of discomfort such as facial grimacing, increased sweating, or increased heart rate.

8. The joint area is left free. Limbs are supported and directed through the exercises. See Protocol.

9. Each joint is moved through its range 3 – 5 times per treatment.

REASONS FOR PLACEMENT OF CAREGIVERS HANDS & BODY AS OUTLINED BELOW:

- Trust and reassurance
- Support, safety, guidance
- Observation
- Balance, direction, control of movement

EXERCISE PROTOCOL:

Motions of the Body and Trunk

A. Flexion:

   1. Bending forward from the waist

   2. Standing in front or side of patient

   3. Place both hands on shoulder or one hand on shoulder and one hand on waist

B. Extension:

1. Straightening from the flexed position to the neutral position
2. Standing to the front or side of the patient, place hand on shoulder (one hand on shoulder) and one hand on waist

C. Lateral Flexion:

1. Bending sideways from the waist, to the right and to the left.
2. Standing to front or side of the patient, place one hand on shoulder, one hand on waist or across the patient's back.

D. Rotation:

1. Turning the shoulders, keeping the hips stationary.
2. Stand in front of the patient; place one hand on the patient's hip and one hand on the opposite shoulder. Bring the shoulder gently towards you.

Motions of the Shoulder

A. Flexion and Extension:

1. Place one hand below the patient's elbow; supporting the shoulder and elbow with one hand.
2. Hold the patient's shoulder with the other hand, while ranging.
3. Lift the patient's arm up from the side of the body.
4. Next, carry the arm slowly and gently toward the patient's head as far as you can go without causing pain.
5. If the headboard prevents your carrying the straight arm all the way back, bend the arm at the elbow.
6. Finally, carry the patient's arm back to the standing position.

B. Abduction and Adduction:

1. One hand supports the patient's shoulder joint.
2. Hold the patient's elbow with your other hand.

3. Next, keeping the patient's arm straight, move it away from the patient's body.

4. Then, return to normal position against the patient's body.

C. Internal and External Rotation:

1. Start by placing the patient's arm pointed away from the patient's body, elbow bent. Hold patient's hand with your other hand.

2. Hold patient's upper arm against mattress.

3. Then, lift patient's lower arm and hand.

4. Next, move patient's lower arm and hand slowly and gently back towards the patient's head, as far as you can go.

5. Return patient's arm to starting position.

D. Cross Adduction:

E. NOTE: Important joint function and range for the hemiplegics (post stroke) patient for turning in bed and dressing by self.

1. Start by placing one of your hands on the patient's shoulder.

2. Hold patient's elbow with your hand.

3. Lift patient's arm

4. Carry patient's arm across his/her chest.

5. Return arm to starting position.

F. Elevation and Depression:

G. Lifting the shoulders towards the ears (hunching) and returning to normal position. Right, then left and/or together.

<u>Motions of the Elbow:</u>

A. Flexion and Extension

Note: Important for self-feeding:

1. Place one hand on elbow, one hand supporting forearm and/or hand.

2. Bend elbow, bringing forearm and hand toward shoulder.

3. Return forearm and hand to starting position.

Motions of the Forearm:

A. Supination and pronation:

1. Start by holding the patient's hand with one of your hands.

2. Place the other hand on the patient's forearm.

3. Gently rotate the hand to the right and to the left.

Motions of the Wrists and Fingers:

A. Flexion and Extension:

1. Start by holding the patient's wrist with one hand; avoid heavy pressure which can occlude the arteries and veins.

2. Hold patient's fingers with your other hand.

3. Next, keeping patient's fingers straight, bend patient's hand backward.

4. Then, straighten the hand.

5. Now, bend patient's hand forward, closing patient's fingers to make a fist.

6. Then open patient's hand to starting position.

Motion of the Knee and Hip:

NOTE: Ideally, bed should be flat. Check with the nurse. This ROM can be effective with the head of the bed raised.

A. Flexion and Extension:

1. Place one hand under the patient's knee, upper calf.

2. Place other hand under the heel of the patient's foot.

3. Then, lift leg, bending it at the knee.

4. Move patient's leg slowly back towards the patient's head as far as it will go without hurting the patient. Next, straighten the patient's knee by lifting the foot upward. Lower the patient's leg, gently, to the starting position.

Motions of the Ankle, Foot and Toe

A. Ankle Dorsiflexion and Plantar flexion:

1. Start by holding the patient's heel with your hand, letting the sole of patient's foot rest against your arm; other hand over ankle/instep.
2. Then, press your arm against the bottom of the foot, moving it back toward the leg. At the same time, pull gently on the heel. (Note: Keep the knee straight).
3. Next, move your arm back to the starting position.
4. Move your hand which was over the ankle up the area just before the toes. Push down on patient's foot to point the toes. At the same time, push up against the heel.

B. Foot inversion and Eversion:

1. Place one hand across the ankle.
2. Grasp foot with other hand.
3. Start by turning the whole foot outward.
4. Then, turn the whole foot inward.
5. Return foot to starting position.

C. Toe Flexion and Extension:

1. Pull up on the toes (one hand on sole of foot).
2. Push down on the toes (one hand on heel).

IN-SERVICE EDUCATION:

- All nursing staff are instructed in the techniques of active and passive ROM, during orientation and ongoing (classroom and on the unit), all shifts.

DOCUMENTATION:

RNA Intervention in the EMR.

REFERENCES:

- Med Pass, Inc. (Updated February 6, 2015). Facility Guide to OBRA Regulations, 483.25 (e) (1), 483.25 (e) (2), United States of America, Med Pass Inc.

- California Code of Regulations (2021). Title 22. §72315. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT: **RENAL DOSAGE ADJUSTMENT PROTOCOL**	SECTION: ***Clinical Pharmacy Drug Protocols*** **Page 1 of 3**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To effectively promote rational, safe and effective drug use and to minimize or prevent adverse drug events by dose adjusting renally cleared medications in patients with decreased renal function using medical staff approved renal dosing protocols.

POLICY:

Renal Dose Adjustments (RDA) (consisting of reducing the dose of renally cleared drugs, according to the pharmaceutical manufacturer's published guidelines) are automatically adjusted by the pharmacist at the time of order processing using a medical staff approved protocol and policy.

AFFECTED AREAS/PERSONNEL: *MEDICAL STAFF; PHARMACY; NURSING*

PROCEDURE:

1. The Clinical Pharmacist will adjust the medications listed in this policy based upon the patient's renal function unless the prescriber writes on the order "No Dosage Adjustment."

2. For purposes of avoiding subtherapeutic serum levels in patients who may be septic, all renal dose adjustments for antibiotic therapy will be delayed for the first 24 hours. In the event that it is deemed to be a supratherapeutic dose that puts the patient at risk, the pharmacist will contact the physician. Any subtherapeutic dose will be adjusted by the Clinical Pharmacist with the recommendation from Lexicomp Online: Drug specific 'Dosing: Renal Impairment' section.

3. When the required information (i.e. SCr) is not available, the pharmacist may write the required lab order, or request nursing obtain the needed information (i.e. patient weight).

4. The Clinical Pharmacist will use the estimated Cockcroft-Gault creatinine clearance as provided on the laboratory reports in MEDITECH (EMR) to identify patients receiving medications that may require a dose adjustment based upon a patient's estimated renal function.

5. When the estimated creatinine clearance is not provided in MEDITECH, the pharmacist will use the Cockcroft and Gault formula for estimating renal function in adults not receiving dialysis.[1]

   a. Creatinine Clearance (mL/min MALE) = $\frac{(140 - \text{age}) \text{ IBW (kg)}}{\text{SCr (mg/dL)} \times 72}$

   b. Creatinine Clearance (mL/min FEMALE) = Creatinine Clearance (mL/min MALE) X 0.85

6. The Pharmacist will use their clinical judgement in combination with pharmacy resources such as Lexicomp to adjust the dose & utilize either Ideal body weight or adjusted body weight in their calculations based on clinical judgement and information from pharmacy resources. The notation "Renal Dose Adj" may be notated in the order to give notice to users why adjustment was made.

7. If the physician elects to change the dose adjusted by the pharmacist, no further adjustments will be made for that medication on that patient.

8. In cases where the Clinical Pharmacist has made renal dose adjustments and the patient's renal function has improved or declined during the course of the hospital stay, the Clinical Pharmacist shall have the authority to adjust the medication dose or frequency as indicated by the newly calculated CrCl and according to clinical judgement using resources such as Lexicomp for confirmation of new dose.

9. Dose adjustments shall be limited to no more than once every 24 hours.

10. The following medications may be subject to renal adjustment per protocol:

Acyclovir (Zovirax®)
Alendronate (Fosamax®)
Allopurinol (Zyloprim®)
Aminoglycosides – Gentamicin, Tobramycin, Amikacin
Amoxicillin/Clavulanate (Augmentin®)
Ampicillin (Principen®)
Ampicillin – Sulbactam (Unasyn®)
Aztreonam (Azactam®)
Cefazolin (Ancef®)
Cefepime (Maxipime®)
Ceftazidime (Fortaz®)
Ciprofloxacin (Cipro®)
Cotrimoxazole (Bactrim®, Septra®)
Daptomycin (Cubicin®)
Enoxaparin (Lovenox®)
Erythromycin
Famotidine (Pepcid®)
Fluconazole (Diflucan®)
Fonadaparinux (Arixtra®) – Non-Formulary
Gabapentin (Neurontin®)
HCTZ
Imipenem-Cilastatin (Primaxin®)
Ketorolac (Toradol®)
Levofloxacin (Levaquin®)
Meropenem (Merrem®)
Metformin (Glucophage®)
Metoclopramide (Reglan®)
Metronidazole (Flagyl®)
Nafcillin
Nitrofurantoin (Macrobid®)
Oseltamivir (Tamiflu®)
Penicillin G

Phenazopyridine (Pyridium®)
Piperacillin (Pipracil®)
Piperacillin-Tazobactam (Zosyn®)
Ranitidine
Rosuvastatin (Crestor®)
Spironolactone (Aldactone®)
Voriconazole (Vfend®)

11. For other medications not included in the list above requiring renal dose adjustments, the Clinical Pharmacist shall notify the physician of the recommended change and it will be the physician's option to make the change.

REFERENCES:

- Lexicomp Online
- Cockcroft DW and Gault MH. *Prediction of Creatinine Clearance from Serum Creatinine*. Nephron 1976; 16(1):31-41.
- Demirovic JA, Pai AB, Pai MP. *Estimation of creatinine clearance in morbidly obese patients*. Am J Health-Syst Pharm 2009 Apr 1; 66(7): 642-648.
- Trotman RL, Williamson JC, Shoemaker DM, and Salzer WL. *Antibiotic Dosing in Critically Ill Adult Patients Receiving Continuous Renal Replacement Therapy*. Clin Infect Dis 2005 Oct 15; 41(8):1159-66.
- Heintz BH, Matzke GR, Dager WE. *Antimicrobial Dosing Concepts and Recommendations for Critically Ill Adult Patients Receiving Continuous Renal Replacement Therapy or Intermittent Hemodialysis*. Pharmacotherapy 2009 May; 29(5):562-577.
- Aronoff, GR, Bennett WM, Berns JS, et al. *Drug Prescribing in Renal Failure: Dosing Guidelines for Adults and Children*. Fifth Edition, 2007. Philadelphia: American College of Physicians.
- Bartlett JG, Auwaerter PG, and Pham PA, editors. *John Hopkins ABX Guide: Diagnosis and Treatment of Infection Diseases*. Second Edition, 2010. Sudbury, MA: Jones & Bartlett Learning.
- Gilbert DN, Moellering RC, Eliopoulos GM, Chambers HF, Saag, MS, editors. *The Sanford Guide to Antimicrobial Therapy 2012*. 42nd Edition, 2012. Sperryville, VA: Antimicrobial Therapy, Inc.
- Murdaugh LB. *Competence Assessment Tools for Health-System Pharmacies*. Fourth Edition, 2008. Bethesda, MD: American Society of Health-System Pharmacists.

SUBJECT: **RESIDENT RIGHTS-MEDICAL DECISIONS**	SECTION: Social Services **Page 1 of 1**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define the manner in which Sierra View Medical Center's Distinct Part Skilled Nursing Facility (DPSNF) assures the patient's ability to exercise self-determination in medical decision-making throughout their stay in the facility.

POLICY:

Each resident or surrogate completes the POLST (Physicians Orders for Life-Sustaining Treatment) document at the time of admission.

AFFECTED PERSONNEL/AREAS: *SOCIAL SERVICES, NURSING*

PROCEDURE:

1. The Social Service Designee shall initiate discussion with the resident/surrogate annually on the anniversary of admission, to determine whether the form still accurately reflects the treatment preferences of the resident/surrogate.

2. If the resident has an Advance Directive, the Social Service Designee shall review it annually with the resident/surrogate, to ensure that it remains current and correct, as to directives stated and any agents that are named. If not, it must be changed as soon as possible and placed in the medical record. If no changes are needed, it may be left as is.

3. When this annual review of the POLST or Advance Directive is completed, the Social Service Designee shall record it in a Progress Note in the resident's medical record.

4. If the resident/surrogate wishes to discuss medical treatment issues in order to clarify their preferences, the Social Service Designee shall refer them to the Medical Director.

5. If the resident/surrogate wishes to clarify their preferences in terms of family values, dynamics, or other psychosocial issues, the Social Service Designee should contact the unit Director to arrange for appropriate consultation.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, 72527, San Francisco, California, Title 22.

- Med Pass, Inc. (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.10, 483.10 (a) and (b). United States of America, Med Pass Inc.

SUBJECT: **RESTORATIVE PROGRAM**	SECTION: 1 **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

To establish guidelines for a restorative program.

AFFECTED PERSONNEL/AREAS: RESTORATIVE NURSE AIDE *(RNA), CERTIFIED NURSING ASSISTANT (CNA)*

PROCEDURE:

1. Passive and /or active range of motion (ROM) is given 3-6 days a week daily by RNA/CNA to all residents needing assistance in activities of daily living (ADL). As per the Physicians/Physical Therapy orders.

   Hand rolls will be used whenever hands are contracted or beginning to show signs of contractures.

   Ambulation will be encouraged for all residents on a daily basis if able.

2. Independent ambulators:

   a. Residents who are independent in ambulation will be encouraged to ambulate to their tolerance, in their room and in the hallways.

3. Ambulatory needing assistance:

   a. Residents will be encouraged to ambulate whenever possible, including ambulation to the toilet. Commodes and bedpans will be discouraged unless physically needed by the resident.

   b. Residents will be ambulated daily in hallways as tolerated per PT orders.

   c. The distance ambulated will be documented on the Restorative Nurse Assistant Intervention in the EMR.

4. All residents are encouraged to be up in chairs, wheelchairs or Geri-chairs as scheduled, as tolerated except when contraindicated by medical conditions. All residents are encouraged to leave their room for a change of environment two (2) times a week and attend activities.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, 70557, San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1

SUBJECT: **RESTRICTED AREAS ON THE NURSING UNIT**	SECTION:

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To establish guidelines and boundaries for the unit and to assure the work environment is operated in a safe and orderly manner.

POLICY:

The facility will maintain the confidentiality of residents, and rights of residents and employees. In order to assure this, some areas are restricted at all times from resident, family and visitors.

AFFECTED PERSONNEL/AREAS:

ALL FACILITY STAFF

PROCEDURE:

1. All staff are to politely enforce this restriction.
2. The following areas are off-limits to non-staff:
    a. Nurse's Lounge
    b. Behind Nurse's desk
    c. Medication Room (restricted to Licensed Nurses only)
    d. Utility Rooms (clean and soiled)
    e. Residents' Pantry

REFERENCES:

- Thomson Reuters (revised edition April 1, 1990) Barclay's California Code of Regulations, 72325, San Francisco, California, Title 22.

SUBJECT:	SECTION:
RESTRAINT USE – NON-VIOLENT, NON SELF-DESTRUCTIVE (NVNSD) AND EMERGENCY-VIOLENT SELF DESTRUCTIVE (VSD)	***Provision of Care, Treatment & Services (PC)***

PURPOSE:

To guide the application of ***Non-Violent, Non-Self-Destructive (NVNSD)*** **and** ***Violent Self Destructive (VSD) behavior*** restraint in all settings with the goal of minimizing the frequency/duration of restraint use to that which is absolutely necessary for resident care and resident and provider safety.

SCOPE:

The following are not considered restraint under this policy:

- Standard healthcare practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures and the related post-procedure care processes.
- Adaptive support in response to assessed resident need.
- Forensic or correctional restrictions used for security purposes.

POLICY:

1. Seclusion will not be employed at this hospital.
2. Physical restraint may be used according to this policy when warranted by the resident's condition and therapy, and when less-restrictive means of protecting the resident are not indicated.
3. All staff assigned to apply or monitor restraint will demonstrate corresponding competence.
4. Staff will ensure that residents are treated with dignity and privacy, including during periods of restraint.

AFFECTED PERSONNEL/AREAS:

NURSING, MEDICAL, ADMINISTRATION, DP/SNF

PROCEDURE:

NON – VIOLENT- NON SELF DESTRUCTIVE RESTRAINT

1. ***Definition:*** ***Non-violent, non-self-destructive (NVNSD)*** restraint means restricting a resident's movement to assist with the provision of medical or surgical care. Resident immobilization that is a normal component of a procedure (e.g., magnetic resonance imaging, surgery, etc.) is not considered restraint.

2. ***Indications:*** Prior to the initiation and continuation of ***NVNSD*** restraint, the resident must be assessed every 2 hours and documented in Meditech (EMR), to determine whether he/she requires restraint to prevent interference with his/her treatment plan.

3. ***Consideration of less-restrictive means:*** Prior to the initiation and continuation of restraint, alternative means of protecting the patient will be considered.

4. ***Conversation with Resident and Family:*** To the extent practical, the issue of restraint will be discussed with the resident and family prior to its use. Resident/family education will be documented. Consent will be obtained from appropriate resident representative before use of the restraint if able or as soon as possible, within 48 hours.

5. ***Orders:*** Restraint will be initiated or continued at the order of the physician. The order for restraint will include the type and site(s) of restraint to be applied and the specific actions or conditions that indicate restraint. As needed (PRN) restraint orders will be neither issued nor accepted. If a resident has been removed from restraints but a valid order is still in effect, the registered nurse may reapply the restraint without obtaining a new order, as long as the resident is exhibiting the same behaviors that met the original indication.

6. ***Initiation without Physicians Order:*** If a physician is not available, an RN may initiate restraint (subject to the assessments and indications mentioned elsewhere in this policy) without the prior order of a physician. If restraint was necessary due to a significant change in the resident's condition, the physician will be notified immediately for an order. Otherwise, the physician must be notified and a restraint order requested within 12 hours of its initiation.

7. ***Initial In-person Physician Assessment within 24-hours of Initiation:*** The treating physician will perform an in-person assessment of the restrained resident within 24-hours of initiation to verify that restraint is needed and that less-restrictive means are not appropriate.

8. ***Early Discontinuation of Restraint:*** Restraint will be discontinued as soon as it is no longer warranted by the resident's actions or the nature of the resident's treatment plan. Restraint may not be reapplied without a new order.

9. ***Resident Monitoring:*** Residents will be observed at least every two *(2)* hours to ensure that restraint remains necessary, that restraining devices remain safely applied, and that the resident remains safe and as comfortable as possible.

10. ***Documentation:*** The following will be documented in the medical record whenever medical restraint is applied:

    a. The resident's actions or condition that indicated the initial and continued use of restraint

    b. The less-restrictive alternative(s) to restraint considered

    c. Restraint orders

d. Resident monitoring

e. Significant changes in the resident's condition

f. Discussions and education with the resident and family (as appropriate) regarding restraint

g. The resident's plan of care will be updated any time a restraint is used

h. Record of Consent

VIOLENT AND SELF DESTRUCTIVE BEHAVIOR RESTRAINT (VSD)

1. ***Definition:*** ***Violent and Self Destructive Behavior Restraint*** is the restriction of a resident's movement in response to severely aggressive, destructive, violent, or suicidal behaviors that place the resident or others in imminent danger.

2. ***Consideration of Less Restrictive Means:*** Prior to the initiation and continuation of ***VSD*** restraint, alternate means of protecting the resident and others will be considered.

3. ***Conversation with Resident and Family:*** To the extent practical, the issue of restraint will be discussed with the resident and the family prior to its use and resident being sent to the Emergency Department. Resident and family education will be documented, as appropriate.

4. ***Discontinuation of Restraint:*** ***VSD*** restraint will be discontinued as soon as it is no longer indicated by the resident's behavior or the nature of the resident's treatment plan.

5. ***Orders:*** ***VSD*** restraint will be initiated or continued upon the order of a treating physician with current privileges at this institution. The order for restraint will include the type of restraint to be applied and will be based on specific violent/self-destructive behaviors that indicate restraint. PRN restraint orders will not be issued or accepted. ***VSD*** restraint may not be ordered for longer than four (4) hours for adult residents. Residents on the DP/SNF unit will be taken to the Emergency Room for full evaluation before VSD restraints are used, especially if the resident has a diagnosis of dementia, and/or has become violent and can harm self or others. The resident will not remain on the DP/SNF unit if VSD restraints are used.

6. ***Initiation without Orders:*** An RN may initiate ***VSD*** restraint in an emergency in advance of a physician's order. In such cases, the resident will be sent to the ER for evaluation and a treating physician will perform a face-to-face assessment of the resident within one *(1)* hour of its application.

7. ***Notification of the Nurse Manager:*** The nurse manager on duty will be notified:

   a. of any ***VSD*** restraint that continues to be applied for more than eight hours

b. any reapplication of VSD restraint within 12 hours after discontinuation

8. Patient Monitoring: After initial observation in the Emergency Department and continual use of the VSD restraint is identified, the resident will be placed in ICU where staff will continuously observe the resident. Such monitoring will be documented at least every 15 minutes.

Documentation: Document the following in the medical record whenever VSD restraint is applied: The patient's actions or condition that indicated the initial and continued use of restraint;

a. The less-restrictive alternative(s) to restraint considered

b. Restraint orders

c. Patient monitoring

d. Significant changes in the patient's condition.

e. Discussions and education with the patient and family (as appropriate) regarding restraint.

f. The residents' plan of care will be updated any time a restraint is used.

g. Transfer to Emergency Room order.

CHEMICAL RESTRAINT

1. ***Definition:*** A chemical restraint is any medication used as a restriction to manage the resident's behavior or restrict the resident's freedom of movement that is not a standard treatment or dosage for the resident's condition. Therefore, administration of an antianxiety or antipsychotic drug to alleviate symptoms of mental illness need not be considered a chemical restraint. Routine scheduled use of medications or PRN use, either oral or IM, of these same medications for approved indications does not need to be considered a chemical restraint.

2. On the rare occasion that chemical restraint is used in the acute setting, and also accompanies the initiation of ***VSD*** restraint, the protections afforded to the resident for this physical restraint *(See Non-violent, Non-Self Destructive details)* also ensures the resident's rights in the event of use of chemical restraint. Immediate transfer to the ER precedes the initiation of both VSD and chemical restraints.

REPORTING DEATHS RELATED TO RESTRAINT

Staff will promptly notify management of the death of any resident during or within 24 hours of the end of an episode of restraint use.

Management, in consultation with the department of quality, member and regulatory services, will notify the California Department of Public Health (CDPH) (on behalf of the Centers for Medicare & Medicaid Services [CMS]) of any resident who dies during restraint use.

STAFF EDUCATION:

1. During the initial orientation period, all levels of staff that have direct resident care responsibilities are oriented to this policy and procedure and trained in the proper and safe application and use of restraints.

2. Competency validation related to the proper and safe application and use of restraints is documented prior to the independent performance of the application or monitoring of a resident requiring restraint.

3. Only Registered Nurses (RN), who have demonstrated competence, or physicians may apply restraints in an emergency situation.

Contract/agency staff with direct resident care responsibilities will have documented competency in the hospital's restraint policies and procedures prior to caring for residents in restraints

REFERENCES:

- Thomson Reuters (2016-2020) Barclay's California Code of Regulations, Title 22, Division 6, §72082, §72319, San Francisco, California, Retrieved from: https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- MedPass, Inc. (Updated February 6, 2015) *Facility Guide to OBRA Regulations,* 483.13 (a) United States of America, Med Pass Inc.

CROSS REFERENCES:

- DP/SNF Policy & Procedure Manual RESTRAINTS, CHEMICAL

- DP/SNF Policy & Procedure Manual CARE OF RESIDENTS WITH DEMENTIA ON THE DP/SNF UNIT

SUBJECT: **SCOPE OF OCCUPATIONAL THERAPY**	SECTION: *[Enter manual section here]* **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To establish guidelines for the scope of Occupational Therapy Practice in Sierra View Medical Center Distinct Part Skilled Nursing Facility (DPSNF).

POLICY:

DEFINITIONS:

1. Scope of Practice:

a. Occupational Therapy is a profession which develops, coordinates and utilizes select knowledge and skills in planning, organizing and implementing programs for the care of individuals whose ability to function is impaired or threatened by disease or injury.

b. This leads to the selection and implementation of appropriate therapeutic procedures to maintain, improve or restore these functions. Services are provided to outpatients and inpatients on acute and sub-acute.

2. Types of Patients:

All types of orthopedic conditions and soft tissue injury, neurological conditions, wound care for diabetic and venous stasis ulcers and medical conditions, if the condition impacts activities of daily living (ADLs).

3. Age of Patients:

Middle Adult: 21 - 65 years

Late Adult: Over 65

4. Services:

Occupational Therapy services include, but are not limited to:

a. Evaluation and assessment prior to the provision of services.

b. Determination and development of a treatment program established to prevent or reduce disability or pain and to restore loss of function.

c. Interventions that focus on posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, pain and activities of daily living.

d. Procedures that include application of heat or ice, ultrasound, massage, mobilization and therapeutic exercises.

e. Wheelchair training and assessment, including application of assistive or prosthetic devices as appropriate.

5. Hours of operation:

Occupational Therapy consult/services are provided on an as needed basis.

6. Department Goals:

a. Goals are to provide effective and efficient patient care, increase professional and lay awareness and encourage on-going education and research in the field of physical therapy.

b. Occupational Therapy incorporates a broad spectrum of activities such as direct patient care, multidisciplinary interchange, supervision, teaching, administration, research and community service.

c. It also accepts responsibility for education at many levels, recruitment of personnel and ethical standards of practice for the welfare of patients and its own members.

7. Staffing Plan:

a. Services are provided by a per diem employee on a per consult basis.

b. Restorative Nursing Aide to collaborate with Occupational Therapist for compliance with the OT program.

8. Qualification of staff

a. Fulfill state requirements for licensure, certification or registration. Internationally educated occupational therapists must complete occupational therapy education programs that are deemed comparable (by the credentialing body recognized by the state occupational therapy regulatory board or agency) to entry-level occupational therapy programs in the United States.

b. **Occupational Therapy staff will have Basic Life Support (BLS) certification.**

AFFECTED PERSONNEL/AREAS: *ALL OCCUPATIONAL STAFF*

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, Article 4, §72413, §72415, §72417, San Francisco, California, Title 22.

SUBJECT:	SECTION:
SCOPE OF PRACTICE – LICENSED VOCATIONAL NURSE	***DP/SNF***

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To clarify the *Scope of Practice* for Licensed Vocational Nurses (LVNs) working for Sierra View Medical Center within the DP/SNF.

POLICY:

A. Nursing staff members licensed in the State of California as Vocational Nurses shall adhere to all statutes defining their scope of practice as published by the Board of Vocational Nurses and Psychiatric Technicians.

B. Licensed Vocational Nurses (LVNs) shall adhere to the LVN Job Description, practice guidelines, policies and procedures, and competencies as established by Sierra View Medical Center in compliance with the acute care hospital, DP/SNF, and outpatient departments, in regard to all patient care practices, including IV certification and administration of medications to patients under the care of the LVN.

C. Only LVNs who have successfully completed an IV certification, completed competency validation course and passed the Medication Math testing, may start peripheral IVs and superimpose intravenous solutions of electrolytes, nutrients, vitamins, blood, and blood products.

D. LVNs are directly supervised by a registered nurse.

REFERENCE:

- Vocational Nursing Practice Act with Rules and Regulations (Includes amendments through July 31, 2015). Retrieved on Oct 4, 2017 from https://www.bvnpt.ca.gov/about_us/laws.shtml.

SUBJECT: **SEEING/HEARING/COMPANION DOG (SERVICE ANIMALS)**	SECTION: ***Ethics, Rights & Responsibilities (RI)*** **Page 1 of 3**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

The purpose of this policy is to establish ADA-based guidelines for accommodating patients, visitors and/or employees the use of seeing/hearing/guide service dogs as an auxiliary aid within the confines of SVMC facilities.

DEFINITIONS:

ADA – American with Disabilities Act

AOC – Administrator-on-call

PACU – Post-Anesthesia Care Unit

Service Animal – ADA regulations narrowly define a "service animal" as any dog that is specially and individually trained to do work or perform tasks for the benefit of a disabled individual. Emotional support animals are expressly excluded from qualifying as a service animal under the ADA.

SVMC – Sierra View Medical Center

AFFECTED AREAS/PERSONNEL:

This policy covers all SVMC personnel, medical staff, patients and visitors.

POLICY:

SVMC will allow any patient, visitor, or employee the use of a service dog(s) as an auxiliary aide. The dog may be used in all situations *except* where it is clearly demonstrated that the presence or use of a service dog would pose a significant health risk (see "Exceptions" section on page 2), or when a dog's behavior is uncontrollable and/or disruptive.

PROCEDURE:

Hand Hygiene

1. Anyone handling or touching a Seeing/Hearing/Companion Service Dog(s) must perform hand hygiene after each and every contact.

Outpatient Areas

1. Service dogs will be allowed to work in any outpatient setting where the public and patients are routinely allowed to go.

Inpatient Areas

1. Any patient with a disability will be allowed to keep their service dog in a private room for the duration of their hospital stay. The patient is responsible for all service animal care, including grooming, feeding, and toileting the dog. If the patient is unable to care for the service dog, the patient can make arrangements for a family member or friend to come to the hospital to provide this care.
2. If the patient is unable to care for the service animal or is unable to arrange for someone else to care for the service dog, the hospital may place the dog in a boarding facility until the patient is released, or make other appropriate arrangements. However, the hospital must give the patient the opportunity to make arrangements for the dog's care before taking such steps.
3. Hospital staff is not obligated to supervise or otherwise care for a service animal. In an extreme emergency, the House Supervisor will be notified to assist with toileting.

Visitors

1. Visitors may make use of a service dog in accordance with the Hospital's Visitor Guidelines Policy.

Employees

1. Any disabled individual offered employment at SVMC will be allowed the use of a service dog while at work.
2. If at any time a current employee or a member of the medical staff needs accommodations, employees must make a request through Human Resources and medical staff must make a request through the Medical Staff Office.

EXCEPTIONS:

1. Areas where service dogs will not be allowed may include, but are not limited to: the operating room, the labor and delivery room, the newborn nursery, sterile processing and sterile processing storage areas, PACU, and the kitchen.
2. A case-by-case assessment will be made with medically qualified personnel, and the AOC in situations not covered by this list.
3. Proof of immunizations and training of the service animal may be requested in *specialized* cases or as needed in conjunction with ADA regulations.

REFERENCES:

1. Timeline of the Americans with Disabilities Act. Website last updated in August, 2022. URL: https://adata.org/ada-timeline
2. ADA.gov – Information and Technical Assistance on the Americans with Disabilities Act. Retrieved on August 18, 2022, last updated on August 1, 2022. URL: https://www.ada.gov/

3. ADA.gov – Service Animals. Retrieved on July 2, 2024. URL: https://www.ada.gov/topics/service-animals/

SUBJECT: **SHAVING**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

The purpose is to increase cleanliness and improve the resident's self-image.

POLICY:

- It is the policy of this facility to provide for the removal of facial hair as a component of the resident's hygienic program.
- Male residents will be shaved at least every other day and female residents will be shaved as needed.

AFFECTED PERSONNEL/AREAS: *CERTIFIED NURSING ASSISTANTS (CNAs)*

EQUIPMENT:

- Safety razor or rechargeable razor
- Basin
- Bath towels
- Washcloth
- Soap or shaving cream
- Tissues
- After shave lotion (optional)
- Gloves

PROCEDURE:

1. Explain procedure to resident. Provide privacy. Wash hands thoroughly.
2. Assist resident to comfortable position.
3. Place towels over chest and under head.

<u>WHEN USING SAFETY RAZOR:</u>

a. Fill basin half full of warm water

b. Apply gloves

c. Apply moderately warm washcloth to face

d. Apply shaving cream

e. Pull skin tight in opposite direction to razor and shave

f. Rinse blades frequently

g. Rinse face, dry and apply after shave lotion as desired

h. Remove gloves

i. Wash hands thoroughly

DOCUMENTATION:

1. Report any unusual observations to licensed nurse for follow up.

2. Document procedure of resident's refusal to shave on nurse assistant activities of daily living (ADL) Intervention in the electronic medical record (EMR).

REFERENCES:

- Thomson Reuters (2019) Barclay's California Code of Regulations, 72315 (d), San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT: **SKIN CARE TIPS FOR NURSING ASSISTANTS**	SECTION:

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

The purpose is to assure skin integrity is maintained.

POLICY:

Sierra View Medical Center (SVMC) will utilize protocols for skin care to promote resident comfort and to provide preventive skin care measures.

AFFECTED PERSONNEL/AREAS: *CNAs*

PROCEDURE:

A. INCONTINENT:

1. Check residents at least every 2 hours for wetness. Change as needed. Make a point to check incontinent residents between other duties.
2. Wash perineal area and dry at each change.
3. Use diaper or padding under resident in bed or up in chair; not up between legs. Do not layer incontinent pads between resident and pressure relief devices.
4. Check for redness and report it to the licensed nurse.
5. Toilet residents that are up in chairs at least every 2 hours or according to individualized toileting schedule.

B. CONTACTURES:

1. Practice gentle handling of area; move slowly so you do not hurt the resident.
2. Wash skin gently with wash cloth, dry well and pat with a soft cloth.
3. Check resident's fingernails, and trim if needed so they do not cut into the palms of hands. Check for redness, and report it to the nurse.

C. PRESSURE INJURIES:

1. Turn resident every 2 hours or more often as needed.
2. Do not leave resident on reddened area longer than to bathe or feed.
3. If incontinent, change as soon as wet, wash and dry.
4. Do not rub reddened area.

5. Any change in skin condition should be reported to the nurse.

D. SKIN:

1. Never rub. Only pat to wash and to dry.
2. Dress slowly, so cloth does not pull skin.
3. Be careful during transfers.
4. Use lotion to keep skin lubricated.

E. SKIN FOLDS:

1. Wash and dry under every skin fold.
2. If a patient is obese, padding may be needed under breast or stomach.
3. If redness is found, report it to the licensed nurse.

F. GENERAL:

1. Tuck linen loosely over residents and pressure relief devices.

REFERENCES:

- California Code of Regulations (2021). Title 22. §72315 (5) (6). Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT: **SPECIMENS PATHOLOGICAL/ BACTERIOLOGICAL, CARE OF**	SECTION: **Page 1 of 6**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To provide guidance for perioperative surgical **specimen** management, including handling of specific types of specimens collected during surgical and other invasive procedures that may be sent to the pathology laboratory for examination.

POLICY:

1. Specimens removed during a surgical procedure will routinely be sent to the Laboratory/Pathologist for evaluation.

2. Specimens will be properly labeled and packaged in preservative as designated, according to Premier Pathology's "Specimen Collection Manual."

3. Specimens will be logged in either the Pathology or Laboratory Specimen Log record.

4. The pathologist will examine all specimens sent to Pathology. The pathologist and medical staff will make the determination of which categories of specimens require only a gross description for diagnosis conjointly.

5. The medical staff, in consultation with the pathologist, will decide the exceptions to sending specimens removed during a surgical procedure. Exceptions will be made under the following conditions:

    a. When the quality of care will not be compromised by the exception.

    b. Specimen will be verified by surgeon and a surgical service pathology worksheet will be used for proper documentation.

6. The limited categories of specimens that may be exempted from the requirement to be examined by the pathologist includes, but is not limited to, the following:

    a. Specimens that by their nature or condition do not permit fruitful examination. These include cataracts, orthopedic appliances, foreign bodies, teeth or a portion of the rib removed solely to enhance operative exposure.

    b. Traumatically injured members that have been amputated, for which examination for either medical or legal reasons is not deemed necessary.

    c. Therapeutic radioactive sources, the removal of which will be guided by radiation safety monitoring requirements;

    d. Specimens known to rarely show pathological change and are from a highly visible area, such as foreskin from pediatric patient;

    e. Placenta that is grossly normal.

AFFECTED AREAS/ PERSONNEL: *MAIN OPERATING ROOM (OR), MATERNAL CHILD HEALTH (MCH) OR, POST ANESTHESIA CARE UNIT (PACU), ENDOSCOPY/RN, LVN, ORT*

EQUIPMENT NEEDED:

- Containers for specimens (plastic bag with seal or bucket)
- Fixative
- Surgical Tissue Request
- Specimen Log Records

PROCEDURE:

1. For specimens submitted for preparation and examination refer to "***Specimen Collection and Handling Manual***," Premier Pathology Laboratories, Inc. Policy Manual.

2. "*Surgical Tissue Request Form,"* patient's face sheet and a copy of the reimbursement source is to be submitted with each specimen. Specimens are stored in the Pathology room and retrieved by the pathology personnel each day.

3. When a surgeon requests a "stat" report (RED BALL) for a specimen, a red dot is placed on the specimen container, "*Surgical Tissue Request Form*" and in the log record indicating immediate processing. Pathology personnel need to be informed regarding the specimen. The report is phoned to the physician.

4. Anatomical specimens – Those specimens too large to be placed in a container with formalin are to be wrapped securely in two red bags (padding bony prominences), labeled and placed in the hospital laboratory refrigerator. A note will be placed in the Specimen Log record that the specimen has been placed in the laboratory.

5. Specimens for the laboratory (e.g., cultures, stone for chemical analysis) are entered into the computer; labels retrieved, logged in the Laboratory Log Record and sent to lab. **(Fixative is not used with the laboratory specimens.)**

6. The circulating nurse is responsible for correctly completing the documentation and identifying the containers of specimens with the proper labels. Questions regarding the specimen shall be directed to the surgeon.

7. The scrub tech/nurse must properly handle the specimen from the time of removal until the circulating nurse receives it.

8. Different containers will be used for each specimen.

9. Label containers with:

   a. Patient name

   b. Date of birth (DOB)

   c. Body site location

   d. Specimen source and type

   e. Clinician name

   f. Date of collection

   g. Breast specimens must include the time tissue is removed and the time it was placed in formalin on both the requisition and the bottle.

10. Requisitions must include:

   a. Complete patient name

   b. Date of birth (DOB)

   c. Sex

   d. Date of collection

   e. Medical record number

   f. Clinician name

   g. Attending physician name

   h. Hospital

   i. Source of specimen

   j. All relevant clinical information

   k. Pre/post-op diagnoses

   l. Examination requested

11. GYN cases must also include the following on the requisition

a. All relevant clinical history

12. Specimens will be properly packaged in preservative as designated

a. Tissue Specimens

- Place in 10% neutral buffered formalin immediately after removal. Formalin must fully cover specimen to provide adequate infiltration. Formalin volume is usually 15 to 20 times the specimen volume.
- Small biopsy containers are adequate for skin, GI, GYN and GU biopsies.
- Larger biopsy containers are available if needed.

b. Breast Specimens

- Place tissue in formalin immediately upon collection to avoid decomposition of the breast tumor; this is the "cold ischemia time". (Note: If the specimen requires radiographic imaging after collection, current guidelines are to keep this time to 1 hour or less.)
- Malignant breast tumors must be processed within 24 hours.
- Note time of collection of breast tissue and time of placement in formalin of the requisition and specimen container.
- Collect specimen and immediately place it in 10% neutral buffered formalin in a container large enough to accommodate the specimen in a volume of fixative that is 15 to 20 times its volume.

c. Chromosomal Studies

- Physician selects specimen to send.
- Specimen is placed in a PRMI medium located in the malignant hyperthermia refrigerator.
- Date and time of collection is included on the label and lab slip.
- Lab is called for pick-up ASAP.
- Specimen must be sent out and received within 24 hours or study may give false reading.

- When weekend request is made for chromosomal studies, inform physician of the 24 hour protocol. Deliver specimen directly to the Lab to be refrigerated until processed.

d. Cytology Specimens

- Fluids are submitted in the Saccamano fixative (green fluid) unless otherwise specified by the physician.

e. Stones for chemical analysis

- Do not place in formalin.
- Place stones in dry specimen container.

13. Package for transport and label specimen container with all of the following on the Surgical Requisition (green sheet):

a. Patient name

b. Date of birth (DOB)

c. Body site location

d. Date and time of specimen collection and time specimen was placed in the formalin.

e. Physician name.

f. Place specimen in biohazard bag.

g. Place requisition in outer pocket of bag and log into Path Book.

h. If daily courier pick-up is not scheduled, call to request pick-up.

i. If specimen will be stored overnight, keep at room temperature.

REFERENCES:

- Barclays California Code of Regulations, Regulation 70243, Clinical Laboratory Service General Requirements.
- Thermo Scientific for Fixation of Cytology Specimen, 2015. Thermo Fisher, retrieved from https://assets.thermofisher.com/TFS-Assets/APD/manuals/IS81848-RAS-Saccomanno-Fluid-IFU.pdf.
- Association of Perioperative Nurses. Guidelines. Specimen Management. December 21, 2020.

Retrieved from https://aornguidelines.org/guidelines/content?sectionid=173724676&view=book#245907872.

CROSS-REFERENCE:

- Premier Pathology, "Specimen Collection Manual for Hospitals and Physicians"

SUBJECT: **SPLINT APPLICATION AND USE**	SECTION:

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

The purpose of this policy is to maintain optimal quality of life and prevent the progression of contractures.

POLICY:

The facility will utilize splints to prevent contractures or the progression of contractures.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSE (RN), LICENSED VOCATIONAL NURSE (LVN), CERTIFIED NURSING ASSISTANT (CNA), RESTORATIVE NURSE ASSISTANT (RNA), PHYSICAL THERAPIST, AND OCCUPATIONAL THERAPIST*

PROCEDURE:

1. Splints are to be worn according to the schedule determined by written order of the physician.

2. The Occupational Therapist assists in determining the need for and coordinating a referral for splint fabrication, if needed, or a pre-made splint, if appropriate.

3. The Physical Therapist or Occupational Therapist assesses for proper fit and instructs the CNA in proper application.

4. CNA and/ or RNA monitors the patient every 2-3 hours for proper positioning, fit, and resident's tolerance of the splint.

5. Resident's refusal for splint application will be documented promptly by the RNA or CNA per the department's documentation system. A care plan regarding this concern will be written accordingly and reviewed as appropriate.

6. The skin will be checked for redness, irritation, or pressure marks during care at least every 2-3 hours.

7. Any problem with fit or resident tolerance is relayed to the Physical Therapist or Occupational Therapist for reassessment.

8. The fit and effectiveness of the splint is reassessed monthly at Interdisciplinary Team (IDT) and PRN by the Physical Therapist or Occupational Therapist. Any need for adjustment or modification of the splint is made to the appropriate vendor.

REFERENCES:

- Thomson Reuters (Revised edition April 1, 1990) Barclay's California Code of Regulations, §72319 (k) (1) (5) (2A & B), San Francisco, California, Title 22. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT:	SECTION:
STROKE ALERT & ACUTE CARE STROKE MANAGEMENT: EMERGENCY DEPARTMENT & IN PATIENT UNITS	**Page 1 of 13**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To define the core stroke team as well as the roles and responsibilities of Sierra View Medical Center (SVMC) personnel responding to stroke alert notifications; to delineate the stroke alert process, and to assure timely and optimal care for all potential acute and non-acute strokes, as well as Transient Ischemic Attack (TIA) patients.

This policy will also outline the procedure for implementing current evidence-based practice for the management and care of the patient presenting with signs and symptoms of acute stroke and to implement clinical practice guidelines to further reduce the morbidity and mortality associated with stroke.

These guidelines support the primary principals and detailed aspects of successful stroke systems of care.

The scope of SVMC's stroke program is adult patients ages 18 and older who have suffered a stroke or TIA. This mission of the stroke program is to promote health through primary prevention and ensure access to the highest standard of stroke care through advanced medicine and collaborative partnerships, supported by evidence-based practice.

DEFINITIONS:

1. **Stroke Alert** – An overhead page or electronic notification announcing the presence and location of a potential stroke patient. Activated any time for any patient that displays the onset of stroke signs and symptomsup to 24 hours after the Last Known Well Time (LKWT). Calling a Stroke alert is a nurse –driven process.

   - Patients with new or worsening neurological deficits (if National Institute of Health Stroke Scale (NIHSS) worsens by 4 or more points.)
   - Anyone with a positive BE FAST exam (Balance, Eyes, Face, Arms, Speech, Time).
   - Any other signs or symptoms concerning for stroke

   The alert activates members of the stroke team, who mobilize to the patient's location so that treatment of a potential acute stroke can begin as soon as possible.

2. **Core Stroke Team:** the core stroke team consists of a medical director and stroke program coordinator. The Medical Director and Stroke Coordinator are appointed based on education, training, or experience and collaborate to define, implement, and direct the Advanced Primary Stroke Center's stroke program.

3. **Stroke Team** – The Stroke Team members are based on the location of the stroke alert and includes, but is not limited to:

   - Emergency Department (ED) Attending Physician or midlevel provider**
   - Stroke & Sepsis Coordinator Ω,
   - CT Technologist **,± (remains at CT scanner)
   - ED Registered Nurse (RN)**
   - ICU RN ±
   - Phlebotomist**,, ±
   - Hospitalist √ (in-patient), OR
   - Intensivist §(in-patient)
   - Pharmacist §
   - Nursing Supervisor Ω,

- Respiratory Therapy §
- TeleNeurologist +

** denotes presence required upon stroke alert notification in the ED
± denotes presence required upon stroke alert notification in-house.
Ω denotes presence required when available for both ED & in-house stroke alerts
√ denotes presence required upon inpatient stroke alert notification
§ denotes required to be available in person or by phone
+ denotes presence required on Neurology cart, or be phone

4. **BE FAST** – an acronym for symptoms of acute stroke, it stands for:

B - Balance – Is there a sudden loss of balance or coordination?

E - Eyes - Is there sudden blurred or double vision or sudden, persistent vision trouble?

F - Face - Ask the person to smile. Is one or both sides of the face drooping?

A - Arms - Ask the person to raise both arms. Does one side drift downward? Is there weakness or numbness on one side?

S - Speech - Does the person have slurred or garbled speech? Can he/she repeat simple phrases?

T - Time - Call 911 if you are outside the hospital, Call 55 if inside the hospital. Note the date and time the person was last known to be normal. Some clinical areas precede the stroke alert with a call to the Rapid Response Team (RRT).

5. **Clinical Practice Guidelines** – Recommendations for clinicians about the care of patients with certain conditions. SVMC follows clinical practice guidelines by the American Heart Association (AHA) / American Stroke Association (ASA).

6. **Last Known Well Time (LKWT)** – The time documented in an hour and minute format, that the patient was last known to be at their "baseline "- or "normal" – self.

7. **NIHSS**-National Institutes of Health Stroke Scale- a stroke severity assessment scale.

8. **Acute Ischemic Stroke (AIS)** – a disruption of blood flow to the brain that results in permanent damage to the brain. This disruption is usually caused by either:

- Cerebral Thrombosis: Blood supply to part of the brain is cut off because atherosclerosis or a blood clot has blocked a blood vessel.

- Cerebral Embolism: Generally, a blood clot that forms at another location in the circulatory system, usually the heart and large arteries of the upper chest and neck. A piece of the blood clot breaks loose, entering the bloodstream, and travels through the brain's blood vessels until it reaches vessels too small to let it pass, thereby blocking the vessel. A second important cause of embolism is an irregular heartbeat, known as **atrial fibrillation**. This creates a condition where clots can form in the heart, dislodge and travel to the brain.

Ischemic strokes account for 87% of all strokes. Time to reperfusion predicts clinical outcomes.

9. **Acute Hemorrhagic Stroke**: This results from a weakened blood vessel that ruptures and bleeds into the surrounding brain. The blood accumulates and compresses the surrounding brain tissue. There are two types of hemorrhagic strokes:

   - Intracerebral Hemorrhage (ICH): Blood vessels within the brain bursts and leaks into the surrounding brain tissue. This is the most common hemorrhage.
   - Subarachnoid Hemorrhage (SAH): Bleeding in the area between the brain and the tissue covering it, known as the subarachnoid space.
   - Two types of weakened blood vessels usually cause hemorrhagic stroke:
     - Aneurysm: A ballooning of a weakened region of a blood vessel. If left untreated, the aneurysm continues to weaken until it ruptures and bleeds into the brain.
     - Arteriovenous Malformation (AVM): A cluster of abnormally formed blood vessels. Any one of these vessels can rupture, also causing bleeding into the brain.
   - Acute Hemorrhagic Strokes account for about 13% of all strokes.

10. **Transient Ischemic Attacks (TIA):** Sometimes called a "mini-stroke." Blood flow to the brain stops for a short period of time (temporary blood clot) mimicking symptoms of stroke.

    - Most last less than 5 minutes; the average is about one minute
    - Approximately 40% of those experiencing a TIA will go on to develop an acute ischemic stroke

11. **Alteplase** – The only FDA-approved thrombolytic medication for AIS treatment

12. **Tenecteplase (TNKase)** – A thrombolytic medication endorsed by the American Heart Association as an alternative to Alteplase (TPA)for the treatment of Acute Ischemic Stroke (AIS).

POLICY:

In recognition of the Stroke Chain of Survival, the SVMC stroke program strives to provide early recognition, and appropriate treatment throughout the patient's length of stay (LOS). To further the care continuum, referral to appropriate post-acute care takes place.

1. Detection: Early recognition
2. Dispatch: Early EMS Activation
3. Delivery: Transport & Management
4. Door: ED Triage

5. Data: ED Evaluation & Management, Activation of Stroke Alert

6. Decision: Neurology, Therapy Selection

7. Drug: Drug/Device, Reperfusion Approaches

8. Disposition: Admit or Transfer

AFFECTED PERSONNEL/AREAS: *OPERATORS (PBX), EMERGENCY DEPARTMENT (ED) PHYSICIANS, MIDLEVEL PROVIDERS AND STAFF, HOSPITALISTS, RADIOLOGY, IMAGING, INTENSIVE CARE UNIT (ICU), MEDICAL SURGICAL UNIT (MED-SURG), CLINICAL DECISION UNIT (CDU), MATERNAL CHILD HEALTH SERVICES, TELEMETRY, NURSING, RAPID RESPONSE TEAM, STROKE COORDINATOR, LABORATORY, RESPIRATORY THERAPY, NURSING SUPERVISORS, DIAGNOSTIC IMAGING.*

EQUIPMENT:

- Code Cart
- Cardiac Monitor / Transport Monitor
- Stroke Packet/Binder
- CT Scanner
- Tele-Neurology Cart, if needed

ROLES AND RESPONSIBILITIES

A. **Emergency Department Physician or Midlevel Provider**

- Leads the stroke alert team and assumes primary medical care for the patient in the ED. May perform and document the NIHSS.
- Utilizes order sets and clinical pathways, as needed. However, treatment decisions defer to treating provider's clinical judgment.
- Reviews and documents all diagnostic test results.
- Collaborates with Stroke Coordinator and ED registered nurses as needed.
- Considers and consults with Tele-neurologist or Neurologist.
- .
- .
- May Participates in the thrombolytic time out process for thrombolytic- eligible patients.
- Implements the most appropriate treatment.
- Considers and updates the patient's family along the treatment continuum.
- Determines the need to transfer the patient to a tertiary stroke center (consultation with neurology will be considered).

B. **ED Registered Nurse (RN - ED) / Rapid Response RN (inpatient)**

- Performs & documents baseline NIHSS assessment, if not done by TeleNeurologist..
- Performs & documents initial blood sugar, if not done by EMS.

- May perform and document ongoing NIHSS assessments Reviews all test results in collaboration with the resident or attending provider.
- Performs neuro checks and vital signs (VS) as prescribed, or by unit standard, and is responsible for general nursing care of the stroke alert patient.
    - For the post-thrombolysis patient, VS and Neurological Checks will be performed:
        - Every 15 min x 2 hours
        - Every 30 min x 6 hours
        - Every 1 hour x 16 hours
    - Hypertension Management for thrombolytic candidates
        - Pre-thrombolysis:
            - Must be less than 185/110
            - Post-thrombolysis, blood pressure must be maintained below 180/105.
- Considers and updates the patient's family along the treatment continuum.
- If thrombolytics are indicated & administered, patient ratio will be 1: For the first 2 hours
- Consults with pharmacy as needed.

C. **ICU RN – (receiving nurse of patient post - thrombolytics)**

- Performs & documents baseline NIHSS assessment upon arrival to ICU.
- Performs and documents ongoing NIHSS assessments.
- Reports any change of condition to the attending physician.
- Monitors the post thrombolytic patient for bleeding and angioedema, then reports to attending provider.
- Reviews all test results in collaboration with the resident or attending physician.
- Performs neuro checks and vital signs(VS) as prescribed, as needed, or by unit standard, and is responsible for general nursing care of the stroke alert patient.
    - For the post-thrombolytic patient, VS and Neurological Checks will be timed from the administration of the thrombolytic bolus and will be performed:
        - Every 15 min x 2 hours
        - Every 30 min x 6 hours
        - Every 1 hour x 16 hours
    - Hypertension Management for thrombolytic candidates
        - Pre-thrombolysis:
        - Must be less than 185/110
        - Post-thrombolysis, blood pressure must be maintained below 180/105
- Considers and updates the patient's family along the treatment continuum.
- Documents patient and family education as needed on the Interdisciplinary Education Record (IERImplements the stroke/CVA plan of care

D. **Stroke Unit (TELEMETRY) RN or Medical Surgical RN (receiving nurse of non-thrombolytic /non-acute patient)**

- Performs and documents the NIHSS upon admission to the unit, with any change in condition, or as prescribed.
- Reports any change in condition to the attending provider.
- Reviews all test results in collaboration with the resident or attending provider.
- Performs neuro checks and vital signs as prescribed, and/or as needed.
- Is responsible for general nursing care of the stroke/TIA/stroke alert patient.

- Considers and updates the patient's family along the treatment continuum. Any patient or family education is documented on the Interdisciplinary Education Record (IER) and/or the plan of care
- Performs and documents the required discharge education, when appropriate.
- Institutes the plan of care for stroke / CVA patients, or TIA patients.

E. **Nursing Supervisor**

- Evaluates the need and provides the necessary staffing coverage for the affected units during the stroke alert, and/or to accommodate staffing needs of the patient receiving thrombolytics.
- Eliminates operational and administrative barriers

F. **Radiologist**

- Interprets CT scans for stroke alert patients with a time target of 25 minutes. Results will be called to the ordering provider when there are focal neurological findings on the initial head CTscan. Interprets diagnostic imaging, including Magnetic Resonance Imaging (MRI) scans. Results are also available in the Electronic Medical Record (EMR).

G. **Diagnostic Imaging**

- Coordinates start time of patient's stat CT scan, Computed Tomography Angiography (CTA), and/or MRI exam.
- Will follow the stroke protocol for related diagnostic exams.
- Notifies the on duty Radiologist when imaging is complete.
- Obtains and processes the patient's chest x-ray (if ordered).

H. **Neurologist**

- Provides expert consultation.
- When consulted, responds by phone or in person, as needed or requested.
- Utilizes order sets and clinical pathways, as needed. However, treatment decisions defer to treating provider's clinical judgment.
- Reviews and documents relevant diagnostic test results.
- Collaborates with ED/ICU providers, ED /ICU/Telemetry nurses, pharmacy, and stroke coordinator as needed.
- When consulted, recommends a plan of action, and assists with treatment & transfer decisions
- .

I. **Tele-Neurologist**

- Provides expert consultation in the neurologist role (as above), via a video and audio-enabled computer cart.
- Collaborates with the ED/ICU providers, ED/ICU nurses, and stroke coordinator as needed.
- Whenconsulted, Assumes neurological care of the ED or inpatient, orders thrombolytic (if appropriate), and documents in the medical record. Documents consent for thrombolytics

- If no thrombolytics are given, documents the reason
  Updates the attending physician as needed

J. **Laboratory / Phlebotomist**

- Draws STAT labs per stroke orders and assures transport directly to lab for immediate processing.
- PT/PTT/INR results will be available as quickly as possible with a time target of 30 minutes, while the remainder of laboratory tests will result with a time target of 45 minutes from time specimen is received.

K. **Certified Nursing Assistant (CNA)**

- Assists the RN as needed / directed.
- May obtain & enter an accurate patient height and weight into the EHR.
- In the ED, obtains EKG and gives to the provider within a time target of 45 minutes from arrival (without delaying CT scan).

L. **Pharmacist**

- Available for consultation by phone and/ or in person during working hours, and by phone after hours.
- May assist with the evaluation of and administration of medications with specific emphasis on thrombolytic medication.
- Trained RNs will be responsible for mixing thrombolytics at the bedside, with the pharmacist available (as above) for consultation.

M. **Respiratory Care Practitioner (RCP)**

- As needed, will assist with the evaluation, management, and maintenance of a patent airway on the patient.
- As needed, will assist with the evaluation, management, and maintenance of oxygen therapy.

N. **Stroke Coordinator** – Available as a resource and for stroke process consultation.

O. **Intensivist or Hospitalist** – May provide primary patient management for inpatient stroke alerts:

- May assume care of suspected or confirmed stroke patients from the ED.
- Utilizes order sets and clinical pathways, as needed. However, treatment decisions defer to treating provider's clinical judgment.
- Reviews and documents all diagnostic test results.
- Collaborates with Stroke Coordinator and registered nurses as needed.
- Considers and consults with Tele-neurology or neurology.
- Implements the most appropriate treatment.
- Considers and updates the patient's family along the treatment continuum.
- Determines need to transfer patient to a tertiary stroke center (consultation with neurology will be considered).

PROCEDURE:

In accordance with the stroke chain of survival:

1. Out of Hospital

a. Activation of Emergency Medical Services (EMS)

b. EMS will be assessing in the field for symptoms of stroke and intervene per EMS policy & procedure.

c. Preferably, EMS alerts the Emergency Department of incoming suspected acute stroke arriving within 5 min, OR an acute stroke is identified upon arrival to the ED. An ED staff member will call Ext. 55 and have "STROKE ALERT" announced overhead with the location such as "Stroke Alert, ER, Bed 3" (repeated x 3).

2. Walk-Ins

a. Rapid ED triage: B.E. F.A.S.T.

b. Stroke Alert activation

3. In-Patient

a. Rapid evaluation by RRT using B.E. F.A.S.T., if appropriate

b. Stroke Alert activation

TIME TARGETS FOR STROKE

Activity	Time Targets
1. **Critical Assessment/Actions @ ED Arrival** • Support ABCs • Immediate general assessment and stabilization • Approximate NIHSS, if able • Activate Stroke Alert, if within 24 hrs of LKWT • Apply cardiac monitor and pulse ox prior to transport to CT • Initiate stroke alert order set, if desired by provider • Assess vital signs • Provide oxygen as ordered • Obtain IV access • Point of Care glucose check (if not done by EMS) • Initial NIHSS performed – do not delay CT • Emergent non-contrast CT of the brain, followed by CTA, if ordered– labs per discretion of medical provider • Stat lab draws including CMP, CBC, Troponin, Coagulation studies, and beta-HCG in women of	Immediate Initiate stroke alert within 10 min of arrival **ED provider must see patient within 15 min of arrival** **Within 20 min of ED arrival**

SUBJECT: **STROKE ALERT & ACUTE CARE STROKE MANAGEMENT: EMERGENCY DEPARTMENT & IN PATIENT UNITS**	SECTION: **Page 9 of 13**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

	childbearing age, POC glucose (if not done prior)– **do not delay CT**. Delay CT only to treat low blood sugar. • EKG – **do not delay CT** • CXR – **do not delay CT**	**45-60 min for ancillary tests**
2.	**CT of brain / CTA completed:** a. Neurological assessment b. Review patient history c. Establish Last Known Well Time d. NIHSS, if not done earlier e. Labs, if not done earlier f. CXR & EKG, if not done earlier	
3.	***Tele-Neuro / notification of neurologist (if not already done)** a. CT scan read – expert diagnosis b. Does CT show a hemorrhage? i. No -> possible ischemic stroke *see Acute Ischemic Stroke Treatment ii. Yes -> * see hemorrhagic stroke management	Within 10 min of stroke alert If pre-alerted by EMS, Teleneurology will be activated prior to patient arrival.
4.	**STAT Labs resulted**	**45 min, 30 min for PT/PTT/INR**
5.	**Acute Ischemic Stroke Treatment** a. Tenecteplase may be used for acute ischemic stroke at a dose of 0.25 mg /kg, MAX of 25 mg. b. c. If thrombolytics are given, no aspirin / anticoagulants to be given for 24 hours d. Complete a thrombolytic time out with others in the room e. Observe for orolingual angioedema f. Blood pressure management **i. If patient is post-thrombolytics, blood pressure is maintained < 180/105 and post-thrombolytic VS & neuro check routine is maintained: VS & neuro checks Q 15 min x 2 hrs** **ii. VS & neuro checks Q 30 min x 6 hrs** **iii. VS & neuro checks Q 60 min x 16 hrs** g. Repeat and document NIHSS post – thrombolytic, every 4 hours for the first 24 hrs, then every shift.	Door to treatment time = less than 60 min in 50% of all eligible stroke patients receiving rt-PA: The Golden Hour of Acute Ischemic Stroke – from the TJC 2015: In patients eligible for IV rt-PA, betime dependent, and treatment should be initiated as quickly as possible. The door to needle time (time of bolus administration) should be within 60 min of hospital arrival. [Class 1; level of evidence A]

h. Repeat and document NIHSS every shift and with any change in condition for the non-thrombolytic patient. i. Admit to designated stroke bed. Admit to ICU, if thrombolytic was given – no exceptions. i. Nurse Swallow Screen done by RN prior to any oral intake	
6. **Acute Hemorrhagic Stroke Management** a. Physician to consult with neurology, as needed b. Consider Hemorrhagic stroke order set c. Consider transfer to higher level of care i. Physician to consult with consulting neurosurgeon for acceptance of patient to stroke tertiary center d. Anticoagulation/ Thrombolytics are contraindicated	Immediate – seek expert consultation Transfer to neurosurgical capable facility as soon as possible. Time Target: 120 min.
7. **Non-acute Stroke or Transient Ischemic Attack (TIA)** a. Initiation of stroke alert if LKWT is within 24 hrs b. Establish whether stroke is acute or non-acute c. If patient is not eligible for thrombolytics, document reason and proceed based upon physician's orders / clinical pathway	

Nursing Bedside Swallow Screening (see attachment A) – If the patient needs to receive food, fluids, or medications orally, whether in the ED or in-patient unit, the attached evidence-based tool shall be utilized to screen the patient's swallow. The Nurse Swallow Screen must be completed by the RN to identify swallowing difficulties and potential aspiration risk. The Nurse Swallow Screen is documented in the EHR. Keep patient NPO until the patient passes the nurse swallow screen, and/or is evaluated by the Speech Language Pathologist. The Nurse Swallow Screen does not replace the evaluation by a Speech Language Pathologist.

If the patient has passed the screen, and then has a change in condition, mental status worsens, or the patient exhibits signs of poor swallowing, the swallow screen process should be repeated.

REFERENCES:

- (2020) American Heart Association. Advanced Cardiovascular Life Support, provider manual.

- (2017) American Stroke Association. Impact of stroke (stroke statistics). Retrieved 7/6/17 from http://www.strokeassociation.org/STROKEORG/AboutStroke/Impact-of-Stroke-Stroke-statistics_UCM_310728_Article.jsp#.WW1NsxXythF.
- (2017) American Stroke Association. "Target: Stroke, Phase II." Retrieved 7/7/17 from http://www.strokeassociation.org/STROKEORG/Professionals/TargetStroke_UCM_314495_SubHomePage.jsp.
- (2019) Guidelines for the Early Management of Patients with Acute Ischemic Stroke: 2019 Update to the 2108 Guidelines for the Early Management of Acute Ischemic Stroke: A guidelines for healthcare professionals from the American Heart Association / American Stroke Association, *Stroke,* 2019;50:e344-e418. 55248F2D31984959BE25687599A4E3AA2
- Demaerschalk, B.M., Kleindorfer, D.O., and Adeoye, O.M. et al (2016). Scientific rationale for the inclusion and exclusion criteria for intravenous alteplase in acute ischemic stroke: A statement for healthcare professionals from the American heart association/american stroke association. *Stroke,*47, p. 1-61.
- (2024) The Joint Commission. Advanced disease-specific care certification requirements for primary stroke center. *Comprehensive Certification Manual for Disease-Specific Care,*PSC 1-48.
- Adapted from and Referenced: Lin, Y. T.; Yu, J. L.; Wang, W. H.; Sung, H. C.; Wang, Y. Y (2014) Nurses' performance of using a screening tool to screen swallowing functions among hospitalized patients with acute stroke. *International Journal of Evidence-Based Healthcare. September, 2014.* doi: 10.1097/01.XEB.0000455242.14367.85 & Massey, R & Jedlicka, D. (2002) The Massey Bedside Swallowing Screen. *Journal of Neuroscience Nursing, 34*(5), 252- 260

CROSS REFERENCE:

- Thrombolytic Therapy in Acute Ischemic Stroke Policy – Sierra View Medical Center

ATTACHMENT A: Swallow Screen Tool

SIERRA VIEW MEDICAL CENTER — NURSING SWALLOW SCREEN

DOES PATIENT HAVE ABDOMINAL FEEDING TUBE OR TRACHEOSTOMY PRESENT?

☐ Yes ☐ No **(If yes, stop screen, document result as Fail, make NPO, notify MD and request SLP)**

PART 1

Patient:

• Awake and alert 15 minutes	☐ Yes	☐ No
• Responds to speech and makes eye contact	☐ Yes	☐ No
• Able to be positioned upright with head control	☐ Yes	☐ No
• Face symmetrical, tongue protrusion midline	☐ Yes	☐ No
• Demonstrates rotary chewing motion	☐ Yes	☐ No

If answer is No to any of the questions above, go no further. Keep patient NPO and notify MD.

PART 2

Patient:

• Coughs when asked to	☐ Yes	☐ No
• Able to breathe freely and / or able to maintain SpO2	☐ Yes	☐ No
• Able to control saliva, can close lips	☐ Yes	☐ No
• Has a dry/clear sounding voice	☐ Yes	☐ No

If answer is No to any of the questions above, STOP, notify MD and obtain MD order for ST Swallow Evaluation.
If Yes, proceed to Water Swallow Screen.

PART 3

Instructions:

1) Sit patient up as close to 90 degrees as possible,

2) give a teaspoonful (5 mls) of water. MAKE SURE THE WATER IS SWALLOWED (total of 3 trials)

If any of the following identified:

• no attempt to swallow	☐ Yes	☐ No
• water leaks out of mouth	☐ Yes	☐ No
• coughing, choking or breathlessness	☐ Yes	☐ No
• wet / gurgly voice	☐ Yes	☐ No

–>–>–> Stop the screen, FAIL the patient, notify the MD for SLP referral order

Repeat 2nd and 3rd teaspoonful of water. If there are still NO PROBLEMS EVIDENT (from list above), give 2 oz (60 mls) of water.

If there is NO PROBLEM, notify physician for a diet order.
Make sure patient is **upright** and **supervised** when eating the **test meal**.

Nursing Bedside Swallow Screen Result:

Pass: ☐ Fail: ☐ (Notify MD and refer to SLP, if not notified above)

Adapted from and Referenced: **Lin, Y. T.; Yu, J. L.; Wang, W. H.; Sung, H. C.; Wang, Y. Y** (2014) Nurses' performance of using a screening tool to screen swallowing functions among hospitalized patients with acute stroke. *International Journal of Evidence-Based Healthcare*: September, 2014. doi: 10.1097/01.XEB.0000455242.14367.85. **Massey, R & Jedlicka, D.** (2002) The Massey Bedside Swallowing Screen. *Journal of Neuroscience Nursing, 34*(5), 252-260.

Date	Time	Evaluated by Signature	Title

SUBJECT: **TRANSFER OF PATIENT TO HIGHER LEVEL OF CARE**	SECTION: **Page 1 of 2**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To provide guidelines for a safe and timely transfer of the patient from the Ambulatory Surgery Department (ASD) to Sierra View Medical Center (SVMC) in the event of an emergency or unexpected length of recovery.

POLICY:

Patients treated at the ASD who require a higher level of care due to unexpected complications will be transferred to the Emergency Department of SVMC.

Patients who require an extended recovery past six hours will be transferred to SVMC for direct admission onto an inpatient unit under Outpatient Observation Status. The transfer order, along with nursing care orders, and an observation order will be entered into the electronic medical record (EMR) by the physician.

AFFECTED AREAS/PERSONNEL: *AMBULATORY SURGERY PERSONNEL AND MEDICAL STAFF*

PROCEDURE:

1. Emergency Transfer

    a. Immediately alert the nurse manager, surgeon, and anesthesia provider (if applicable) to the emergency situation or need to transfer.

    b. Dial 911 and advise of the need for emergency transport from the ASD to the Main Hospital. (Give facility address of 577 W. Putnam Ave.)

    c. Dial 784-8885 (SVMC Emergency Department) to notify staff of incoming patient and give appropriate report to expedite preparation for the patient.

    d. Event Reporting Management System notification required to report incident.

2. Non-Emergency Transfer:

    a. In the event of an unexpected extended length of recovery, the surgeon may deem it necessary to transfer the patient to SVMC for further evaluation. In accordance with the Medical Staff Bylaws, those surgeons with Ambulatory Surgery privileges will be required to have admitting privileges at SVMC, or must designate a Practitioner with SVMC admitting privileges in order to follow their patients to transfer the patient to SVMC under their care.

    b. The patient will be stabilized in the ASD Post-Anesthesia Care Unit (PACU) by the anesthesia provider or surgeon.

c. The surgeon will arrange for the hospital admission.

d. Transportation will be arranged through Ambulance Dispatch at 784-8500.

3. Nursing responsibilities: (Non-Emergency Transfer)

a. Notify patient's family if not already done by physician.

b. Provide patient information as necessary to Admission Staff.

c. Notify Ambulance Company of estimated time of transfer and monitoring equipment needed.

d. Give report and necessary documentation to ambulance personnel.

e. Assist ambulance personnel with transfer of patient if necessary.

f. Send all belongings with patient and/or family.

g. Call report to receiving nurse at SVMC.

h. Event Reporting Management System notification required to report incident.

REFERENCE:

- The Joint Commission (2023). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

CROSS REFERENCE:

- EMTALA - INTERFACILITY TRANSFERS, MSE, EMERGENCY CARE AND STABILIZATION

SUBJECT: **WATER PASS**	SECTION: **Page 1 of 1**

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

PURPOSE:

To provide fresh cold water to residents daily and as needed to maintain hydration.

POLICY:

It is the policy of this facility to provide residents with a clean water pitcher and cover, glass and fresh cold water on a daily basis and as needed, unless the resident is NPO, or on restricted fluids.

AFFECTED PERSONNEL/AREAS:

LICENSED NURSES, CNAs

PROCEDURE:

1. Establish a schedule to provide nursing with clean, disposable pitchers, covers and plastic cups.

2. Nursing will ensure that the clean pitcher liners are changed and filled with fresh water according to the schedule established.

3. Each resident (unless they are NPO) will be provided with a covered pitcher of fresh water and a clean cup daily. Pitchers and cups will be made available on resident's bedside stands or over bed tables.

4. All Nursing Assistants will offer water or fluids every 2 hours and assist those residents capable of PO intake to drink as needed (unless NPO). Then, the CNA will document in the appropriate area on PCS.

5. Nursing Assistants will replenish water throughout their shift as needed.

REFERENCES:

- Thomson Reuters (Revised April 1, 1990). Barclay's California Code of Regulations, §72315, San Francisco, California, Title 22

- Med Pass, Inc., (Updated February 6, 2015) Facility Guide to OBRA Regulations, 483.25 (j) United States of America, Med Pass Inc.

SIERRA VIEW MEDICAL CENTER

CONSENTIMIENTO INFORMADO PARA LA ADMINISTRACIÓN DE ANESTESIA

CERTIFICACIÓN DEL MÉDICO

Yo, el médico suscrito, por la presente certifico que he explicado al paciente o a la persona autorizada a dar consentimiento para el paciente, la naturaleza de la anestesia que se le va a administrar.

- ❑ Sedación intravenosa moderada
- ❑ Anestesia general
- ❑ Atención de anestesia monitorizada, posible anestesia general
- ❑ Anestesia espinal, posible anestesia general
- ❑ Anestesia regional, posible anestesia general
- ❑ Anestesia epidural, posible anestesia general
- ❑ Monitoreo invasivo: ❑ Línea arterial ❑ Línea central ❑ Swan Ganz

Además de asesorar sobre posibles tipos alternativos de anestesia, he explicado en términos sencillos los posibles riesgos, beneficios, alternativas, riesgos, complicaciones y consecuencias que están o pueden estar asociadas con la administración de anestesia, tratamiento(s) o procedimiento(s). El paciente o la persona autorizada para dar su consentimiento ha indicado su comprensión, ha consentido a su ejecución y ha declarado que se le explicó lo anterior.

Fecha: _____ Hora: _____ AM / PM Firma: _____
(proveedor de anestesia)

❑ Enfermero anestesista registrado certificado ❑ Anestesiólogo

Testigo telefónico de la discusión sobre el consentimiento informado entre el otorgante del consentimiento y el médico:

Fecha: _____ Hora: _____ AM / PM Testigo: _____
(firma del empleado)

Nombre: _____
(letra imprenta)

Entiendo que la anestesia local puede ser administrada por el cirujano o bajo su dirección en lugar del proveedor de anestesia.

Entiendo y doy mi consentimiento para la administración de anestesia, y;

He sido informado de ciertos riesgos, peligros, complicaciones y consecuencias que están asociados con la anestesia y procedimiento(s de anestesia, así como posibles modos alternativos de tratamiento, y no solicito información adicional. Soy consciente que la práctica de la anestesia y la cirugía no es una ciencia exacta y puede implicar riesgos calculados de complicaciones, lesiones o incluso consecuencia que pongan en peligro mi vida, tanto por causas conocidas como desconocidas. Reconozco que tengo derecho a estar informado si mi médico tiene alguna investigación médica independiente o intereses económicos relacionados con el desempeño del procedimiento propuesto.

Fecha: _____ Hora: _____ AM / PM Firma: _____
(paciente o representante legal)

Si firma otra persona que no sea el paciente, indique el nombre y la relación: _____

Fecha: _____ Hora: _____ AM / PM Testigo: _____
(firma)

Nombre: _____
(imprimir)

INTERPRETER'S STATEMENT

I have accurately and completely read the foregoing document to (patient or patient's legal representative) _____ in the patient's or legal representative's primary language _____ (identify language). He/she understood all of the terms and conditions and acknowledged his/her agreement by signing the document in my presence.

Date: _____ Time: _____ AM / PM

Signature: _____ Name: _____
(Interpreter, or remote interpreter's number) *(print)*

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257

INFORMED CONSENT TO THE ADMINISTRATION OF ANESTHESIA

Form # 014758 REV. 9/24

CHART - MEDICAL RECORD
SECOND SHEET - ANESTHESIOLOGIST

Sierra View Medical Center is a service of the Sierra View Local Health Care District.

PATIENT'S LABEL

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MINUTES OF A REGULAR MEETING OF THE
BOARD OF DIRECTORS OF
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The monthly **October 22, 2024 at 5:00 P.M.** in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California

Call to Order: Chairman REDDY called the meeting to order at 5:02 p.m.

Directors Present: **REDDY, LOMELI, MARTINEZ, KASHYAP**
Director Absent: PANDYA

Others Present: Donna Hefner, President/Chief Executive Officer, Melissa Mitchell, VP of Quality and Regulatory Affairs, Craig McDonald, Chief Financial Officer, Ron Wheaton, VP of Professional Services/Physician Recruitment, Terry Villareal, Executive Assistant and Clerk to the Board, Kim Pryor-DeShazo, Director of Marketing & Community Services, Dan Blazar, Patient Experience Officer, Silvia Roberts, Manager of Care Integration , Bryan Brassfield, Director of Pharmacy, Cindy Gomez, Compliance Privacy Officer, Lori Winston, M.D., Alex Reed-Krase, Legal Counsel, Harpreet Sandhu, Chief of Staff

I. Approval of Agenda:

Chairman REDDY motioned to approve the Agenda. The motion was moved by Director KASHYAP, seconded by, Vice Chairman LOMELI and carried to approve the agenda. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Absent
KASHYAP	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:02 p.m. to discuss the following items:

A. Pursuant to Evidence Code Section 1156 and 1157.7; Health and Safety Code Section 32106(b): Chief of Staff Report

B. Pursuant to Evidence Code Section 1156 and 1157.7:

1. Evaluation – Quality of Care/Peer Review/Credentials

2. Quality Division Update – Quality Report

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service and Strategic Planning (1 Item) Estimated Date of Disclosure – January 2025

Closed Session Items C,F,E and G were deferred to the conclusion of Open Session as there was not enough time for discussion prior to Open Session's scheduled start time.

III. Open Session: Chairman REDDY adjourned Closed Session at 5:34 p.m., reconvening in Open Session at 5:35 p.m.

Pursuant to Gov. Code Section 54957.1; Action(s) taken as a result of discussion(s) in Closed Session.

A. Chief of Staff Report provided by Chief of Staff Sandhu.
Information Only; No Action Taken.

B. Pursuant to Evidence Code Section 1156 and 1157.7:

1. Evaluation – Quality of Care/Peer Review/Credentials

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director KASHYAP, and carried to approve the Evaluation – Quality of Care/Peer Review/Credentials as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Absent
KASHYAP	Yes

2. Quality Division Update – Quality Report

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director MARTINEZ, and carried to approve the Quality Division Update – Quality Report as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Absent
KASHYAP	Yes

D. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning
Information Only; No Action Taken

IV. Public Comments

None

V. Consent Agenda

The Medical Staff Policies/Procedures/Protocols/Plans and Hospital Policies/Procedures/Protocols/Plans were presented for approval (Consent Agenda attached to the file copy of these Minutes). It was moved by Vice Chairman LOMELI, seconded by Director MARTINEZ, and carried to approve the Consent Agenda. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Absent
KASHYAP	Yes

Consent Agenda – Empower 403(b)

Item was pulled from Consent Agenda for review and discussion, it was moved by Vice Chairman LOMELI and seconded by Director MARTINEZ to approve the 403(b) Retirement Plan by Empower for Sierra View Local Health Care District.

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Absent
KASHYAP	Yes

Consent Agenda – Empower 403(b)

Additionally, it was moved by Vice Chairman LOMELI and seconded by Director MARTINEZ to give authority to CEO and CFO to sign and execute the 403(b) Retirement Plan by Empower for the District.

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Absent
KASHYAP	Yes

VI. Approval of Minutes:

A. Following review and discussion, it was moved by Vice Chairman LOMELI and seconded by Director MARTINEZ to approve the September 24, 2024 Regular Board Meeting Amended Minutes as presented. The motion carried and the vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Absent
KASHYAP	Yes

VII. Business Items

A. Moss Adams Single Audit Review

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director MARTINEZ and carried to approve the single audit review as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Absent
KASHYAP	Yes

B. Annual Graduate Medical Education Report

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director MARTINEZ and carried to approve the annual graduate medical education (GME) report as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Absent
KASHYAP	Yes

C. September 2024 Financials

Craig McDonald, CFO presented the Financials for September 2024. A copy of this presentation is attached to the file copy of these minutes.

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director MARTINEZ and carried to approve the September 2024 Financials as presented. The vote of the Board is as follows:

REDDY	Yes

LOMELI	Yes
MARTINEZ	Yes
PANDYA	Absent
KASHYAP	Yes

D. Resolution 10.22.2024/01 Appointing CFO, Craig McDonald to Treasurer of the Board

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director KASHYAP and carried to approve to appoint the CFO, Craig McDonald as the Treasurer of the Board. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Absent
KASHYAP	Yes

VIII. CEO Report

Donna Hefner, President/CEO provided a report of activities and happenings around Sierra View.

IX. Announcements:

A. Regular Board of Directors Meeting – October 22, 2024 at 5:00 p.m.

X. Closed Session: Board adjourned Open Session at 6:20 p.m., reconvening in Closed Session at 6:30 p.m. to discuss the following items.

C. Pursuant to Gov. Code Section 54956.9(d) (2), Conference with Legal Counsel about significant exposure to litigation involving a matter of compliance; privileged communication (1 Item).

F. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (1 Item). Estimated date of Disclosure: January 1, 2025

E. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (1 Item). Estimated date of Disclosure: September 1, 2026

G. Pursuant to Gov. Code Section 54956.9(d)(2), Conference with Legal Counsel about recent work product (b)(1) and (b)(3)(F): significant exposure to litigation; privileged communication (1 Item).

XI. Open Session: Chairman REDDY adjourned Closed Session at 6:37 p.m., reconvening in Open Session at 6:42 p.m.

Pursuant to Gov. Code Section 54957.1; Action(s) taken as a result of discussion(s) in Closed Session.

C. Conference with Legal Counsel: Anticipated Litigation

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director KASHYAP, and carried to reject claim for breach of contract. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Absent
KASHYAP	Yes

Additionally it was moved by Vice Chairman LOMELI, seconded by Director MARTINEZ, and carried to approve to send a notice of deficiency of claim for the claim of defamation. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Absent
KASHYAP	Yes

F. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning
Information Only: No Action Taken

E. Discussion Regarding Trade Secrets Pertaining to Service

Additionally it was moved by Vice Chairman LOMELI, seconded by Director KASHYAP, and carried to approve and direct leadership team to pursue acute care rehabilitation services. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Absent
KASHYAP	Yes

G. Conference with Legal Counsel
Information Only: No Action Taken

XII. Adjournment

The meeting was adjourned at 7:40 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: tv

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FINANCIAL PACKAGE
October 2024

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
October 2024

Statistic	Oct-24 Actual	Oct-24 Budget	Oct-24 Over/ (Under)	Oct-24 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 24 YTD	Increase/ (Decrease) 10/2023	% Change
Utilization											
SNF Patient Days											
Total	24	56	(32)	-57.3%	116	225	(109)	-48.4%	323	(207)	-64.1%
Medi-Cal	24	56	(32)	-57.1%	116	224	(108)	-48.2%	323	(207)	-64.1%
Sub-Acute Patient Days											
Total	1,025	970	55	5.7%	4,071	3,879	192	5.0%	3,772	299	7.9%
Medi-Cal	514	765	(251)	-32.9%	2,107	3,169	(1,062)	-33.5%	3,081	(974)	-31.6%
Acute Patient Days	1,630	1,648	(18)	-1.1%	6,308	6,590	(282)	-4.3%	6,730	(422)	-6.3%
Acute Discharges	463	427	36	8.5%	1,773	1,707	66	3.8%	1,762	11	0.6%
Medicare	177	168	9	5.5%	693	649	44	6.9%	669	24	3.6%
Medi-Cal	225	209	16	7.7%	850	839	11	1.3%	866	(16)	-1.8%
Contract	60	43	17	38.9%	217	203	14	6.8%	210	7	3.3%
Other	1	7	(6)	-85.8%	13	17	(4)	-21.5%	17	(4)	-23.5%
Average Length of Stay	3.52	3.86	(0.34)	-8.8%	3.56	3.86	(0.30)	-7.8%	3.82	(0.26)	-6.9%
Newborn Patient Days											
Medi-Cal	178	161	17	10.5%	639	636	3	0.5%	743	(104)	-14.0%
Other	33	31	2	6.0%	150	133	17	12.5%	143	7	4.9%
Total	211	192	19	9.8%	789	769	20	2.6%	886	(97)	-10.9%
Total Deliveries	107	99	8	8.1%	403	396	7	1.8%	438	(35)	-8.0%
Medi-Cal %	80.37%	83.43%	-3.06%	-3.7%	82.18%	83.43%	-1.25%	-1.5%	83.07%	-0.89%	-1.1%
Case Mix Index											
Medicare	1.5177	1.6368	(0.1191)	-7.3%	1.6051	1.6368	(0.0317)	-1.9%	1.5509	0.0542	3.5%
Medi-Cal	1.1886	1.1975	(0.0089)	-0.7%	1.1836	1.1975	(0.0139)	-1.2%	1.1579	0.0257	2.2%
Overall	1.2969	1.3724	(0.0755)	-5.5%	1.3468	1.3724	(0.0256)	-1.9%	1.3216	0.0252	1.9%
Ancillary Services											
Inpatient											
Surgery Minutes	7,152	8,224	(1,072)	-13.0%	31,182	32,896	(1,714)	-5.2%	33,665	(2,483)	-7.4%
Surgery Cases	87	94	(7)	-7.2%	367	375	(8)	-2.1%	380	(13)	-3.4%
Imaging Procedures	1,592	1,404	188	13.4%	5,883	5,617	266	4.7%	5,512	371	6.7%
Outpatient											
Surgery Minutes	12,816	12,775	41	0.3%	54,848	51,100	3,748	7.3%	53,282	1,566	2.9%
Surgery Cases	187	204	(17)	-8.2%	763	815	(52)	-6.4%	817	(54)	-6.6%
Endoscopy Procedures	184	192	(8)	-3.9%	741	766	(25)	-3.3%	829	(88)	-10.6%
Imaging Procedures	4,663	3,886	777	20.0%	16,522	15,543	979	6.3%	15,295	1,227	8.0%
MRI Procedures	298	302	(4)	-1.2%	1,217	1,207	10	0.9%	1,235	(18)	-1.5%
CT Procedures	1,276	1,237	39	3.2%	4,963	4,948	15	0.3%	5,171	(208)	-4.0%
Ultrasound Procedures	1,359	1,244	115	9.3%	5,404	4,975	429	8.6%	5,100	304	6.0%
Lab Tests	32,173	32,140	33	0.1%	127,276	128,561	(1,285)	-1.0%	128,609	(1,333)	-1.0%
Dialysis	4	6	(2)	-36.8%	10	25	(15)	-60.5%	8	2	25.0%

Sierra View Medical Center
Financial Statistics Summary Report
October 2024

	Oct-24				YTD					Increase/	
Statistic	Actual	Budget	Over/ (Under)	% Var.	Actual	Budget	Over/ (Under)	% Var.	Fiscal 24 YTD	(Decrease) 10/2023	% Change
Cancer Treatment Center											
Chemo Treatments	2,147	1,924	223	11.6%	8,614	7,695	919	11.9%	5,980	2,634	44.0%
Radiation Treatments	1,907	1,836	71	3.9%	7,823	7,343	480	6.5%	7,733	90	1.2%
Cardiac Cath Lab											
Cath Lab IP Procedures	18	11	7	60.0%	45	45	-	0.0%	50	(5)	-10.00%
Cath Lab OP Procedures	44	30	14	47.1%	142	120	22	18.7%	133	9	6.77%
Total Cardiac Cath Lab	62	41	21	50.6%	187	165	22	13.6%	183	4	2.19%
Outpatient Visits											
Emergency	3,423	3,415	8	0.2%	13,740	13,658	82	0.6%	13,694	46	0.3%
Total Outpatient	14,976	13,994	982	7.0%	56,854	55,977	877	1.6%	53,891	2,963	5.5%
Staffing											
Paid FTE's	867.05	855.00	12.05	1.4%	873.07	855.00	18.07	2.1%	851.97	21.10	2.5%
Productive FTE's	753.73	734.21	19.52	2.7%	741.45	734.21	7.24	1.0%	738.53	2.92	0.4%
Paid FTE's/AOB	5.05	4.98	0.06	1.3%	5.18	4.94	0.24	4.8%	4.99	0.19	3.9%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	11,386	10,552.20	834	7.9%	11,212	10,552	659	6.2%	10,520	692	6.6%
Cost/Adj.Patient Day	2,753	2,644	109	4.1%	2,740	2,641	99	3.8%	2,595.71	144	5.6%
Revenue/Adj. Discharge	52,749	53,065	(316)	-0.6%	52,832	53,065	(233)	-0.4%	51,835	997	1.9%
Cost/Adj. Discharge	12,755	13,296	(541)	-4.1%	12,912	13,279	(367)	-2.8%	12,790	122	1.0%
Adj. Discharge	1,150	1,057	92	8.7%	4,397	4,230	167	3.9%	4,262	135	3.2%
Net Op. Gain/(Loss) %	2.47%	-5.32%	7.79%	-146.5%	-2.43%	-5.32%	2.89%	-54.3%	-6.40%	3.97%	-62.0%
Net Op. Gain/(Loss) $	371,283	(709,693)	1,080,976	-152.3%	(1,346,967)	(2,765,304)	1,418,337	-51.3%	(3,280,880)	1,933,913	-58.9%
Gross Days in Accts Rec.	84.65	95.03	(10.37)	-10.9%	84.65	95.03	(10.37)	-10.9%	94.07	(9.41)	-10.0%
Net Days in Accts. Rec.	43.91	57.75	(13.84)	-24.0%	43.91	57.75	(13.84)	-24.0%	61.13	(17.22)	-28.2%

COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

	OCT 2024	SEP 2024
ASSETS		
CURRENT ASSETS:		
CASH & CASH EQUIVALENTS	$ 15,427,835	$ 13,003,907
SHORT-TERM INVESTMENTS	630,775	1,072,560
ASSETS LIMITED AS TO USE	2,336,009	1,858,542
PATIENT ACCOUNTS RECEIVABLE	160,859,869	171,559,318
LESS UNCOLLECTIBLES	(23,019,350)	(22,899,094)
CONTRACTUAL ALLOWANCES	(118,552,812)	(126,999,294)
OTHER RECEIVABLES	23,907,325	23,047,401
INVENTORIES	4,360,181	4,361,557
PREPAID EXPENSES AND DEPOSITS	3,165,715	2,451,985
LEASE RECEIVABLE - CURRENT	339,208	314,237
TOTAL CURRENT ASSETS	69,454,755	67,771,117
ASSETS LIMITED AS TO USE, LESS CURRENT REQUIREMENTS	31,566,256	31,472,462
LONG-TERM INVESTMENTS	133,999,478	133,891,008
PROPERTY, PLANT AND EQUIPMENT, NET	75,140,852	75,653,158
INTANGIBLE RIGHT OF USE ASSETS	375,340	387,341
SBITA RIGHT OF USE ASSETS	2,219,111	2,349,279
LEASE RECEIVABLE - LT	1,028,220	901,631
OTHER INVESTMENTS	250,000	250,000
PREPAID LOSS ON BONDS	1,426,614	1,447,593
TOTAL ASSETS	$ 315,460,626	$ 314,123,590

COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

	OCT 2024	SEP 2024
LIABILITIES AND FUND BALANCE		
CURRENT LIABILITIES:		
BOND INTEREST PAYABLE	$ 462,350	$ 346,763
CURRENT MATURITIES OF BONDS PAYABLE	4,235,000	4,235,000
CURRENT MATURITIES OF LONG TERM DEBT	1,804,611	1,888,832
ACCOUNTS PAYABLE AND ACCRUED EXPENSES	5,078,539	4,271,665
ACCRUED PAYROLL AND RELATED COSTS	7,446,283	7,147,980
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	3,494,136	3,524,136
LEASE LIABILITY - CURRENT	141,812	141,812
SBITA LIABILITY - CURRENT	1,043,842	1,110,658
TOTAL CURRENT LIABILITIES	23,706,573	22,666,846
SELF-INSURANCE RESERVES	2,197,657	2,191,729
BONDS PAYABLE, LESS CURR REQT	33,275,000	33,275,000
BOND PREMIUM LIABILITY - LT	2,494,233	2,546,190
LEASE LIABILITY - LT	256,173	267,849
SBITA LIABILITY - LT	1,365,620	1,435,230
DEFERRED INFLOW - LEASES	1,295,874	1,145,013
TOTAL LIABILITIES	64,591,129	63,527,856
UNRESTRICTED FUND	248,385,511	248,385,511
PROFIT OR (LOSS)	2,483,986	2,210,223
TOTAL LIABILITIES AND FUND BALANCE	$ 315,460,626	$ 314,123,590

COMBINED INCOME STATEMENT FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

OCT 2024 ACTUAL	OCT 2024 BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE		Y-T-D ACTUAL	Y-T-D BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE
				***** OPERATING REVENUE *****				
5,436,256	5,253,784	(182,472)	4%	INPATIENT - NURSING	20,861,445	21,015,136	153,691	(1)%
19,026,202	17,396,290	(1,629,912)	9%	INPATIENT - ANCILLARY	73,008,275	69,585,162	(3,423,113)	5%
24,462,458	22,650,074	(1,812,384)	8%	TOTAL INPATIENT REVENUE	93,869,720	90,600,298	(3,269,422)	4%
36,175,790	33,463,072	(2,712,718)	8%	OUTPATIENT - ANCILLARY	138,409,176	133,852,287	(4,556,889)	3%
60,638,248	56,113,146	(4,525,102)	8%	TOTAL PATIENT REVENUE	232,278,896	224,452,585	(7,826,311)	4%
				DEDUCTIONS FROM REVENUE				
(18,259,440)	(18,243,309)	16,131	0%	MEDICARE	(70,095,030)	(72,973,236)	(2,878,207)	(4)%
(16,024,177)	(18,032,202)	(2,008,025)	(11)%	MEDI-CAL	(67,689,189)	(72,128,808)	(4,439,620)	(6)%
(4,863,739)	(6,660,852)	(1,797,113)	(27)%	OTHER/CHARITY	(27,949,095)	(26,643,408)	1,305,687	5%
(6,635,113)	(9,556)	6,625,557	69,334%	DISCOUNTS & ALLOWANCES	(12,137,478)	(38,224)	12,099,254	31,654%
(338,690)	(499,610)	(160,920)	(32)%	BAD DEBTS	(1,229,198)	(1,998,440)	(769,242)	(39)%
(46,121,159)	(43,445,529)	2,675,630	6%	TOTAL DEDUCTIONS	(179,099,989)	(173,782,116)	5,317,873	3%
14,517,089	12,667,617	(1,849,472)	15%	NET SERVICE REVENUE	53,178,907	50,670,469	(2,508,438)	5%
516,878	682,482	165,604	(24)%	OTHER OPERATING REVENUE	2,240,278	2,729,928	489,650	(18)%
15,033,966	13,350,099	(1,683,867)	13%	TOTAL OPERATING REVENUE	55,419,185	53,400,397	(2,018,788)	4%
				***** OPERATING EXPENSE *****				
5,726,409	5,584,236	142,173	3%	SALARIES	22,773,007	22,193,206	579,801	3%
647,780	680,797	(33,017)	(5)%	S&W PTO	2,358,696	2,705,102	(346,407)	(13)%
1,454,086	1,461,565	(7,479)	(1)%	EMPLOYEE BENEFITS	5,784,758	5,868,381	(83,624)	(1)%
1,631,466	1,424,318	207,148	15%	PROFESSIONAL FEES	6,103,563	5,695,977	407,586	7%
936,556	823,196	113,360	14%	PURCHASED SERVICES	3,316,929	3,365,739	(48,810)	(2)%
2,320,606	2,028,210	292,396	14%	SUPPLIES & EXPENSES	8,386,501	8,131,499	255,002	3%
240,451	265,797	(25,346)	(10)%	MAINTENANCE & REPAIRS	983,130	1,102,874	(119,744)	(11)%
300,037	277,064	22,973	8%	UTILITIES	1,337,900	1,108,256	229,644	21%
36,940	19,605	17,335	88%	RENT/LEASE	133,821	78,417	55,404	71%
91,049	121,228	(30,179)	(25)%	INSURANCE	480,280	484,912	(4,632)	(1)%
941,027	1,019,404	(78,377)	(8)%	DEPRECIATION/AMORTIZATION	3,854,775	4,115,234	(260,459)	(6)%
336,278	354,372	(18,094)	(5)%	OTHER EXPENSE	1,252,794	1,316,104	(63,310)	(5)%
0	0	0	0%	IMPAIRED COSTS	0	0	0	0%
14,662,683	14,059,792	602,891	4%	TOTAL OPERATING EXPENSE	56,766,152	56,165,701	600,451	1%
371,284	(709,693)	(1,080,977)	(152)%	NET GAIN/(LOSS) FROM OPERATIONS	(1,346,967)	(2,765,304)	(1,418,337)	(51)%
138,253	138,253	0	0%	DISTRICT TAXES	553,012	553,012	0	0%
385,022	343,454	(41,568)	12%	INVESTMENTS INCOME	1,572,625	1,373,817	(198,808)	15%
55,690	54,011	(1,679)	3%	OTHER NON OPERATING INCOME	203,087	216,042	12,956	(6)%
(75,941)	(80,574)	(4,633)	(6)%	INTEREST EXPENSE	(308,745)	(322,293)	(13,548)	(4)%
(64,356)	(36,953)	27,403	74%	NON-OPERATING EXPENSE	(172,918)	(147,812)	25,106	17%
438,668	418,191	(20,477)	5%	TOTAL NON-OPERATING INCOME	1,847,061	1,672,766	(174,295)	10%
809,952	(291,502)	(1,101,454)	(378)%	GAIN/(LOSS) BEFORE NET INCR/(DECR) FV INVSMT	500,094	(1,092,538)	(1,592,632)	(146)%
(536,188)	100,000	636,188	(636)%	NET INCR/(DECR) IN THE FAIR VALUE OF INVSTMT	1,983,892	400,000	(1,583,892)	396%
273,763	(191,502)	(465,265)	(243)%	NET GAIN/(LOSS)	2,483,986	(692,538)	(3,176,524)	(459)%

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
10/31/24

	CURRENT MONTH	YEAR TO DATE
Cash flows from operating activities:		
Operating Income/(Loss)	371,284	(1,346,967)
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation and amortization	941,027	3,854,775
Provision for bad debts	120,256	(526,925)
Change in assets and liabilities:		
Patient accounts receivable, net	2,252,967	5,054,212
Other receivables	(859,924)	(5,657,142)
Inventories	1,376	(69,529)
Prepaid expenses and deposits	(713,730)	(844,311)
Advance refunding of bonds payable, net	20,979	83,918
Accounts payable and accrued expenses	806,874	(1,245,053)
Deferred inflows - leases	150,861	71,958
Accrued payroll and related costs	298,303	(1,113,536)
Estimated third-party payor settlements	(30,000)	(162,809)
Self-insurance reserves	5,928	8,657
Total adjustments	2,994,917	(545,785)
Net cash provided by (used in) operating activities	3,366,201	(1,892,752)
Cash flows from noncapital financing activities:		
District tax revenues	138,253	553,012
Noncapital grants and contributions, net of other expenses	(19,234)	(16,738)
Net cash provided by (used in) noncapital financing activities	119,019	536,274
Cash flows from capital and related financing activities:		
Purchase of capital assets	(416,720)	(1,133,100)
Proceeds from lease receivable, net	(151,560)	(74,537)
Principal payments on debt borrowings	-	(4,055,000)
Interest payments	(1,744)	(791,016)
Net change in notes payable and lease liability	(102,155)	(402,175)
Net changes in assets limited as to use	(571,262)	2,531,878
Net cash provided by (used in) capital and related financing activities	(1,243,441)	(3,923,950)
Cash flows from investing activities:		
Net (purchase) or sale of investments	(644,658)	(3,280,225)
Investment income	385,022	1,572,625
Net cash provided by (used in) investing activities	(259,636)	(1,707,600)
Net increase (decrease) in cash and cash equivalents:	1,982,143	(6,988,028)
Cash and cash equivalents at beginning of month/year	14,076,467	23,046,638
Cash and cash equivalents at end of month	16,058,610	16,058,610

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
October 2024

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
Nov-23	11,048,937	5,395,178	16,444,115
Dec-23	9,261,593	1,749,227	11,010,820
Jan-24	12,040,509	3,417,973	15,458,481
Feb-24	10,531,309	1,474,392	12,005,701
Mar-24	11,275,398	3,178,205	14,453,603
Apr-24	13,314,378	6,920,700	20,235,078
May-24	11,564,879	10,488,610	22,053,489
Jun-24	10,598,225	7,664,994	18,263,219
Jul-24	13,499,837	278,849	13,778,686
Aug-24	10,684,807	298,095	10,982,902
Sep-24	12,800,001	1,611,606	14,411,607
Oct-24	**14,933,404**	**1,420,062**	**16,353,466**

NOTE:

Cash receipts in "Other Activity" include the following:

- Other Operating Revenues - Receipts for Café, rebates, refunds, and miscellaneous funding sources

- Non-Operating Revenues - rental income, property tax revenues

- Medi-Cal OP Supplemental and DSH Funds
- Medi-Cal and Medi-Care Tentative Cost Settlements
- Grants, IGT, HQAF, & QIP Supplemental Funds
- Medicare interim payments

October 2024 Summary of Other Activity:

44,219	Beta Healthcare Group Dividend 1st Installment
882,601	M-Cal IP DSH 07/24 - 09/24
249,900	M-Care interim payments
243,342	Miscellaneous
1,420,062	10/24 Total Other Activity