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

AGENDA
August 27, 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. As a courtesy, this month the public meeting will be broadcast over zoom. Public comments must be made in person as the broadcast will not allow participation. To observe the meeting, use the following link:
https://svmc.zoom.us/j/84915342299

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

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
BOARD OF DIRECTORS AGENDA
August 27, 2024

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): Compliance Report Quarter 4

C. Conference with Sierra View Local Health Care District Real Property Negotiator to give instructions regarding price and sale terms pursuant to Cal. Gov. Code § 54956.8. Property: 633, 663, and 643 N. Westwood Street, Porterville, CA 93257. Sierra View Local Health Care District Hospital Negotiator: Ron Wheaton. Prospective Purchaser: Chris Mano negotiating on behalf of the Burton School District or any other interested parties.

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning

E. 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. Compliance Report – Quarter 4
Recommended Action: Approve/Disapprove Report as Given

C. Conference with Legal Counsel Re: Real Property Negotiations
Recommended Action: Action to be taken at the discretion of the Board

D. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning
Recommended Action: Information Only: No Action Taken

E. 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. **July 23, 2024 Minutes of the Regular Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove July 23, 2024 Minutes of the Regular Meeting of the Board of Directors

B. **August 10, 2024 Minutes of the Special Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove August 10, 2024 Minutes of the Special Meeting of the Board of Directors

IX. Business Items

A. **Biannual Sierra View Foundation Report**
Recommended Action: Information only: no action taken

B. **July 2024 Financials**
Recommended Action: Approve/Disapprove July 2024 Financials

C. **Capital Budget Report Quarter 4**
Recommended Action: Approve/Disapprove Capital Budget Report Q4

D. **Investment Report Quarter 4**
Recommended Action: Approve/Disapprove Investment Report Q4

X. CEO Report

XI. Announcements:

A. Regular Board of Directors Meeting – September 24, 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	8/27/2024
Board of Director's Approval	
Bindusagar Reddy, MD, Chairman	8/27/2024

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
August 27, 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 ↓
• Catering Services	1-2	
Plans:		
• Emergency Operations Plan	3-19	
• Hazardous Materials and Waste Management Plan	20-31	
• Life Safety Management Plan	32-41	
• Medical Equipment Management Plan	42-52	
• Utility Systems Management Plan	53-63	
Reports:		
• Human Resources Report Quarter 2	64-88	
• Marketing Report Quarter 2	89-114	

SUBJECT: **CATERING SERVICES**	SECTION: **Page 1 of 2**

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

PURPOSE:

Catering services are provided for meetings and special events at Sierra View Medical Center (SVMC).

POLICY:

1. Catering will be provided in support of the Board of Director's meetings, administration and special events approved by administration *(town hall, benefits fair, etc.)*. Physicians may be provided a pre-plated meal when attending meetings during their meal period. A banquet style setup may be provided for meetings such as General Medical Staff Meeting, Medical Executive Committee, Tumor Board, Cancer Support Group, Weekly Physician's Mingler and physician's office staff training.

2. It is the requesting party's responsibility to reserve the conference room for their catered event. SVMC conference rooms may be reserved through Microsoft Outlook.

2.1. All caterings provided by Food & Nutrition Services Department must be on the hospital campus.

3. Catering expenses for events are tracked utilizing the catering FormStack request form.

4. Catering requests will be received no less than 7 days prior to the event. Requests for events with attendance of 50 or more will be received 30 days in advance. Short notice requests may be directed to the Café for meal compensation.

5. Linen will only be utilized for hospital approved events. Linen will not be used for department planned events *(Christmas parties, pot lucks, birthday parties, etc.)*.

6. Catering requests from outside vendors or community groups for hospital events must be approved by administration.

AFFECTED PERSONNEL/AREAS: *ALL DEPARTMENTS*

PROCEDURE:

1. Catered events will be requested and processed using the catering FormStack on SVMC's intranet. The catering request form is located on the front page of the SVMC intranet, under "Service Requests".

2. If a change occurs (i.e., meeting cancelled, the number of individuals attending changes, room changes, etc.), it is the responsibility of the requesting party to notify the Food and Nutrition Services (FNS) Department immediately at extension 4758.

3. Catering menus will be determined by the FNS Department.

4. If the catering event concludes early, FNS will be notified at extension 4758 for cleanup.

5. To prevent food poisoning incidents, loss of catering equipment, and to meet health department and federal government food guidelines for hazard analysis critical control points (HACCP), left-over food, supplies and equipment will **not** be removed from the catering location.

REFERENCES:

- Human and Health Service Agency, Tulare County Environmental Health Department. Retrieved from https://tularecountyeh.org/eh/.

- Hazard Analysis Critical Control Point (HACCP). Retrieved from https://www.fda.gov/food/guidance-regulation-food-and-dietary-supplements/hazard-analysis-critical-control-point-haccp.

SUBJECT: **EMERGENCY OPERATIONS PLAN**	SECTION: ***Emergency Management Program*** **Page 1 of 17**

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

SCOPE OF SERVICES:

The scope of Sierra View Medical Center (SMVC)'s Emergency Operations Plan is to provide for a program that ensures effective mitigation, preparation, response and recovery to disasters or emergencies affecting the environment of care. This hospital has developed an "all hazards" approach that supports a level of preparedness sufficient to address a wide range of emergencies regardless of cause. The program is applied to Sierra View Medical Center, Distinct Part Skilled Nursing Facility, Cancer Treatment Center, Ambulatory Surgical Department, Wound Healing Center, Urology Clinic, Sierra View Community Health Clinic, Clinical Lab, Surgery Clinic and Medical Office Building of Sierra View Medical Center. The Emergency Operations Plan (EOP) and associated Emergency Management Program extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care, business occupancies and temporary alternate care sites of Sierra View Medical Center. The plan also affects all staff, volunteers, contract staff, medical staff and associates, including contracted services of Sierra View Medical Center.

OBJECTIVES:

- Six (6) critical areas of emergency response shall be managed in order to assess the hospital's needs and prepare personnel to respond to incidents. The six critical areas are:
  - Communication
  - Resources and assets
  - Safety and security
  - Personnel responsibilities
  - Utilities management
  - Patient clinical and support activities
- The objective of the Emergency Operations Plan is to effectively prepare for, manage an emergency, and restore the facility to the same operational capabilities as pre-emergency levels, to include the following:
  - Identify procedures to prepare and respond to potential disasters or emergencies
  - Provide education to personnel on the elements of the Emergency Operations Plan
  - Establish and implement procedures in response to an assortment of disasters and emergencies
  - Identify alternate sources for supplies and services in the event of a disaster or emergency through establishing mutual-aid agreements with neighboring hospitals and/or healthcare

systems; public health departments; hazardous materials response teams; local fire department; local police departments; area pharmacies; medical supply vendors

- Identify recovery strategies and actions to be activated in the event of a disaster or emergency

GOAL:

Coordinate with Tulare County Emergency Services to perform a community wide drill.

RESPONSIBILITY:

- The Safety Officer, in conjunction with the Safety Committee, is responsible for developing, implementing and monitoring all aspects of the Emergency Operations Plan, including hazard vulnerability analysis, mitigation, preparedness, response and recovery.
  - The Safety Officer shall also track National Incident Management System (NIMS) implementation.
  - It is understood that the Safety Officer has a working knowledge of emergency management, hospital operations (daily operations and emergency operations) and the Hospital Incident Command Center operations.
- Hospital leaders, as well as medical personnel, shall actively participate in the organization's Emergency Operations Plan.
- The Emergency Operations Plan shall be developed in coordination with community agencies.
  - The Hospital shall communicate its needs and vulnerabilities to community emergency response agencies, and identify the capabilities of the community in meeting the needs of the hospital.

SPECIFIC PROCEDURES IN RESPONSE TO A VARIETY OF EMERGENCIES BASED ON A HAZARD VULNERABILITY ANALYSIS PERFORMED BY THIS HOSPITAL:

- The Hospital has developed specific procedures in response to potential disasters and emergencies that may occur. Additionally, the Hospital will perform routine Hazard Vulnerability Analysis (HVA) to identify areas of vulnerability and undertake provisions to lessen the severity and/or impact of a disaster or emergency that could affect the services provided by the Hospital.
- The HVA is evaluated on an annual basis and input from the local fire department and community agencies will be obtained to assure that the Hospital is aware of hazards in the community to which an emergency response may be required.
- This hospital has developed a Utilities Disruption Matrix designed to provide available operational hours prior to departmental shut down or commencing of evacuation procedures. The Utilities

Disruption Matrix is based on the hospital being self-sufficient for up to 96 hours without the assistance of external resources.

- For each emergency identified in the hospital's HVA, the following shall be defined:
  - Mitigation activities that are designed to reduce the risk of and potential damage due to an emergency
  - Preparedness activities that organize and mobilize essential resources
  - Response strategies and actions to be activated during the emergency
  - Recovery strategies/actions that will help to restore the systems that are critical to resuming normal operations of the Hospital
  - A documented inventory of assets and resources on-site that are needed during an emergency. At a minimum, this inventory should include:
    - Personal Protective Equipment (PPE)
    - Water
    - Fuel
    - Staffing
    - Linen
    - Cleaning Supplies
    - Food
    - Medical and surgical resources
    - Pharmaceutical resources
  - The inventory of assets and resources shall be evaluated on an annual basis or as needed
  - Methods shall be in place for the monitoring of the inventory of assets and resources during an emergency

    See Hazard Vulnerability Analysis (HVA) Policy / Utilities Disruption Matrix

DEFINE AND INTEGRATE THE FACILITY'S ROLE WITH THE COMMUNITYWIDE EMERGENCY OPERATIONS EFFORTS TO PROMOTE INTEROPERABILITY BETWEEN THE FACILITY AND THE COMMUNITY:

- The Emergency Operations Plan shall be tested. Exercises shall be developed based on the Hospital's HVA. Exercises should validate the effectiveness of the Emergency Operations Plan and identify opportunities to improve.
- The Emergency Operations Plan shall be tested a minimum two (2) times per year, either in response to an actual emergency or in a planned exercise.
- One (1) exercise per year shall include an influx of volunteer or simulated patients.
- At least one (1) exercise per year shall be evaluated to see how effectively the Hospital performs when the Hospital cannot be supported by the local community for up to 96 hours. (Tabletop sessions are acceptable to meet the community portion of this exercise.)
- If applicable, the Hospital will participate in at least one (1) community-wide drill annually that is relevant to the priority of emergencies identified in the hazard vulnerability analysis. (Tabletop sessions are acceptable to meet the community portion of this exercise.)
- The Manager of the Environment of Care is identified as the designee whose sole responsibility during emergency response exercises is to monitor performance and document opportunities for improvement.
- The Hospital cooperates with all local, county and state emergency management drills. The Safety Officer is a member of the countywide emergency management system and coordinates with other agencies any large scale drills. Tulare County Department of Public Health & Human Services Agency/Emergency Medical Services (EMS) and statewide disaster planning efforts coordinate with local police, fire and ambulance services in conjunction with the acute care facilities.

  See Emergency Operations Plan - Hospital Incident Command System Responsibilities Job Checklists, Hospital Command Center Policy and Emergency Management Evaluation Policy.

COMMAND STRUCTURE:

The command structure utilized by this facility in coordination with the community-wide command structure is the Hospital Incident Command System (HICS).

INITIATING THE PLAN, INCLUDING DESCRIPTION OF PLAN ACTIVATION:

The plan will be initiated when it has been determined that a disaster or emergency has occurred or has the potential for occurring.

Definition of Emergency:

- The Joint Commission's definition of an emergency is *"a natural or man-made event that significantly disrupts the environment of care; that significantly disrupts care and treatment; or that results in sudden, significantly changed or increased demands for the organization's services. Some emergencies are called 'disasters' or 'potential injury-creating events'."*

When the facility is notified of an emergency, the person receiving notification will immediately notify the Chief Executive Officer or his/her designee of the situation, whether it be an internal or external emergency. The Nursing House Supervisor will respond to the site of an internal emergency and report back to the Chief Executive Officer, or his/her designee, the status of the situation. The Chief Executive Officer or his/her designee will evaluate the emergency to determine whether the Emergency Operations Plan will be activated. If the plan is to be activated, the Chief Executive Officer or his/her designee will notify the Switchboard Operator to call "Triage Code 1" (Internal) or "Triage Code 2" (External).

The Chief Executive Officer or appointed designee will assume responsibility of the Hospital Incident Command Center and activate the appropriate positions noted on the Incident Management Team Chart as deemed necessary for the occurrence.

- Until the Incident Command System is in place, the Chief Executive Officer or his/her designee will determine if the Labor Pool will be opened depending on the size of the emergency. If the Labor Pool is not opened, the House Supervisor may assign additional help to the Emergency Area as needed. Additional personnel will be called in as needed via the staff callback system.

- The House Nursing Supervisor will notify additional outside agencies that may need to assist the hospital in the event of an internal emergency. (i.e. fire department, police department or other agencies).

The recovery phase will be initiated after the emergency is over and the Engineering Department has evaluated the facility. The recovery phase of the plan is to be initiated by the Chief Executive Officer or his/her designee.

COMMUNICATION:

Notification of External Authorities:

- The Hospital shall have a communications system in place, including two-way radio equipment and operators who are familiar with the equipment's operation.

- The hospital will provide for alternate communication methods in the event of a failure. Two-way radio equipment and cell phones shall be available in the event of an emergency. In the event that cell phones are not working, microwave communications satellite phones, ham radios or portable 800 MHz radios may be used.

- The Security/Branch Director will approve media access to the facility, with only the appointed Public Information Officer interacting with the media.

  A medical record system will be used to meet the minimum requirements of emergency management operations.

  See Disaster Communications Policy – Emergency Operations Policy Procedure Manual

PERSONNEL RESPONSIBILITIES:

Notification of Personnel When Emergency Operations Plan is initiated:

- In an emergency which is so widespread to be considered an emergency and/or involving mass casualties, all hospital personnel, regardless of position, are expected to report to the hospital for duty as soon as it is feasible to travel. Each department director maintains a current callback list of all personnel. Once the Emergency Operations Plan has been activated, the department director in cooperation with Human Resources will assign a staff member to initiate the callback list.

- In the event that there are excess personnel, the Hospital Command Center will communicate with department directors regarding rescheduling of personnel for future needs. The medical staff will report to the Chief of Medical Staff or Medical Specialist Officer for assignments.

  See Hospital Incident Command System Responsibilities Job Checklists.

Alternate Roles and Responsibilities of Personnel During Emergencies:

- Personnel may not be assigned to their regular duties. Personnel will be asked to perform various jobs, which will be considered vital to the effective operation of the hospital. Personnel will be assigned duties based on the needs of the hospital. If personnel are not needed in their usual units/departments, they will be sent to the Labor Pool for assignment.

See Hospital Incident Command System Responsibilities Job Checklists and Labor Pool Policy

Identification of Personnel in Emergencies:

- Personnel on duty during activation of the Emergency Operations Plan will be identified by picture identification nametag, which is to be worn at all times by all personnel while on duty.

- Only persons wearing proper identification or possessing valid credentials shall be allowed entrance into the hospital during an emergency.

Personnel Activities and Support:

- The Hospital has made provisions for staff support that can be implemented in the event of a community-wide emergency. Such provisions may include, but not limited to:
  - Temporary housing/lodging needs
  - Transportation needs
  - Family support needs, as necessary (including short term child care)
  - Incident stress debriefing and counseling

Orientation and Training:

- Personnel will attend orientation upon hire and annually thereafter, reviewing their specific roles and responsibilities during an emergency/disaster.
- In-service education will be given to specific staff on the backup communication system and obtaining supplies/equipment in the event of an emergency/disaster.
- The Safety Officer or designee is responsible for in-servicing personnel to the hospital wide Emergency Operations Plan.
- The department directors are responsible for in servicing department personnel on the department specific responsibilities during an emergency/disaster.

EMERGENCY CREDENTIALING OF CAREGIVERS:

- To provide a mechanism for emergency credentialing and granting of privileges to volunteer/non-staff licensed independent practitioners in the event of a disaster.

The Chief Executive Officer or Chief of Staff or their designee(s) may grant emergency privileges upon presentation of a valid picture ID (issued by a state, federal, or regulatory agency) e.g., driver's license or passport, and at least one of the following:

- A current license to practice or primary source verification of the license.
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT).
- Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state or municipal entity.

- Presentation by current hospital or medical staff member(s) with personal knowledge regarding practitioner's identity.

Verification of Information:

- Verification of the required information shall be done by the Medical Staff Office or designee as soon as feasible. A record of this information will be retained in the Medical Staff Office.

Conditions of Emergency Privileges:

- The emergency designee must practice under the direction and supervision of an existing member of the Sierra View Medical Center Medical Staff.

  See Emergency / Disaster Credentialing & Privileging Of Non-Staff Practitioners and Allied Professionals – Medical Staff Policy & Procedure Manual.

  Authorization for Volunteer Caregivers During Disasters – Emergency Operations Procedure Manual – Response & Assignment of Staff

RESOURCES AND ASSETS:

- The Hospital keeps a documented inventory of assets it has on site that would be needed in the event of an emergency or disaster. At a minimum, the inventory should include:
  - Linen
  - Cleaning supplies
  - Personal protective equipment
  - Water
  - Food
  - Fuel
  - Staffing
  - Medical resources and assets
  - Surgical resources and assets
  - Pharmaceutical resources and assets

- Methods are established to monitor quantities of assets and resources during an emergency or disaster.
- Arrange for emergency/disaster supporting services to be performed by local businesses, utility companies, government agencies and individuals. Emergency/disaster supporting services may include:
  - Transportation
  - Communications
  - Traffic control
  - Food supplies
  - Utility maintenance
  - Medical supplies
- These arrangements must be coordinated with the assistance of the Safety Officer, Tulare County Department of Public Health, or the local Emergency Management Agency Director, whenever possible.
- The hospital shall estimate its emergency needs for each kind of support and, when feasible, arrange to have supporting supplies, equipment and manpower pre-designated for hospital use.
- Essential supplies, pharmaceuticals, medical supplies, equipment, food, water, linen, cleaning supplies and utilities shall be provided to meet shelter requirements for up to 96 hours when the hospital cannot be supported by the community. Procedures are in place for the procurement of additional supplies in an emergency.
- In the event that the hospital cannot be supported by the local community for at least 96 hours, the Chief Executive Officer/Incident Commander, Incident Command staff, in consultation with community leaders, will evaluate the following options and implement those options that best serve the hospital and community:
  - Conservation of resources
  - Curtailment of services
  - Supplementing of resources from outside of the local community
  - Staged evacuation

- Total evacuation

See Emergency Management - Bed Space Availability Form, Emergency Water Supply Policy, Equipment and Supplies - Emergency Management Policy.

SAFETY AND SECURITY:

- Efficient traffic flow must be established:
  - Prepare floor plans which designate areas for specific patient care functions and ensure that personnel are familiar with these plans
  - Prepare and have available traffic control tools to show external and internal routing of casualties and other traffic
  - Assign and train volunteers to perform traffic control and security functions
- At the time the Emergency Operations Plan is activated, the Security Department personnel on duty will be responsible for locking all exits and entrances with the exception of the ambulance entrance. The security staff shall maintain control of entry and egress from the facility. Personnel of the hospital are required to wear badges identifying them as personnel. Only persons with proper identification shall be admitted to the hospital during an emergency.

  See Disaster Response Security Policy – Emergency Operations Procedure Manual

- Radioactive or Chemical Isolation and Decontamination:
  - There is a designated decontamination room with a separate ventilation system or ventilation shutoff available for radioactive or chemical isolation and decontamination. Personnel are trained in the response to radiological, biological, chemical or hazardous material contamination.
  - Arrange with a local or State Emergency Management Agency Director (if applicable) for the training of hospital personnel who would perform the radiological monitoring of casualties and hospital areas and the acquisition of necessary radiological monitoring equipment. This equipment shall be stored in the hospital as a part of its essential emergency supply equipment.

    See Contamination With Radioactive Materials Policy – Emergency Operations Procedure Manual

UTILITIES MANAGEMENT:

- The hospital will provide for alternative sources of essential utilities, including:
  - An emergency source of electrical power capable of operating all essential electrical equipment and a plan for failure of back-up generators

- An alternate source of safe water
- An alternate source for medical gas and vacuum delivery
- An alternate means of waste disposal in the event of sewage system failure
- Sufficient fuel to last for at least 96 hours of expanded operation

See Disruption of Services Procedure Policy, Disruption of Hospital Services Notification Policy,. See additional policies in the Utilities Management subsection.

PATIENT CLINICAL AND SUPPORT ACTIVITIES:

- Management of Patients During Emergencies (i.e., Scheduling, Modification or Discontinuation of Services, Control of Patient Information and Patient Transportation):
  - Upon activation of the Emergency Operations Plan, normal admission requirements will be modified. Initially, admissions to the hospital will be limited to those whose survival depends upon services obtainable only through hospital bed care.
  - Outpatient care will be restricted to those whose lives may ultimately depend upon the present expenditure of medical supplies and health manpower time.

All elective admissions and procedures will be canceled, including elective surgery, non-emergent outpatient procedures and transferring patients who are stable to be discharged.

- Patients may be transferred to other facilities, so that emergency victims may be accommodated.
- Individuals may be redirected or relocated for a Medical Screening Exam in the event that the hospital's Emergency Operations Plan is activated. (Section 1135(b) of the Social Security Act §489.24(a)(2)).
- In the event that the hospital's Emergency Operations Plan is activated, persons may be transferred prior to being stabilized if, based upon the circumstances of the emergency, the hospital is unable to provide proper care, treatment or services. (Section 1135(b) of the Social Security Act and CFR §489.24(a)(2)).

  See Admissions and Bed Capacity Policy – Emergency Operations Procedure Manual

EVACUATION OF THE FACILITY:

- When a situation arises requiring evacuation of patients from threatened or affected areas, safety of lives is Sierra View Medical Center's primary concern. Authority to order an evacuation is vested

only in the Chief Executive Officer, his/her designee, or the Safety Officer. Patients shall be evacuated to an area of safety by whatever means are available. Formal agreements are in place with ambulance services and alternate care sites to transfer patients as necessary.

- All personnel have been trained in evacuation procedures. Evacuation routes are posted throughout the hospital.
- Relocation to alternate health facility or place of safety (i.e., churches, schools):
  - Prepare maps of routes to the relocation site
  - Confirm periodically the availability of the relocation site
  - Establish lists of supplies and equipment, by priority, to be relocated
  - Arrange adequate transportation for evacuation and relocation

See Evacuation Procedure Policy – Emergency Operations Procedure Manual

Establishing an Alternate Care Site When the Environment Cannot Support Adequate Patient Care:

- Formal agreements are in place so that patients may be transferred to a facility that can provide adequate patient care. The Liaison Officer will be responsible for inter-facility communication between the hospital and the designated alternative care site, and for retaining records of which patients were transferred to and/or from an alternative care site. The patient care unit transferring the patient is responsible for obtaining copies of the patient's medical records, gathering personal belongings and ensuring the patient's medications are continued throughout the transfer. If any hospital equipment is transferred with the patient, the patient care unit is responsible for documenting what equipment was transferred with the patient so that the equipment may be retrieved during the recovery phase post emergency. The following agreements are in place:
  - Ambulance contract agreements for transfer of patients between facilities
  - Transfer agreements will be made between neighboring facilities
  - Emergency acquisitions of medical supplies, pharmaceuticals, food, equipment, water, linen, emergency repair services, etc.

NOTE: Alternate care sites must be able to provide the necessary resources to care for patients, i.e., emergency power, site access and security, access to or the ability to obtain utility resources, such as medical gases, vacuum, etc., communications, personnel.

See Evacuation Procedures Policy – Emergency Operations Procedure Manual

CONTINUING AND/OR RE-ESTABLISHING OPERATIONS FOLLOWING AN EMERGENCY:

- The hospital has mechanisms in place to restore the operational capabilities of the facility to pre-emergency levels. Once the emergency is over, the Engineering Department, including the Facilities Manager, Safety Officer, Risk Manager and administration representatives, will begin assessing the damage to the facility and the environmental concerns to determine whether the facility can safety provide medical care to the community and provide a safe environment for patients, personnel and visitors.

  - Pictures and/or videos will be taken of all damages to the facility's buildings, grounds, equipment, etc., including all off-campus structures.

  - Architects, building inspectors and structural engineers may be called in to determine if the buildings are safe for occupancy.

  - All potential environmental concerns will be evaluated for proper function, i.e., hazardous waste, fuel tanks, to ensure there is not leakage into the local sewer or water system or any other impact on other environmental concerns.

  - Ensure personnel support programs have been instituted, i.e., crisis counseling, flexible work hours, cash advances, day care, particularly if personnel and the hospital have been directly impacted by the emergency.

  - Clear debris and secure unsafe buildings as necessary.

  - Restore internal and external communication devices.

  - Inventory equipment and supplies for damage and determine if additional supplies need to be obtained from suppliers. Pictures/videos will be taken of all damaged supplies and equipment for insurance purposes. Damaged supplies and equipment will be retained until approval is received from insurance providers for disposal.

Notify the community through local media services regarding the services the hospital will be providing and where they will be provided in the event that services are moved off the hospital campus.

- Notify the hospital's insurance provider and contact a third-party expert to prepare the claim.

- Ensure records and data have been protected and restore information as necessary from backup tapes.

- Keep detailed records.

NIMS PREPAREDNESS FUNDING:

- The Hospital shall establish a working relationship with State and Tulare County Department of Health and Human Services Agency / EMS and state hospital associations to identify activities to obtain and appropriately allocate preparedness funding.

- A proactive process shall be developed and implemented to seek other federal funding to support preparedness that takes advantage of developing interoperability training with local and regional multi-disciplinary partners.

PERFORMANCE STANDARDS:

- There is a planned, systematic, interdisciplinary approach to process design and performance measurement, analysis and improvement related to organization wide safety. The organizational Safety Committee will develop and establish performance measures and related outcomes, in a collaborative fashion, based on those priority issues known to be associated with the healthcare environment. Performance measures and outcomes will be prioritized based upon high risk; high volume, problem prone situations and potential or actual sentinel event related occurrences. Criteria for performance improvement measurement and outcome indicator selection will be based on the following:
  - The measure can identify the events it was intended to identify
  - The measure has a documented numerator and a denominator statement or description of the population to which the measure is applicable
    - The measure has defined data elements and allowable values
    - The measure can detect changes in performance over time
    - The measure allows for comparison over time within the organization or between the organization and other entities
    - The data intended for collection is available
    - Results can be reported in a way that is useful to the organization and other interested stakeholders
- The Safety Committee on an ongoing basis monitors performance regarding actual or potential risk related to one or more of the following:
  - Personnel knowledge and skills
  - Level of personnel participation

- Monitoring and inspection activities
- Emergency and incident reporting
- Inspection, preventive maintenance and testing of safety equipment
- Other performance measures and outcomes will be established by the Safety Committee, based on the criterion listed above. Data sources, frequency of data collection, individual(s) responsible for data collection, aggregation and reporting will be determined by the Safety Committee.

- To identify opportunities for improvement/corrective action, the Safety Committee will follow the organization's improvement methodology. The basic steps to this model will consistently be followed, and include planning, designing, measuring, analyzing/assessing, improving and evaluating effectiveness. Should the Safety Committee feel a team approach (other than the Safety Committee) is necessary for performance and process improvement to occur, the Safety Committee will follow the organization's performance improvement guidelines for improvement team member selection.

- Determination of team necessity will be based on those priority issues listed (high-risk, volume and problem prone situations and sentinel event occurrence). The Safety Committee will review the necessity of team development, requesting team participation only in those instances where it is felt the Safety Committee's contributions toward improvement would be limited (due to specialty, limited scope and/or knowledge of the subject matter). Should team development be deemed necessary, primarily, team members will be selected on the basis of their knowledge of the subject identified for improvement, and those individuals who are "closest" to the subject identified. The team will be interdisciplinary, as appropriate to the subject to be improved.

- Performance improvement monitoring and outcome activities will be presented to the Safety Committee by the Safety Officer at least on a quarterly basis, with a report of performance outcome forwarded to the Organizational Performance Improvement Patient Safety Committee, Medical Executive Committee and Board of Directors quarterly.

ANNUAL EVALUATION OF THE EMERGENCY OPERATIONS PLAN OBJECTIVES, SCOPE, PERFORMANCE AND EFFECTIVENESS:

- The annual evaluation of the Emergency Operations Plan will include a review of the scope according to the current Joint Commission standards and National Incident Management System (NIMS) requirements to evaluate the degree in which the program meets accreditation standards, NIMS requirements and the current risk assessment of the hospital.
  - A comparison of the expectations and actual results of the program will be evaluated to determine if the goals and objectives of the program were met.

- The overall performance of the program will be reviewed by evaluating the results of performance improvement outcomes. The overall effectiveness of the program will be evaluated by determining the degree that expectations were met.

- The Emergency Operations Plan shall be revised and updated based on the annual evaluation of the Emergency Operations Program, including the Hazard Vulnerability Analysis.

- The performance and effectiveness of the Emergency Operations Plan shall be reviewed by the Safety Committee, the Performance Improvement/Patient Safety Committee, and Administration and reported to the Board of Directors.

REFERENCES:

- The Joint Commission (2024). Hospital accreditation standards. EM.12.01.01 Joint Commission Resources. Oak Brook, IL.

- Section 1135(b) of the Social Security Act. (n.d.) https://www.ssa.gov/OP_Home/ssact/title11/1135.htm.

- Code of Federal Regulations §489.24(a)(2). (1991). https://www.ecfr.gov/cgi-bin/text-idx?c=ecfr;sid=060daea35afcfbf6b1c6a8bf685d6f87;rgn=div5;view=text;node=42:5.0.1.1.7;idno=42;cc=ecfr.

CROSS REFERENCES:

- ACTIVATION OF THE COMMAND CENTER
- ADMISSIONS AND BED CAPACITY
- AUTHORIZATION FOR VOLUNTEER CAREGIVERS DURING DISASTERS
- CONTAMINATION WITH RADIOACTIVE MATERIALS
- DISASTER COMMUNICATIONS
- DISASTER RESPONSE SECURITY
- DISRUPTION OF SERVICES

- EVACUATION PROCEDURES
- MEDICAL GASES
- PERFORMANCE IMPROVEMENT MONITORING AND EVALUATION PLAN
- UTILITY SYSTEM OPERATIONAL PLANS AND FAILURE PROCEDURES

SUBJECT:	SECTION:
HAZARDOUS MATERIALS AND WASTE MANAGEMENT PLAN	*Hazardous Materials & Waste Management*

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

I. EXECUTIVE SUMMARY

Each environment of care poses unique risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The Hazardous Materials and Waste Management Program is designed to identify and manage the risks related to the presence of several types of materials and waste present in the buildings and portions of buildings operated and owned by Sierra View Medical Center (SVMC). The specific risks of each environment are identified by applying appropriate criteria to materials and waste to determine which have hazards. A Hazardous Material and Waste Management Program based on applicable laws, regulations, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by Sierra View Medical Center.

The Management Plan for Hazardous Materials and Waste describes the risk and daily management activities that Sierra View Medical Center has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people coming to the organization's facilities. The Management Plan and the Hazardous Materials and Waste Management Program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

The program is applied to Sierra View Medical Center, Distinct Part Skilled Nursing Facility, Cancer Treatment Center, Ambulatory Surgical Department, Medical Office Building, Urology Clinic, Sierra View Community Health Clinic, Clinical Lab and Wound Healing Department of Sierra View Medical Center. The Hazardous Materials and Waste Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care, business occupancies and temporary alternate care sites of Sierra View Medical Center. The plan also affects all staff, volunteers, contract staff, medical staff and associates including contracted services of Sierra View Medical Center.

II. PRINCIPLES

A. The activities of the Hazardous Materials and Waste Management program are designed based on applicable national, state, and local codes and regulations and the inventory of materials in use and waste generated at each location housing healthcare services of Sierra View Medical Center.

B. The specific activities, environments, protective equipment and engineering controls required to the risk of adverse human or environmental impact related to the handling, use, storage or disposal of materials and waste are determined from Safety Data Sheets (SDS) or other documents provided by suppliers and manufacturers.

C. The four basic management requirements for assuring the minimum potential of adverse human or environmental impact of hazardous materials or hazardous waste include:

1. Appropriate design of space, including installation and maintenance of engineering control systems and other equipment to manage the hazards of the types of materials or waste to be stored in the area.

2. Regular inspection and maintenance of the spaces where hazardous materials or hazardous waste is stored, handled, held for disposal, etc. to assure that all engineering controls are working properly, that proper procedures and controls for the separation, storing, and handling of hazardous materials or hazardous waste are being implemented, and that other equipment is used effectively.

3. Education and training of staff responsible for handling and using any hazardous materials or hazardous waste that addresses the specific hazards of each type and the procedures and controls required to manage those hazards.

4. Development and testing of emergency response procedures designed to minimize the human and environmental impact of any exposure to, release of, or spill of hazardous materials or hazardous waste.

III. OBJECTIVES

A. Develop and maintain a site and area-specific inventory of Hazardous Materials or Hazardous Waste, SDS, and other appropriate documentation for each location housing healthcare services of Sierra View Medical Center.

B. Develop and manage procedures and controls to select, transport, store, and use the identified hazardous materials or hazardous waste.

C. Inspect all areas where hazardous materials and hazardous waste are stored, handled, and disposed of at least annually.

D. Monitor hazardous gases and vapors as required by law, regulation, or industry standards of practice.

E. Educate and train staff about the specific risks of hazardous materials and hazardous waste they use or are exposed to in the performance of their assigned duties and the procedures and controls for managing them.

F. Respond to spills, releases, and exposures to hazardous materials and hazardous waste in a timely and effective manner.

G. Analyze and report all spills, releases, and exposures to hazardous materials and hazardous waste as required by law, regulations, and the incident reporting process of Sierra View Medical Center.

H. Manage the Hazardous Materials and Hazardous Waste Program to assure compliance with the Joint Commission's requirements and other regulatory agency requirements.

IV. PROGRAM MANAGEMENT STRUCTURE

A. The Safety Officer works with the Safety Committee to conduct a risk assessment of hazardous materials and hazardous waste throughout the organization. The results of the risk assessment are used to develop appropriate procedures and controls as the foundation of an appropriate Hazardous Material and Hazardous Waste Management Program is implemented. The Safety Officer also collaborates with the Manager of Safety and Security to develop reports of the Hazardous Material and Hazardous Waste performance for presentation to the Safety Committee on a quarterly basis.

B. The reports summarize organizational experience, performance management and improvement activities, and other Hazardous Materials or Hazardous Waste issues.

C. The Board of Directors of Sierra View Medical Center receives regular reports of the activities of the Hazardous Materials and Hazardous Waste Program from the Safety Committee. The Board reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety Officer and appropriate clinical staff. The Board of Directors collaborates with the Chief Executive Officer (CEO) and other senior leaders to assure budget and staffing resources are available to support the Hazardous Materials and Hazardous Waste program.

D. The CEO or designee of Sierra View Medical Center receives regular reports of the activities of the Hazardous Materials and Hazardous Waste program. The CEO or designee collaborates with the Safety Officer and other appropriate staff to address Hazardous Materials or Waste Management issues and concerns. The CEO or designee also collaborates with the Safety Officer to develop a budget and operational objectives for the Hazardous Materials and Waste program.

E. The Director of Environmental Services, staff and selected outside service company staff schedule and complete all activities required to assure safe, effective management of hazardous chemical waste and regulated medical waste.

F. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

V. ELEMENTS OF THE HAZARDOUS MATERIALS AND WASTE PLAN

EC.01.01.01 EP6 – Management Plan for Hazardous Materials & Waste

The Hazardous Materials and Waste Management program is described in this management plan. The Hazardous Materials and Waste Management plan describes the procedures and controls in place to minimize the potential that any patients, staff, and other people coming to the facilities of Sierra View Medical Center experience an adverse Hazardous Material (HAZMAT) event.

EC.02.02.01. EP1 – Identifying and Inventorying Hazardous Materials & Hazardous Waste

The manager(s) of the components of the Hazardous Materials and Waste Program develop criteria based on law, regulation, or industry standards to identify the types of HAZMAT addressed by this program.

The manager(s) of the components of the Hazardous Materials and Waste Program participate in the proactive risk assessment with the Safety Committee to coordinate the development of a departmentalized inventory of hazardous materials and waste. The inventory lists the quantities, types, and location of hazardous materials and waste found in each department. The list includes chemicals, chemotherapeutic materials, and radioactive materials, regulated medical waste including medical sharps, gases and vapors. The inventory is updated at least annually.

The inventory of Hazardous Materials or Hazardous Waste is used to develop procedures and controls for selecting, handling, storing, transporting, using, and disposing. It is the policy of Sierra View Medical Center to use the least hazardous materials that are effective for their intended purpose.

EC.02.02.01 EP3/4 – Emergency Response Procedures

The manager(s) of the Hazardous Materials and Hazardous Waste components develop and maintain written emergency procedures and controls designed to assure rapid, effective response to spills and releases or exposures.

The emergency procedures and controls are designed to evaluate spills to determine if outside assistance is necessary. Incidental spills are managed by staff with training appropriate to the type of spill. All spills are documented as incidents.

Spills exceeding the capability of the trained staff of Sierra View Medical Center to neutralize the hazard and to manage the clean-up and disposal of the waste generated require implementation of the Code Orange hazardous materials emergency response plan.

In all such cases, the Incident Commander, or designee, assigns qualified staff to assess the area affected to determine if evacuation, ventilation, isolation, or other actions are required to manage the hazards until a commercial or fire department HAZMAT team arrives on site. The Sierra View Medical Center Incident Commander, or designee, works with the outside Incident Commander to coordinate the procedures for neutralizing and cleaning up the spill in a manner that minimizes human and environmental impact.

The Sierra View Medical Center Incident Commander or designee and the Safety Officer prepare and file appropriate incident reports regarding the Hazardous Materials spill with the Risk Management Department and other outside regulatory agencies as required.

If spill kits, personal protective equipment, or other equipment and supplies were expended during the management of a hazardous material spill, the Safety Officer is responsible for acquiring and stocking replacements to appropriate areas.

EC.02.02.01 EP5 – Hazardous Chemicals

Hazardous chemicals and chemical waste are managed in accordance with the organization procedures and controls and applicable laws and regulations from the time of receipt to the point of final disposal. The inventory of hazardous chemicals is maintained by the Safety Officer. The inventory for each department is maintained in a departmental log. The Safety Data Sheets corresponding to the chemicals in the inventory are available through an online electronic service and a fax on demand option for the same service. In addition, a complete set of current Safety Data Sheets is maintained by Environmental Services. Some department managers may choose to maintain hard copies of Safety Data Sheets for training and for immediate access due to the high risk of a spill or exposure related to normal daily operations.

The manager of each department with an inventory of hazardous materials implements the appropriate procedures and controls for the safe selection, storage, handling, use and disposal of them.

The procedures and controls include use of Safety Data Sheets to evaluate products for hazards before purchase, orientation and ongoing education and training of staff, management of storage areas, and participation in the response and analysis of spills and releases of or exposures to Hazardous Materials or Hazardous Waste.

The Director of Laboratory Services maintains an inventory of all laboratory chemicals as part of the Chemical Hygiene Plan. The plan is available for reference at all times. The Director of Laboratory Services is responsible for maintaining the plan, including an up to date reference library of Safety Data Sheets.

EC.02.02.01 EP6 – Radioactive Materials

Radioactive materials are managed by the Radiation Safety Officer (RSO). The RSO is responsible for assuring that all areas where radioactive materials are used are maintained in compliance with applicable Nuclear Regulatory Commission regulations.

All areas where radioactive materials are stored and where wastes are decayed are secured from entry by unauthorized staff. All second and third shift deliveries of radioactive materials by representatives of outside radio-pharmacy companies are monitored by the on duty RSO. A log of each delivery is maintained.

Spills of and unwanted exposures to radioactive materials are managed by the RSO. Appropriate decontamination, monitoring, and treatment of any contaminated or exposed persons are managed by a qualified member of the medical staff or by referral to a qualified physician.

Reports of spills and exposures are reported to the Environmental Safety Committee and to outside agencies in accordance with applicable regulations.

If any outside inspections result in findings of inappropriate management of radioactive materials, the RSO shall develop and implement a plan of correction as soon as possible.

EC.02.02.01 EP7 – The hospital minimizes risks associated with selecting and using hazardous energy sources

All equipment that emits ionizing and non-ionizing radiation is inventoried as part of the Medical Equipment Management Program.

The energy emitted by each piece of equipment is analyzed to determine the hazards posed to patients, staff and licensed independent practitioners.

The Safety Officer, the Radiation Safety Officer, and other appropriate individuals are responsible for determining what procedures and controls are required to minimize the risks. All staff and licensed independent practitioners who work with or around hazardous energy sources are oriented and trained to develop an understanding of how to perform work related tasks or how to interact with the environment where the source of the hazardous energy is in use. Staff and licensed independent practitioners are also provided with appropriate personal protective equipment including energy monitoring devices when appropriate.

The Safety Officer, the Radiation Safety Officer, and other appropriate individuals are responsible for determining what quality control programs are required to manage each type of hazardous energy source and for conducting any required quality control measurement, maintenance, calibration, testing, or monitoring.

When equipment or staff performance does not meet established standards, the Safety Officer, the Radiation Safety Officer, and other appropriate individuals are responsible for taking action to address the identified deficiencies.

EC.02.02.01 EP8 – The hospital manages risks associated with disposing of hazardous medications

As part of the Hazardous Materials and Waste program, the Director of Pharmacy and the Nursing Directors of Oncology and Medical Surgical departments are responsible for the safe management of dangerous hazardous medications including chemotherapeutic materials. The pharmacy orders, stores, prepares, distributes, and disposes of hazardous medications. All materials mixed on site are managed in accordance with applicable regulations for assuring product safety and purity. All hazardous medications are managed at the bedside to assure that the

materials, doses, and patients are all correct before any are administered. All hazardous medication waste including the material, tubing, bags, syringes, needles, etc. are disposed of in containers designed for and labeled as hazardous medication waste. Spills of hazardous medications are cleaned up by a trained member of the nursing staff. Spills ≥5 cc will be cleaned up by the HAZMAT First Responder team following appropriate procedures.

All staff exposed to hazardous medications is offered the option of treatment through the employee health program.

EC.02.02.01 EP1 & IC.02.01.01 EP6 – Management of Infectious and Regulated Medical Waste Including Sharps

Regulated medical waste are managed by the Environmental Services (EVS) department, which distributes and collects appropriate containers for collection for regulated medical waste and medical sharps. The containers are leak proof and puncture resistant.

The Environmental Services staff is responsible for collecting the filled containers and transporting them to a holding room.

The containers are then transported to a processing facility where the materials are sterilized and rendered unrecognizable. Once the materials are rendered harmless they are disposed of in accordance with applicable community waste regulations.

Any staff member, patient, or visitor exposed to regulated medical waste or suffering a subcutaneous injury related to a medical sharp will be offered treatment and health screening in accordance with employee health and emergency medical treatment procedures.

All spills of blood or body fluids will be cleaned up by nursing or environmental services staff. The areas affected will be sanitized following appropriate procedures for the material involved.

EC.02.02.01 EP9 – 10 – Management of Hazardous Gases and Vapors

The Director of Environmental Services and the Laser Safety Officer is responsible for identifying needs for monitoring gases and vapors. Monitoring requirements and action levels are determined from regulations and industry standards. In addition to chemical gases and vapors, the vapors related to the use of electro-cauterizing devices and lasers during surgical procedures are considered to be hazardous.

The Director of Environmental Services is responsible for identifying all locations requiring monitoring, appropriate test methods, and the appropriate standards against which results of monitoring are compared.

Results of monitoring are documented and reported to the Safety Committee as part of the quarterly report of Hazardous Materials and Hazardous Waste activities.

If a monitored level is higher than the regulatory or industry standard action level, staff activity in the area is suspended or staff is supplied with appropriate protective equipment until the conditions that caused the excessive level are corrected.

EC.02.01.01 EP11 – Management of Permits, Licenses and Manifests

The Director of Environmental Services will maintain all required permits and licenses which are updated as required. Copies of the permits and licenses are posted in areas as required by law or regulation.

The Director of Environmental Services will maintain copies of all manifests required by law or regulation. The manifests are reviewed monthly to assure copies are returned from haulers. If a required manifest copy is not returned from the hauler within 30 days, the appropriate manager contacts the hauler. If a required manifest copy is not returned within 90 days, the affected manager reports the deficiency to the appropriate agency for follow-up action.

EC.02.01.01 EP12 – Labeling of Hazardous Materials and Waste

All staff using hazardous materials or managing hazardous waste are required to follow Federal DOT regulations for labeling. The team conducting environmental tours evaluates compliance with labeling requirements. Deficiencies are reported to appropriate managers for immediate follow-up, including re-education of the staff involved.

EC.02.02.01EP17-18 – The Hospital Monitors Radiation Exposure of Radiology Staff

The Radiation Safety Officer will review staff dosimetry monitoring on at least a quarterly basis to assess whether staff radiation exposure levels are "as low as reasonably achievable and below regulatory limits. The findings are reported to the Radiation Safety Committee for review.

EC.02.02.01EP19 – Routine Storage and Disposal of Trash and Regulated Medical Waste
The Environmental Services Department will collect, transport, and dispose of regular trash and regulated waste in accordance with all state and local regulations.

EC.04.01.01.1 EP1 – EP11 – The hospital monitors conditions in the environment

The Vice President of Quality and Regulatory Affairs coordinates the design and implementation of the incident reporting and analysis process. The Safety Officer works with the Vice President of Quality and Regulatory Affairs to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.

Incident reports are completed by a witness or the staff member to whom a patient or visitor incident is reported.

The completed reports are forwarded to the Vice President of Quality and Regulatory Affairs who works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

In addition, the Vice President of Quality and Regulatory Affairs Management and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated form environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the Safety Committee and the Performance Improvement/Patient Safety (PIPS) Committee, as appropriate, as part of quarterly Environmental Safety reports. The Safety Officer provides summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.

The Safety Officer coordinates the collection of information about environmental safety and patient safety deficiencies and opportunities for improvement from all areas of Sierra View Medical Center. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the seven management sections of the Environment of Care functions use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

The Safety Committee and the Performance Improvement/Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the Environment of Care Management Programs.

The Safety Officer and the Performance Improvement Patient Safety Committee prepare a quarterly report to the leadership of Sierra View Medical Center. The quarterly report summarizes key issues reported to the Committees and their recommendations. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders that management responsibilities have been carried out.

EC.04.01.01 EP15 – Every twelve months the hospital evaluates each Environment of Care Management Plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.

The Safety Officer coordinates the annual evaluation of the management plans associated with the Environment of Care functions.

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

The review also evaluates the operational results of each Environment of Care program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The sources include

aggregate analysis of environmental rounds and incident reports, findings of external reviews or assessments by regulators, benchmarking programs, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Safety Committee by the end of the first quarter of the fiscal year. Each report presents a balanced summary of an Environment of Care program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.

In addition, the annual review incorporates appropriate elements of the Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Safety Officer.

The results of the annual evaluation are presented to the Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, the Board of Directors, organizational leaders, the Patient Safety Committee, and others as appropriate. The Safety Officer is responsible for implementing the recommendations in the report as part of the performance improvement process.

EC.04.01.03 EP2 - Analysis and actions regarding identified environmental issues

The Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

EC.04.01.05 EP1 – Improving the Environment

When the Board of Directors, Senior Leadership, or Quality and Patient Safety concurs with the Safety Committee recommendations for improvements to the Environment of Care Management programs, a team of appropriate staff is appointed to manage the improvement project. The Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement. All final improvement reports are summarized as part of the annual review of the program and is presented to hospital, performance improvement, and patient safety leadership.

Goal:

Continue to work with staff to reduce the cost of Medical Waste Disposal/Adjusted Patient Day/Quarter. The current rate is at the 95th percentile in the Osborne Engineering Benchmarking Database.

HR.01.04.01 EP1 & EP3; HR.01.05.03 EP1 and EC.03.01.01 EP1 & EP2 – Orientation and Ongoing Education and Training

Orientation and training addressing all subjects of the Environment of Care is provided to each employee, volunteer, and to each new medical staff member at the time of their employment or appointment.

In addition, all current employees, as well as volunteers, physicians, and students, participate in an annual update of the orientation program as deemed appropriate. The update addresses changes to the procedures and controls, laws and regulations, and the state of the art of environmental safety.

The Human Resources Department, with assistance from the Education Department, coordinates the general orientation program. New staff members are required to attend the first general orientation program after their date of employment. The Human Resources Department with assistance from the Education Department maintains attendance records for each new staff member completing the general orientation program.

New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job related patient safety and environmental risks and the procedures and controls in place to minimize or eliminate them during routine daily operations.

The Safety Officer collaborates with the Environment of Care Manager, department heads, the Vice President of Quality and Regulatory Affairs the Manager of Infection Control, the Patient Safety Officer and others as appropriate to develop content materials for general and job related orientation and continuing education programs.

The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each Environment of Care program and revised as necessary.

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

Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Safety Committee.

When deficiencies are identified, action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

AFFECTED PERSONNEL / AREAS: *GOVERNING BOARD; MEDICAL STAFF; ALL HOSPITAL EMPLOYEES; VOLUNTEERS; VENDORS; CONTRACT SERVICES AND STAFF*

REFERENCES:

- The Joint Commission. Comprehensive Accreditation Manual for Hospitals. (2024) EC 01.01.01 EP6 Oakbrook Terrace, IL.

CROSS REFERENCES:

- CODE ORANGE- INTERNAL HAZARDOUS MATERIALS SPILL

SUBJECT:	SECTION:
LIFE SAFETY MANAGEMENT PLAN	*Life Safety Management*
	Page 1 of 10

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

I. EXECUTIVE SUMMARY

Each environment of care and the physical condition of occupants poses unique fire safety risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The Life Safety Management Program is designed to identify and manage the risks of the environments of care operated and owned by Sierra View Medical Center (SVMC). The specific fire safety risks of each environment are identified by conducting and maintaining a proactive risk assessment. A fire safety program based on applicable laws, regulations, codes, standards, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by Sierra View Medical Center.

The Management Plan for Life Safety describes the risk and daily management activities that Sierra View Medical Center has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people, coming to the organization's facilities. The management plan and the Life Safety Management Program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

The program is applied to Sierra View Medical Center, Distinct Part Skilled Nursing Facility, Cancer Treatment Center, Ambulatory Surgery Center, Wound Healing Center, Urology Clinic, Clinical Lab, Sierra View Community Health Center (SVCHC), Surgery Clinic and Medical Office Building of Sierra View Medical Center. The Life Safety Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care, business occupancies and temporary alternate care sites of Sierra View Medical Center. The plan also affects all staff, volunteers, medical staff and associates, including contracted services of Sierra View Medical Center.

II. PRINCIPLES

A. All buildings of Sierra View Medical Center housing patient care services must be designed, operated, and maintained to comply with the 2012 edition of the National Fire Protection Association (NFPA) Life Safety Code.

B. All fire alarm, detection, and extinguishing systems and equipment must be maintained to comply with applicable codes and standards.

C. All staff must be educated and trained to respond effectively to fire, smoke, or other products of combustion to minimize the potential of loss of life or property in the event of a fire.

D. Appropriate temporary administrative and engineering controls must be designed, implemented, and maintained whenever existing deficiencies or conditions created by construction activities significantly reduce the level of life safety in any area where patients are cared for or treated.

III. OBJECTIVES

A. Design and construct all spaces intended for housing patient care and treatment services to meet national, state, and local building and fire codes.

B. Conduct required fire drills in all buildings of Sierra View Medical Center that house patient care services.

C. Calibrate, inspect, maintain, and test fire alarm, detection, and suppression systems in accordance with codes and regulations.

D. Inspect and maintain all buildings housing patient care services to assure compliance with the applicable requirements of the 2012 edition of the NFPA Life Safety Code.

E. Train all staff, volunteers, and members of the medical staff to respond effectively to fires.

IV. PROGRAM MANAGEMENT STRUCTURE

A. The Safety Officer assures that an appropriate maintenance program is implemented. The Safety Officer also collaborates with the Safety Officer, Facilities Manager and Manager of Environment of Care to develop reports of Life Safety Management performance for presentation to the Safety Committee on a quarterly basis. The reports summarize organizational experience, performance management and improvement activities, and other fire safety issues.

B. The facilities management technicians and selected outside service company staff schedule and complete all calibration, inspection, and maintenance activities required to assure safe, reliable performance of fire safety equipment in a timely manner. In addition, the technicians and service company staff perform necessary repairs.

C. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job-related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

D. The Board of Directors of Sierra View Medical Center receives regular reports of the activities of the Life Safety Management program from the Safety Committee. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety Officer and appropriate clinical staff. The Board collaborates with the Chief Executive Officer and Senior Leadership to assure budget and staffing resources are available to support the Life Safety Management program.

E. The Chief Executive Officer of Sierra View Medical Center receives regular reports of the activities of the Life Safety Management program. The Chief Executive Officer collaborates with the Safety Officer and other appropriate staff to address fire safety

issues and concerns. The Chief Executive Officer also collaborates with the Safety Officer to develop a budget and operational objectives for the Life Safety Management Program.

V. ELEMENTS OF THE LIFE SAFETY MANAGEMENT PLAN

EC.01.01.01 EP7 – Life Safety Management Plan

The Life Safety Management Program is described in this management plan. The Life Safety Management Plan describes the procedures and controls in place to minimize the potential that any patients, staff, and other people coming to the facilities of Sierra View Medical Center experience an adverse outcome in the event of a fire.

EC.02.01.01 EP1 – Processes for Protecting Building Occupants and Property

The Facilities Manager and Safety Officer are responsible for coordinating the development of design, operations, maintenance, and training processes to minimize the potential for fires and of adverse consequences related to the presence of fire, smoke, or other products of combustion.

Design

The Safety Officer, Facilities Manager and other project managers collaborate with qualified design professionals, code enforcement, and facility licensing agencies to assure that buildings and spaces are designed to comply with local, state, and national building and fire codes. American Institute of Architects (AIA) guidelines are also considered in the design process for compliance with the International Building Codes with California amendments. The Facilities Manager assures that all required permits and inspections are obtained or completed prior to occupancy. The Facilities Manager permanently maintains all plans, inspection reports, and other documents related to the design and construction of any building or space housing patient care or treatment services of Sierra View Medical Center.

Management

The Facilities Manager oversees the design, implementation, and documentation of processes designed to assure optimal performance and continual compliance with code requirements of fire alarm, detection, and suppression systems. Similar programs are in place for maintenance of building elements operating conditions that play a role in the fire safety level of the environment.

The Facilities Manager is responsible for assuring that all renovation and new construction within existing buildings is done in a manner that preserves compliance with codes and standards.

Fire Response Process

The Safety Officer is responsible for the design and management of a fire response plan that meets the unique needs of the occupants of each department or service of Sierra View Medical Center. The current fire response plan is based on the "RACE" principle (remove from immediate

danger, activate alarms, confine fire, extinguish or evacuate area). Area-specific response and evacuation plans that include training and equipment required to manage unique risks identified in areas are in place. The plans are evaluated annually as part of the overall program review.

EC.02.01.03 – The hospital prohibits smoking on all facility grounds

Sierra View Medical Center has developed a Tobacco Free Environment policy. The policy prohibits the usage of any tobacco product (i.e., cigarettes, cigars, pipe, chewing tobacco, e-cigarettes) in any hospital building or grounds by all, including staff, visitors and patients.

Sierra View Medical Center has identified alternatives to tobacco products that are offered to all. Sierra View Medical Center has developed tobacco replacement resources to assist staff and patients with smoking cessation as desired.

The procedures for managing the use of tobacco replacement materials are followed and enforced by all managers and staff.

EC.02.03.01 EP4 – The hospital maintains free and unobstructed access to all exits

Leaders in all areas of the hospital are responsible for assuring that equipment, furniture, and supplies are not stored in corridors. The condition of corridors is evaluated during each environmental rounds activity. All violations are reported to the Director of the area where the deficiency was identified, the Safety Officer, and the Safety Committee.

Repeated violations are evaluated to determine the probable cause and to develop a solution. Directors, where there are multiple violations over a 12 month period of time, may face disciplinary action through the Human Resources process.

EC.02.03.01 EP9 – The hospital has a written fire response plan

The Safety Officer is responsible for coordinating the implementation of the fire response plan. All staff is oriented to the RACE (Rescue/Remove, Alert/Activate, Confine, and Extinguish/Evacuate) response model and effective use of portable fire extinguishers. In addition, all staff are oriented to the department or service-specific plans that account for the unique challenges posed by the condition of occupants and the design of space in which they work.

The department and area-specific fire response plans include information about:

1. The roles of all employees, medical staff, volunteers, contract staff and students near the point of fire origin.

2. The roles of all employees, medical staff, volunteers, contract staff and students away from the point of fire origin.

   Note: Sierra View Medical Center believes strongly in the principle of life safety. The organization recognizes as a practical matter that members of the medical staff and many

volunteers and students are not present much of the time and are not likely to be a reliable resource during a fire response. Therefore, the medical staff, volunteers, and students do not have a specific defined role in the fire response plan. They are instructed to remain in the area they are located at the time an alarm sounds and to render assistance under the direction of the manager or employees of the area as needs arise.

3. Operation of the fire alarm system

4. Exit routes and use of equipment used to relocate or evacuate patients, visitors, and staff

EC.02.03.03 EP1 – 7 Fire Drills

A comprehensive fire response plan is designed to each specific building or portion of a building housing care, treatment, or service areas owned or operated by Sierra View Medical Center. Each fire plan is modified to address physical limitations of occupants and features of the occupied spaces. All staff is educated about the general fire response procedure and the specific manner in which it is applied in assigned work areas.

Regular fire drills are conducted to reinforce training and education. At least 50% of the drills are unannounced. The frequency of drills is based on regulations and accreditation requirements. All healthcare, ambulatory healthcare and overnight sleeping areas are drilled at least once per shift per quarter.

If conditions evaluated as part of the Interim Life Safety Measures (ILSM) indicate a need for additional drills to enhance staff awareness of degraded life safety protection in various areas, there is documentation that the additional drills are performed. All freestanding business occupancies are drilled at least once per shift per year.

All fire drills are evaluated to determine if individual areas respond appropriately. An aggregate evaluation of fire drills is done at least twice a year. The aggregate analysis looks for patterns or trends of deficiencies. When deficiencies are identified, there is documentation that the deficiencies are corrected.

EC.02.03.05 EP1 – 28 - Inspection, Testing, and Maintenance of Fire Safety Systems

The Facilities Manager works with qualified contractors and staff to design a program of calibration, inspection, maintenance, and testing to assure the reliability of all fire safety systems and equipment. The program includes systems and equipment such as fire sprinklers, smoke detection, fire pumps, fire dampers, doors, and shutters, and smoke control elements of the environment. Each system or piece of equipment is maintained to comply with requirements of the National Fire Protection Association or other applicable codes and standards.

When deficiencies are identified, they are corrected within 48 hours. If a deficiency cannot be corrected within 48 hours, the Facilities Manager evaluates the impact of the deficiency using the ILSM criteria to determine if an ILSM plan needs to be put in place until the deficiency can be

corrected. All ILSM plans are monitored for effect, and documentation demonstrating compliance with the plan is maintained by the Safety Officer.

LS.01.01.01 EP1 – Life Safety Management

The Safety Officer is responsible for maintaining the Statement of Conditions. The Safety Officer prepares a quarterly report of the rate of completion of any Plan for Improvement/Requirement for Improvement for the Safety Committee. If any items will not be completed within the established timeframe plus The Joint Commission allowed six month grace period, the Safety Officer is responsible for preparing a letter to the appropriate Joint Commission staff requesting an extension of the timeframe or a change of the method of correction.

LS.01.02.01 EP1 – 15 – Management of Fire Safety Risks

A program of Interim Life Safety Management based on Interim Life Safety Measures (ILSM) is used to manage degradation of the level of life safety required by NFPA 101 – 2012 Life Safety Code. The ILSM program consists of a screening tool used to assess the severity of the potential impact of a degraded level of life safety. When risk factors indicate a need to implement one or more of the ILSM, a project specific Interim Life Safety Management Plan (ILSMP) is designed. The Facilities Manager and Safety Officer are responsible for implementation of the ILSMP. The implementation may include training, installation of engineering controls, posting of temporary advisory signs, and other actions deemed necessary. Affected staff are oriented and drilled, as appropriate, to familiarize them with the Interim Life Safety Management Plan.

The Safety Officer and Facilities Manager are responsible for monitoring the effectiveness of the implementation of the ILSMP. When deficiencies are identified, the Safety Officer and/or the Facilities Manager take appropriate action to resolve the deficiencies.

All monitoring and actions to resolve deficiencies related to an ILSMP are documented. The documentation is presented to the Safety Committee as part of the quarterly Life Safety Management report to the Committee. All ILSM evaluations, plans, and monitoring documentation are maintained for at least three years.

EC.04.01.01 EP1 – EP11 – The hospital monitors conditions in the environment

The Vice President of Quality and Regulatory Affairs coordinates the design and implementation of the incident reporting and analysis process. The Safety Officer works with the Vice President of Quality and Regulatory Affairs to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.

Incident reports are completed by a witness or the staff member to whom a patient or visitor incident is reported. The completed reports are forwarded to the Vice President of Quality and Regulatory Affairs who in turn works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

In addition, the Vice President of Quality and Regulatory Affairs and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the Safety Committee and the Performance Improvement/Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Safety Officer provides summary information related to incidents to the Chief Executive Officer, Board of Directors and Senior Leadership as appropriate.

The Safety Officer coordinates the collection of information about environmental safety and patient safety deficiencies and opportunities for improvement from all areas of Sierra View Medical Center.

Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the seven management of the environment of care functions use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

The Safety Committee and the Performance Improvement Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.

The Safety Officer and the Chairpersons of the Safety Committee and the Performance Improvement Patient Safety Committee prepare a quarterly report to the leadership of Sierra View Medical Center. The quarterly report summarizes key issues reported to the Committees and the recommendations of them.

The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders that management responsibilities have been carried out.

EC.04.01.01 EP15 – Every twelve months the hospital evaluates each environment of care management plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.

The Safety Officer coordinates the annual evaluation of the management plan associated with the Life Safety Management Program functions.

The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care Program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews or assessments by regulators, accrediting

bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Safety Committee by the end of the second quarter of the calendar year. Each report presents a balanced summary of an Environment of Care Program for the preceding calendar year. Each report includes an action plan to address identified weaknesses.

In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Safety Officer.

The results of the annual evaluation are presented to the Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, Senior Leadership, The Board of Directors, the Performance Improvement Patient Safety Committee, and others as appropriate. The manager of each Environment of Care Program is responsible for implementing the recommendations in the report as part of the performance improvement process.

EC.04.01.03 EP2 - Analysis and actions regarding identified environmental issues

The Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

EC.04.01.05 EP1 – Improving the Environment

When the leadership of the hospital, performance improvement, or patient safety concurs with Safety Committee recommendations for improvements to the Environment of Care Management Programs, a team of appropriate staff is appointed to manage the improvement project. The Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.

The Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital leadership, performance improvement, and patient safety leadership.

GOAL:

Confirm that all evacuation maps throughout the main facility and all outpatient building are accurate and up to date.

HR.01.04.01 EP1 & EP3; HR.01.05.03 EP1 and EC.03.01.01 EP1& EP2 – Orientation and Ongoing Education and Training

Orientation and training addressing all subjects of the environment of care is provided to each employee, volunteer, and to each new medical staff member at the time of their employment or appointment.

In addition, all current employees, as well as volunteers, physicians, and students participate in an annual update of the orientation program as deemed appropriate. The update addresses changes to procedures and controls, laws and regulations, and the state of the art of environmental safety.

The Human Resources Department assisted by the Education Department coordinates the general orientation program. New staff members are required to attend the first general orientation program after their date of employment. The Human Resources Department maintains attendance records for each new staff member completing the general orientation program.

New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job related patient safety and environmental risks and the procedures and controls in place to minimize or eliminate them during routine daily operations.

The Safety Officer collaborates with the Environment of Care managers, Department Directors, Vice President of Quality and Regulatory Affairs, Manager of Infection Control, the Patient Safety Officer and others as appropriate to develop content materials for general and job related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each Environment of Care program and revised as necessary.

The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job related physical risks are to be managed or eliminated as part of daily work.

In addition, the Safety Officer evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Environmental Safety Committee. When deficiencies are identified, action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

AFFECTED PERSONNEL / AREAS: *GOVERNING BOARD; MEDICAL STAFF; ALL HOSPITAL EMPLOYEES; VOLUNTEERS; VENDORS; CONTRACT SERVICES AND STAFF*

REFERENCES:

- The Joint Commission (2024). Hospital accreditation standards. EC.01.01.01 EP7 Joint Commission Resources. Oak Brook, IL.
- National Fire Protection Association (NFPA) Life Safety Code 2012 Edition. Retrieved from https://www.nfpa.org/Codes-and-Standards/All-Codes-and-Standards/Codes-and-Standards.

CROSS REFERENCES:

- FIRE RESPONSE PLAN

SUBJECT:	SECTION:
MEDICAL EQUIPMENT MANAGEMENT PLAN	***Medical Equipment Management*** **Page 1 of 11**

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

I. EXECUTIVE SUMMARY

The Environment of Care and the range of patient care services provided to the patients served by Sierra View Medical Center (SVMC) present unique challenges. The specific medical equipment risks of the environment are identified by conducting and maintaining a proactive risk assessment. A Medical Equipment Management plan, based on various risk criteria, including risks identified by outside sources such as The Joint Commission, is used to eliminate or reduce the probability of adverse patient outcomes.

The Medical Equipment Management Plan describes the risk and daily management activities that Sierra View Medical Center has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other individuals coming to the organization's facilities. The management plan and the Medical Equipment Management Program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

The program is applied to Sierra View Medical Center, Distinct Part Skilled Nursing Facility, Cancer Treatment Center, Ambulatory Surgery Department, Clinical Lab, Wound Healing Center, Urology Clinic, Sierra View Community Health Center, Surgery Clinic and Medical Office Building of Sierra View Medical Center. The Medical Equipment Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services, and all facilities including patient care, business occupancies and temporary alternate care sites of Sierra View Medical Center. The plan also affects all staff, volunteers, medical staff and associates, including contracted staff and services of Sierra View Medical Center.

II. PRINCIPLES

A. Selection of appropriate equipment to support the services of Sierra View Medical Center is an essential part of assuring safe, effective care and treatment are rendered to persons receiving services.

B. Orientation, education, and training of operators of medical equipment are an essential part of assuring safe, effective care and treatment are rendered to persons receiving services.

C. Assessment of needs for continuing technical support of medical equipment and design of appropriate calibration, inspection, maintenance, and repair services is an essential part of assuring that medical equipment is safe and reliable.

D. Effective management of medical alarms is a critical part of the patient safety program.

III. OBJECTIVES

A. Use established criteria to identify unique equipment risks. The identified risks are used to develop appropriate procedures and controls for maintenance and orientation and education programs.

B. Identify and respond appropriately to equipment hazards and recall notices in a timely manner.

C. Record, report, and analyze medical equipment problems, failures and user errors.

D. Any event involving medical equipment and resulting in patient injury or death is treated as a Sentinel Event as defined by The Joint Commission. A complete Root Cause Analysis (RCA) is performed for each Sentinel Event.

E. Manage the Medical Equipment Management program to assure compliance with The Joint Commission's requirements.

IV. PROGRAM MANAGEMENT STRUCTURE

A. The Safety Officer is responsible for maintaining the Medical Equipment Management Program. Each department director is responsible for orienting new staff members to the capabilities, limitations, special applications of equipment, basic operating and safety procedures, emergency procedures if failure occurs, maintenance responsibilities, if applicable, and the reporting procedures for equipment problems, failures and user errors.

B. The Board of Directors of Sierra View Medical Center receives regular reports of the activities of the Medical Equipment Management Program from the Safety Committee. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety Officer and appropriate clinical staff. The Board of Directors collaborates with the Chief Executive Officer and Senior Leadership to assure budget and staffing resources are available to support the Medical Equipment Management Program.

C. The Chief Executive Officer of Sierra View Medical Center receives regular reports of the activities of the Medical Equipment Management Program. The Chief Executive Officer collaborates with the Safety Officer and other appropriate staff to address medical equipment issues and concerns. The Chief Executive Officer collaborates with the Safety Officer to develop a budget and operational objectives for the Medical Equipment Management Program.

D. The Safety Officer assures that an appropriate Medical Equipment Maintenance Program is implemented.

E. The Safety Officer will develop reports of Medical Equipment Management Performance for presentation to the Safety Committee on a quarterly basis. The reports summarize organizational experience, performance management and improvement activities, and other medical equipment issues.

F. The biomedical equipment technicians and selected outside contracted service staff schedule and complete all calibration, inspection, and maintenance activities required to assure safe, reliable performance of medical equipment in a timely manner. In addition, the technicians and service company staff perform necessary repairs.

V. ELEMENTS OF THE MEDICAL EQUIPMENT PROGRAM

EC.01.01.01 EP8 – Medical Equipment Management Plan

The Medical Equipment Management Program is described in this Management Plan. The Medical Equipment Management Plan describes the procedures and controls in place to minimize the potential that any patients, staff, and other people coming to the facilities of Sierra View Medical Center experience an adverse event while being monitored, diagnosed or treated with any type of medical equipment.

EC.02.04.01.EP2 – Written Criteria and Inventory

The Safety Officer is responsible for the development of criteria used to identify risks associated with medical equipment.

The criteria are used to evaluate risks related to the function of medical equipment, physical risks related to the use of equipment, and any history of patient safety issues related to the use of the equipment in the healthcare market.

The Safety Officer is responsible for assuring that all medical equipment is screened at the time of commissioning. The Medical Equipment Management screening procedure is applied, as appropriate, to loaner equipment, demonstration equipment, and equipment owned by physicians or other qualified individuals that is used as part of the care or treatment of a patient in any service of Sierra View Medical Center.

EC.02.04.01.EP3 – Identifying High Risk Inventory

The Safety Officer and the Biomedical Department identifies high risk medical equipment on the inventory for which there is a risk of serious injury or death to a patient or staff member should the equipment fail.

EC.02.04.01 EP4-5 - Inspection, Testing, and Maintenance Intervals

The Safety Officer uses manufacturer recommendations, applicable codes and standards, accreditation requirements, and local or reported field experience to determine the appropriate maintenance intervals for assuring safety and maximizing equipment availability and service life.

A computerized maintenance management system is used to schedule and track timely completion of scheduled maintenance and service activities.

The Safety Officer is responsible for assuring that the rate of timely completion of scheduled maintenance and other service activities meets regulatory and accreditation requirements.

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

- Equipment subject to federal or state law or Medicare Conditions of Participation in which inspecting, testing, and maintaining be in accordance with the manufacturers' recommendations, or otherwise establishes more stringent maintenance requirements
- Medical laser devices
- Imaging and radiologic equipment (whether used for diagnostic or therapeutic purposes)
- New medical equipment with insufficient maintenance history to support the use of alternative maintenance strategies

Note: Maintenance history includes any of the following documented evidence:

- Records provided by the hospital's contractors
- Information made public by nationally recognized sources
- Records of the hospital's experience over time

EC.02.04.01.EP9 - Emergency Procedures

The Safety Officer and appropriate clinical caregivers collaborate to identify life-critical medical equipment. Life-critical equipment is defined as equipment, the failure or malfunction of which would cause immediate death or irreversible harm to the patient, dependent on the function of the equipment.

The Safety Officer and the caregivers are responsible for developing appropriate resources to manage the response to the failure or disruption of the function of the identified life-critical equipment. The resources are designed to minimize the probability of an adverse outcome of care.

The resources must include, but are not limited to, information about the availability of spare or alternate equipment, procedures for communication with staff responsible for repair of the equipment, and specific emergency clinical procedures and the conditions under which they are to be implemented.

Copies of applicable emergency procedures are included in the emergency operations manual of each clinical department. Training addressing the medical equipment emergency procedures is included in the department or job-related orientation process. All medical equipment emergency procedures are reviewed annually.

EC.02.04.01 EP10- Quality Control and Maintenance of Radiologic Equipment

The hospital identifies quality control and maintenance activities to maintain the quality of the diagnostic computed tomography (CT), positron emission tomography (PET, magnetic resonance imaging (MRI), and nuclear medicine (NM) images produced. The hospital identifies how often these activities should be conducted.

EC.02.04.03 – Medical equipment is maintained, tested, and inspected

The Safety Officer ensures that all medical equipment is inspected, tested and maintained.

EC.02.04.03 EP1 - Equipment Inventory and Initial Testing

The Safety Officer and the Manager of the Environment of Care establishes and maintains a current, accurate, and separate inventory of all equipment included in a program of planned inspection or maintenance. The inventory includes equipment owned by Sierra View Medical Center, leased and rented equipment, and personally owned equipment used for the diagnosis, treatment, and monitoring of patient care needs.

The Safety Officer assures effective implementation of the program of planned inspection and maintenance. All equipment in the program is tested for performance and safety prior to use on patients.

EC.02.04.03 EP2 - Testing of High Risk Equipment

The Safety Officer assures that scheduled testing of all life support equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter. If the quarterly rate of completion falls below 100%, the Safety Officer will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

EC.02.04.03 EP3 - Testing of Non-High Risk Equipment

The Safety Officer assures that scheduled testing of all non-life support equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter.

If the quarterly rate of completion falls below 100%, the Safety Officer will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

EC.02.04.03 EP4 - Testing of Sterilizers

The Director of Surgical Services, staff and contracted service providers are responsible for testing and maintenance of all types of sterilizers used in Sierra View Medical Center. Records of load testing and regular maintenance are maintained by the Director of Surgical Services. Any improper results are documented as patient safety incidents and reported to Risk Management for evaluation and action.

EC.02.04.03 EP5 - Testing of Dialysis Water Systems

The Director of Acute Renal Services is responsible for maintenance of dialysis equipment used in Sierra View Medical Center. The program of maintenance includes regular cleaning and disinfection of all dialysis equipment and testing for compliance with biological and chemical standards for the dialysis water supply. All out of range results will be documented as patient safety incidents and reported to Risk Management for evaluation and action. Any event resulting in a patient injury or death will be treated as a Sentinel Event.

EC.02.04.03 EP16- Testing & Calibration of Nuclear Medicine Equipment

Qualified hospital staff inspect, test, and calibrate nuclear medicine equipment annually. The dates of these activities are documented.

EC.02.04.03 EP18- Quality of Radiological Images

The Hospital maintains the quality of the diagnostic computed tomography (CT), positron emission tomography (PET), magnetic resonance imaging (MRI), and nuclear medicine (NM) images produced. (See also EC.02.04.01, EP 10)

EC.02.04.03 EP20- Dosage Measurements

The Director of Radiology ensures that for diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist does the following: (1) Measures the radiation dose (in the form of volume computed tomography dose index [CTDIvol]) produced by each diagnostic CT imaging system for the following four CT protocols: adult brain, adult abdomen, pediatric brain, and pediatric abdomen. If one or more of these protocols is not used by the hospital, other commonly used CT protocols may be substituted. (2) Verifies that the radiation dose (in the form of CTDIvol) produced and measured for each protocol tested is within 20 percent of the CTDIvol displayed on the CT console. The dates, results, and verifications of these measurements are documented.

EC.02.04.03 EP21- Evaluation of Computed Tomography (CT) Equipment

For diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist conducts a performance evaluation of all CT imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented and presented to the Radiation Safety Committee. The evaluation includes the use of phantoms to assess the following imaging metrics: 1) Imaging uniformity 2) Slice thickness accuracy 3) Slice position accuracy (when prescribed from a scout image) 4) Alignment light accuracy 5) Table travel accuracy 6) Radiation beam width 7) High contrast resolution 8) Low contrast resolution 9) Geometric or distance accuracy 10) CT number accuracy and uniformity 11) Artifact evaluation .

EC.02.04.03 EP22- Evaluation of Magnetic Resonance Imaging (MRI) Equipment

At least annually, a diagnostic medical physicist or magnetic resonance imaging (MRI) scientist conducts a performance evaluation of all MRI imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented and presented to the Radiation Safety Committee. The evaluation includes the use of phantoms to assess the following imaging metrics: (1) Imaging uniformity for all radiofrequency (RF) coils used clinically (2) Signal to noise (SNR) for all coils used clinically (3) Slice thickness accuracy (4) Slice position accuracy (5) Alignment light accuracy (6) High contrast resolution (7) Low contrast resolution (or contrast to noise ratio) (8) Geometric or distance accuracy (9) Geometric or distance accuracy (10) Magnetic field homogeneity (11) Artifact evaluation.

EC.02.04.03 EP23- Evaluation of Nuclear Medicine (NM) Equipment

At least annually, a diagnostic medical physicist or nuclear medicine physicist conducts a performance evaluation of all nuclear medicine imaging equipment. The evaluation results, along with recommendations for correcting any problems identified are documented and presented to the Radiation Safety Committee. The evaluations are conducted for all of the image types produced clinically by each NM scanner (for example, planar and/or tomographic) and include the use of phantoms to assess the following imaging metrics: (1) Imaging uniformity/system uniformity (2) High contrast resolution/system spatial resolution (3) Sensitivity (4) Energy resolution (5) Count rate performance (6) Artifact evaluation.

EC.04.01.01 EP1 – EP11 – The hospital monitors conditions in the environment

The Vice President of Quality and Regulatory Affairs coordinates the design and implementation of the incident reporting and analysis process. The Safety Officer works with the Vice President of Quality and Regulatory Affairs to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.

Electronic incident reports are completed by a witnessing staff member to whom a patient or visitor incident is reported. The completed reports are forwarded to Risk Management. Risk Management works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

In addition, the Vice President of Quality and Regulatory Affairs and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment or staff behaviors that require action. The findings of such analysis are reported to the Safety Committee and the Performance Improvement/Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Safety Committee Chairperson provides summary information related to incidents to the Chief Executive Officer, Board of Directors, and Senior Leadership as appropriate.

The Safety Officer coordinates the collection of information about environmental safety and patient safety deficiencies and opportunities for improvement from all areas of Sierra View Medical Center. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the seven management areas of the environment of care functions use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

The Safety Committee and the Performance Improvement/Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.

The Safety Officer and the Chairpersons of the Safety Committee and the Performance Improvement/Patient Safety Committee prepare a quarterly report to the leadership of Sierra View Medical Center. The quarterly report summarizes key issues reported to the Committees and the recommendations of them. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders that management responsibilities have been carried out.

EC.04.01.01 EP15 – Every twelve months the hospital evaluates each environment of care management plan, including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.

The Safety Officer coordinates the annual evaluation of the management plans associated with the Environment of Care (EC) functions.

The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each EC program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Safety Committee by the end of the second quarter of the calendar year. Each report presents a balanced summary of an EC program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.

In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Safety Officer.

The results of the annual evaluation are presented to the Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, the Board of Directors, organizational leaders, the Performance Improvement Patient Safety Committee, and others as appropriate. The manager of each EC program is responsible for implementing the recommendations in the report as part of the performance improvement process.

EC.04.01.03 EP2 - Analysis and actions regarding identified environmental issues

The Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified, the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

EC.04.01.05 EP1 – Improving the Environment

When the leadership of the hospital, Performance Improvement, or Patient Safety concurs with Safety Committee recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.

The Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital, performance improvement, and patient safety leadership.

GOAL:

Work with Renovo to complete an updated inventory of all medical equipment that could not be located during scheduled Preventative Maintenance with the goal of tracking down all missing equipment.

HR.01.04.01 EP1 & EP3; HR.01.05.03 EP1 and EC.03.01.01 EP1 & EP2 – Orientation and Ongoing Education and Training

Orientation and training addressing all subjects of the environment of care is provided to each employee, volunteer, and to each new medical staff member at the time of their employment or appointment.

In addition, all current employees, as well as volunteers, physicians, and students, participate in an annual update of the orientation program as deemed appropriate. The update addresses changes to the procedures and controls, laws and regulations, and the state of the art of environmental safety.

The Human Resources Department, with assistance from the Education Department, coordinates the general orientation program. New staff members are required to attend the first general orientation program after their start date of employment.

The Human Resources Department maintains attendance records for each new staff member completing the general orientation program.

New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job related patient safety and environmental risks and the procedures and controls in place to minimize or eliminate them during routine daily operations.

The Safety Officer collaborates with the EC managers, Department Directors, Vice President of Quality and Regulatory Affairs, Manager of Infection Control, the Patient Safety Officer, and others as appropriate to develop content materials for general and job related orientation and continuing education programs.

The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each EC program and revised as necessary.

The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job related physical risks are to be managed or eliminated as part of daily work.

In addition, the Safety Officer evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Safety Committee. When deficiencies are identified, action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

AFFECTED PERSONNEL / AREAS: *GOVERNING BOARD; MEDICAL STAFF; ALL HOSPITAL EMPLOYEES; VOLUNTEERS; VENDORS; CONTRACTED SERVICES AND STAFF*

REFERENCES:

- The Joint Commission (2024). Hospital accreditation standards. EC.01.01.01 EP8 Joint Commission Resources. Oak Brook, IL

SUBJECT: **UTILITY SYSTEMS MANAGEMENT PLAN**	SECTION: **Page 1 of 11**

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

I. EXECUTIVE SUMMARY

The Environment of Care and the range of patient care services provided to the patients served by Sierra View Medical Center present unique challenges. The specific utility system risks of the environment are identified by conducting and maintaining a proactive risk assessment. A Utility Systems Management Plan based on various risk criteria, including risks identified by outside sources such as the Joint Commission, is used to eliminate or reduce the probability of adverse patient outcomes.

The Utility Systems Management Plan describes the risk and daily management activities that Sierra View Medical Center has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people coming to the organization's facilities. The Management Plan and the Utility Systems Management program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

The program is applied to Sierra View Medical Center (SVMC), Distinct Part Skilled Nursing Facility, Cancer Treatment Center, Ambulatory Surgery Department, Clinical Lab, Wound Healing Center, Urology Clinic, Sierra View Community Health Center, Surgery Clinic and Medical Office Building of Sierra View Medical Center. The Utilities Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care, business occupancies and temporary alternate care sites of Sierra View Medical Center. The plan also affects all staff, volunteers, medical staff and associates, including contracted services of Sierra View Medical Center.

II. PRINCIPLES

A. Utility systems play a significant role in supporting complex medical equipment and in providing an appropriate environment for provision of patient care services.

B. Orientation, education, and training of operators, users, and maintainers of utility systems is an essential part of assuring safe, effective care and treatment are rendered to persons receiving services.

C. Assessment of needs for continuing technical support of utility systems and design of appropriate calibration, inspection, maintenance, and repair services is an essential part of assuring that the systems are safe and reliable.

III. OBJECTIVES

Design, operate and maintain utility systems serving the buildings that house the healthcare services of Sierra View Medical Center to provide a safe, comfortable, appropriate environment that supports patient care and business operations.

Perform recommended maintenance to maximize system service life and reliability.

Manage the Utility Systems Management program to assure compliance with the Joint Commission requirements.

IV. PROGRAM MANAGEMENT STRUCTURE

A. The Facilities Manager assures that an appropriate utility system maintenance program is implemented. The Facilities Manager also collaborates with the Safety Officer to develop reports of Utility Systems Management performance for presentation to the Safety Committee on a quarterly basis. The reports summarize organizational experience, performance management and improvement activities, and other utility systems issues.

B. The Hospital's Board of Directors receives regular reports of the activities of the Utility Systems Management program from the Safety Committee. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Facilities Manager and appropriate clinical staff. The Board of Directors collaborates with the Chief Executive Officer and other Senior Leaders to assure budget and staffing resources are available to support the Utility Systems Management program.

C. The Hospital's Chief Executive Officer receives regular reports of the activities of the Utility Systems Management program. The Chief Executive Officer collaborates with the Facilities Manager and other appropriate staff to address utility system issues and concerns. The Chief Executive Officer collaborates with the Facilities Manager to develop a budget and operational objectives for the program.

D. The facility maintenance technicians, and selected outside service company staff, schedule and complete all calibration, inspection, and maintenance activities required to assure safe, reliable performance of utility systems in a timely manner. In addition, the technicians and service company staff perform necessary repairs.

E. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job-related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

V. PROCESSES OF THE UTILITY SYSTEMS PLAN

EC.01.01.01 EP9 – Plan for the Safe, Reliable, Effective Operation of Utility Systems

The Utility Systems Management Plan describes the procedures and controls in place to minimize the potential that any patients, staff, and other individuals coming to the facilities of Sierra View Medical Center may experience an adverse event while being monitored, diagnosed, or treated

with any type of medical equipment or being housed in an environment supported by the utility systems of Sierra View Medical Center.

EC.02.05.01 EP1 – Design and Installation of Utility Systems

The Facilities Manager works with qualified design professionals, project managers, and the intended end users of the space of Sierra View Medical Center to plan, design, construct, and commission utility systems that meet codes and standards and the operational needs of the patient care and business activities of Sierra View Medical Center. The construction and commissioning procedures are designed to assure compliance with codes and standards and to meet the specific needs of the occupants of every space. In addition, the design process is intended to assure performance capability meets current needs and sufficient additional capacity is available to manage unusual demands and to help assure that future demands on utility systems can be met.

EC.02.05.01 EP3 –Developing an Inventory of Utility Systems and Equipment

All utility systems' components and equipment are included in a program of planned calibration, inspection, maintenance, and testing. The components and equipment are inventoried at the time of installation and acceptance testing. The inventory is maintained on an ongoing basis by the Plant Operations staff. The inventory includes utility system equipment maintained by the Engineering and Maintenance staff and equipment maintained by vendors.

EC.02.05.01 EP4 – Determining System Risk

The Facilities Manager identifies high-risk, operating components of utility systems on the inventory for which there is a risk of serious harm or death to a patient or staff member should the component fail. High-risk, operating components of utility system include life-support equipment.

EC.02.05.01 EP5 & EP6 – Inspection, Testing, and Maintenance Intervals

The Facilities Manager uses manufacturer recommendations, applicable codes and standards, accreditation requirements, and local or reported field experience to determine the appropriate maintenance intervals for assuring safety and maximizing equipment availability and service life.

A computerized maintenance management system is used to schedule and track timely completion of scheduled maintenance and service activities.

The Facilities Manager is responsible for assuring that the rate of timely completion of scheduled maintenance and other service activities meets regulatory and accreditation requirements.

EC.02.05.02 EP1 – 4 – Management of Water Systems

The Facilities Manager and the Manager of Infection Control are responsible for identifying needs for procedures and controls to minimize the potential for the spread of infections through or by the utility systems.

Each clinical care service and support service is evaluated to determine the potential for hospital-acquired illness. Each potential is further evaluated to determine what role physical barriers and utility systems can play in contributing to or minimizing the potential.

The Facilities Manager and the Manager of Infection Control are responsible for developing procedures and controls to manage any identified potential for growth and/or transmission of pathogenic organisms in the domestic hot water system, cooling tower water, and other potential sources of waterborne pathogens.

The procedures may include periodic testing or treatment to control the risk and to inhibit the growth and spread of waterborne pathogens.

EC.02.05.01 EP15 & EP16 – Management of Ventilation Systems

The Facilities Manager and the Manager of Infection Control are responsible for designing procedures and controls for monitoring the performance of air handling equipment. The procedures and controls address maintenance of air flow rates, air pressure differentials in critical areas, and managing the effectiveness of air filtration systems.

Air handling and filtration equipment designed to control airborne contaminants including vapors, biological agents, dust, and fumes is monitored and maintained by Plant Maintenance.

The performance of all new and altered air management systems is verified by a qualified service provider. At a minimum, flow rates and pressure relationships are measured as part of the commissioning of all new building projects and major space renovations.

Periodic measurements of air volume flow rates and pressure relationships are tested in sensitive areas throughout the hospital. When the measured system performance cannot be adjusted to meet code requirements or occupant needs, the Facilities Manager and Manager of Infection Control develops, when appropriate, a temporary Infection Control Risk Management plan to minimize the potential impact of the deficient performance.

EC.02.05.01 EP17 – Mapping of Utility Systems

The Facilities Manager is responsible for maintaining up-to-date documentation of the distribution of all utility systems. The documents include as-built and record drawings, one line drawings, valve charts, and similar documents. The documents include original construction documentation and documentation of renovations, alterations, additions, and modernizations.

Hard copies of the documentation are maintained in the Plant Operations department. Documents that are available in electronic format are maintained on disc or on the Intranet server of the hospital.

EC.02.05.01 EP9 – Labeling of Controls for System Shutdown and Recovery

The Facilities Manager is responsible for assuring that current documents showing the layout of utility systems and the locations of controls that must be activated to implement a partial or complete shut-down of each utility system are available at all times.

The documents must include the original layout of the systems and all modifications, additions, and renovations that affect the process for implementing a partial or complete shutdown of a system. The documents must include information that can be used to identify specific controls. The controls must be identified by a label, numbered tag or other device that corresponds to the information on the documents.

EC.02.05.01 EP9 – 13 – Emergency Procedures

The Facilities Manager and appropriate clinical caregivers collaborate to identify life-critical medical equipment supported by the utility systems. Life-critical equipment is defined as equipment, the failure or malfunction of which would cause immediate death or irreversible harm to the patient dependent on the function of the equipment.

The Facilities Manager and the caregivers are responsible for developing appropriate resources to manage the response to the disruption of the function of the identified life-critical equipment. The resources are designed to minimize the probability of an adverse outcome of care.

The resources must include, but are not limited to, information about the availability of spare or alternate equipment, procedures for communication with staff responsible for repair of the equipment, and specific emergency clinical procedures and the conditions under which they are to be implemented.

Copies of applicable emergency procedures are included in the emergency operations manual of each clinical department. Training addressing the medical equipment emergency procedures is included in the department or job-related orientation process. All utility systems emergency procedures are reviewed annually.

EC.02.05.03 EP1 – 7 and EC.02.05.07 EP1 - 10 – Inspection, Testing, and Maintenance of Emergency Power Systems

The Facilities Manager is responsible for identifying all emergency power sources and for developing procedures and controls for inspection, maintenance, and testing to assure maximum service life and reliability. Sierra View Medical Center uses battery-powered lights, engine-

driven generators, and large UPS stored energy systems to provide power for emergency lighting, operation of critical systems, and operation of information systems equipment.

Each required battery-powered emergency lighting device is tested for 30 seconds each quarter and for 90 minutes annually.

The Emergency Power Supply Systems (EPSS) supply power for emergency exits, patient ventilation, fire and life safety equipment, public safety, communications, data and processes that, if disrupted, would have serious life safety or health consequences. Each required EPSS system is tested in accordance with the code requirements for the class of device.

The Facilities Manager is responsible for assuring that appropriate inspection, maintenance, and testing of the essential electrical system is done. Each motor/generator set serving the emergency power system is tested under connected load conditions 12 times a year. All automatic transfer switches are tested as part of each scheduled generator load test.

Testing parameters are recorded and evaluated by the Plant Operations staff. All deficiencies are rectified immediately or a temporary secondary source of essential electrical service is put in place to serve the needs to critical departments or services until the primary system can be restored to full service.

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

Each diesel engine powered motor/generator not loaded to 30% or more of its nameplate capacity during connected load tests undergoes further evaluation to determine if the exhaust gas temperature reaches or exceeds the manufacturer's recommended temperature to prevent wet stacking. Each diesel engine failing to meet the temperature recommendation will be exercised annually by connecting it to a dynamic load bank and performing the three step test process specified by National Fire Protection Association (NFPA) 99, NFPA 101 and NFPA 110.

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

EC.02.05.05 EP2 - Utility Systems Inventory and Initial Testing

The Facilities Manager establishes and maintains a current, accurate, and separate inventory of all utility systems equipment included in a program of planned inspection or maintenance. The inventory includes equipment owned by Sierra View Medical Center and leased or rented equipment.

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

EC.02.05.05 EP4 - Testing of High Risk Equipment

The Facilities Manager assures that scheduled testing of all utility systems that play a role in life support is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter. If the quarterly rate of completion falls below 100%, the Facilities Manager will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

EC.02.05.05 EP5 - Testing of Infection Control Support Equipment

The Facilities Manager assures that scheduled testing of utility systems equipment that supports critical infection control processes is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter. If the quarterly rate of completion falls below 100%, the Facilities Manager will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

EC.02.05.05 EP6 - Testing of Non-High Risk Equipment

The Facilities Manager assures that scheduled testing of all non-life support equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Safety Committee each quarter. If the quarterly rate of completion falls below 100%, the Facilities will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

EC.02.05.09 EP7 - Medical Gas System Testing

All medical gas systems are maintained and periodically tested to assure system performance. All testing and inspection is done in accordance with the requirements of the 2012 edition of NFPA 99.

UM.EC.02.05.09 EP10 - Modifying / Repairing Medical Gas Systems

When a new medical gas system is installed or an existing system is breached for any reason, the Facilities Manager coordinates certification of the system by a qualified service provider. The certification testing is done in accordance with the requirements of the 2012 edition of NFPA 99. The Facilities Manager maintains a permanent record of all certification testing.

EC.02.05.09 EP11 - Labeling & Accessibility of Medical Gas Controls

The Facilities Manager is responsible for assuring that all medical gas system control valves and monitoring stations are identified appropriately.

In addition, the Facilities Manager is responsible for assuring that each monitoring station and valve is accessible. Accessibility is evaluated during scheduled environmental tours. Deficiencies are reported to the appropriate manager for resolution.

EC.04.01.01 EP1 – 11 – The hospital monitors conditions in the environment

The Vice President of Quality and Regulatory Affairs coordinates the design and implementation of the incident reporting and analysis process. The Safety Officer works with the Vice President of Quality and Regulatory Affairs to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.

Incident reports are completed by a witness or the staff member to whom a patient or visitor incident is reported. The completed reports are forwarded to the Administrative Director of Quality and Care, who in turn works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

In addition, the Vice President of Quality and Regulatory Affairs and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the Safety Committee and the Performance Improvement/Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Safety Officer provides summary information related to incidents to the Chief Executive Officer, Senior Leaders, and the Board of Directors, as appropriate.

The Safety Officer coordinates the collection of information about environmental safety and patient safety deficiencies and opportunities for improvement from all areas of Sierra View Medical Center. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the seven environments of care use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

The Safety Committee and the Performance Improvement Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.

The Safety Officer and the Chairpersons of the Safety Committee and the Performance Improvement/Patient Safety Committee prepare a quarterly report to the leadership of Sierra View Medical Center. The quarterly report summarizes key issues reported to the Committees and their recommendations. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders that management responsibilities have been carried out.

EC.04.01.01 EP15 – Every twelve months the hospital evaluates each Environment of Care Management Plan, including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.

The Safety Officer coordinates the annual evaluation of the management plans associated with each of the Environment of Care functions.

The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The sources include aggregate analysis of environmental rounds and incident reports, benchmarking programs, findings of external reviews or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities.

The findings of the annual review are presented to the Safety Committee by the end of the second quarter of the calendar year. Each report presents a balanced summary of an Environment of Care program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.

In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Environmental Safety/Security Officer.

The results of the annual evaluation are presented to the Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, Senior Leadership, the Board of Directors, Department Directors, the Performance Improvement Patient Safety Committee, and others as appropriate. The manager of each Environment of Care program is responsible for implementing the recommendations in the report as part of the performance improvement process.

EC.04.01.03 EP2 - Analysis and actions regarding identified environmental issues

The Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

EC.04.01.05 EP1 – Improving the Environment

When the Board of Directors, Senior Leadership, and the Vice President of Quality and Regulatory Affairs concurs with the Safety Committee recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.

The Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital, performance improvement, and patient safety leadership.

Goal:

Continue to work with Engineering to improve the Preventative Maintenance quarterly completion rate to 100%. The current rate is 98% in the Osborne Engineering Benchmarking Database.

HR.01.04.01 EP1 & EP3; HR.01.05.03 EP1 and EC.03.01.01 EP1 & EP2 – Orientation and Ongoing Education and Training

Orientation and training addressing all subjects of the environment of care is provided to each employee, volunteer, contract staff and to each new medical staff member at the time of their employment or appointment.

In addition, all current employees, as well as volunteers, physicians, and students, participate in an annual update of the orientation program as deemed appropriate. The update addresses changes to the procedures and controls, laws and regulations, and the state of the art of environmental safety.

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Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Safety Committee. When deficiencies are identified, action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

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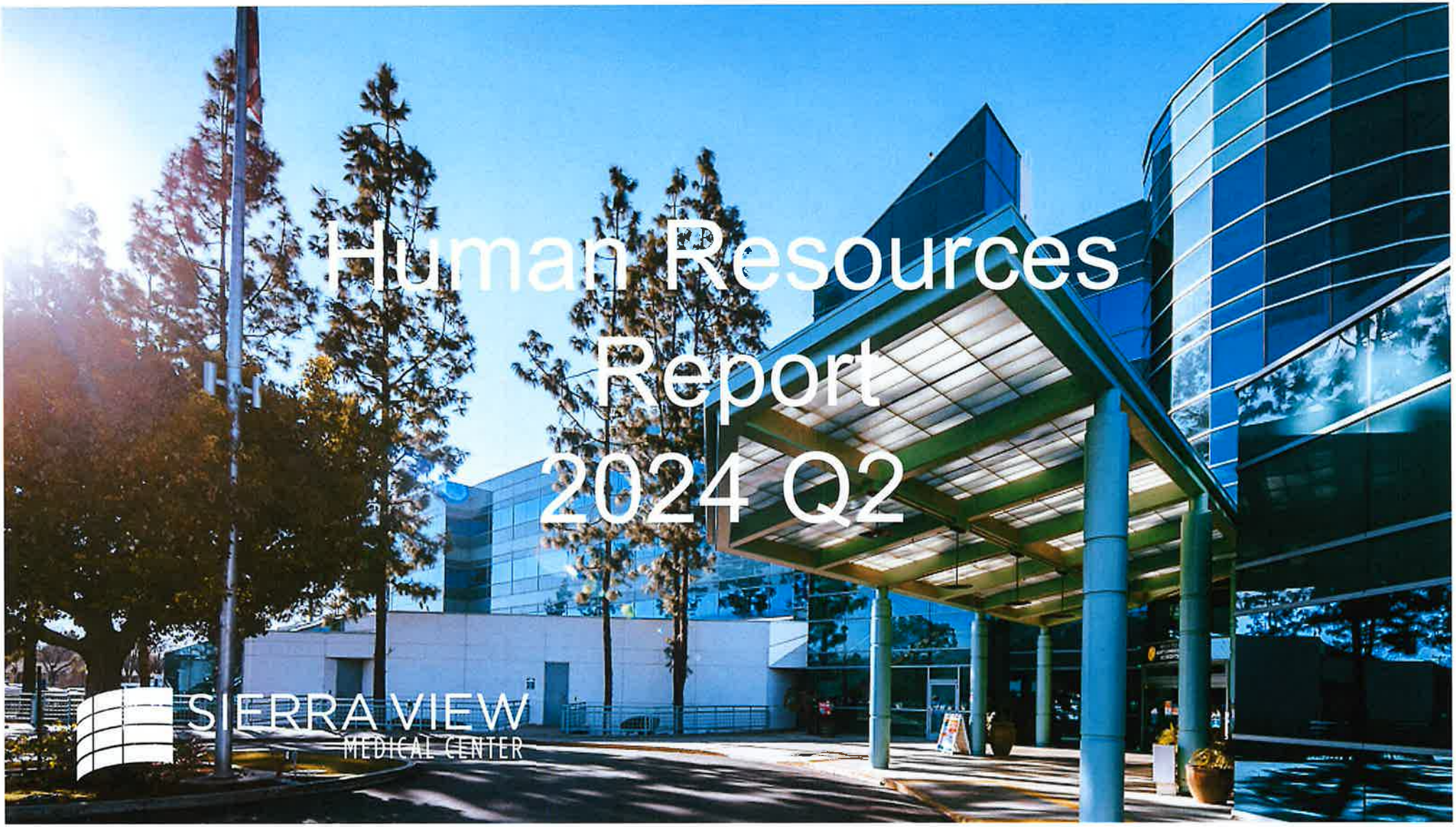
REFERENCES:

- The Joint Commission (2024). Hospital accreditation standards. EC.01.01.01 EP9 Joint Commission Resources. Oak Brook, IL.


Human Resources
Report
2024 Q2
SIERRA VIEW
MEDICAL CENTER

HR Report Card

Measurement	QTR 1	QTR 2	QTR 3	QTR 4	YTD	Annualized	Goal	Variance
EE Referral Rate	35%	31%			33%	33%	NA	NA
Geofencing Rate	2%	8%			5%	5%	NA	NA
Timely Eval	74%	83%			78%	78%	90%	-12%
Turnover	3.7%	4.1%			8%	16%	12%	-4%
RN Turnover	3.0%	4.0%			7%	14%	13%	-1%
Employee Retiention >5 Years	45%	46%			46%	46%	50%	-4%


SVMC Recruitment
SIERRA VIEW
MEDICAL CENTER

Recruitment Update QTR 2

April Hires
Full Time: 22
Per Diem: 5
SPD RN: 1
RN: 9
Transfers: 12
RPO: 0
Total Reqs Filled: 27

May Hires
Full Time: 27
Per Diem: 10
SPD RN: 4
RN: 9
Transfers: 8
RPO: 2
Total Reqs Filled: 37

June Hires
Full Time: 23
Per Diem: 7
SPD RN: 0
RN: 8
Transfers: 8
RPO: 2
Total Reqs Filled: 30

Totals
Full-Time Staff: 72 Per-Diem: 22
SPD RNs: 5 RNs: 26 RPO: 4
Total New Hires: 68 – Total Reqs filled: 94

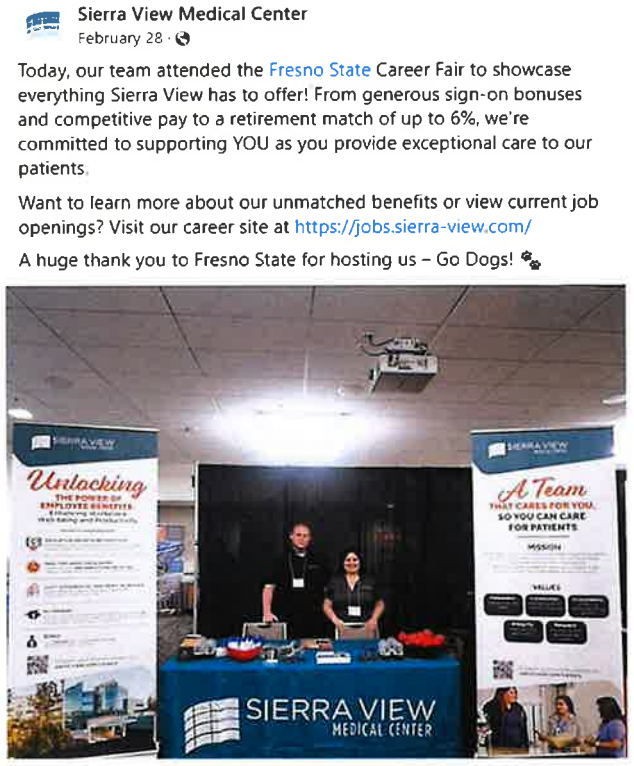
Recruitment Metrics in QTR 2

- Talent Acquisition Activity
  - Average days from Submittal of Application to Interview: 6 DAYS
  - Average days from Interview to Offer: 1 DAY
  - Average days from Offer to Decline (if declined offer): 1 DAY
  - Average days from Acceptance to Start: 27 DAYS
  - Top Reason for Offers Declined: Accepted Another Offer.

- Candidate Activity
  - Total # of Jobs Opened: 83
  - Total # of Jobs Closed: 94
  - Total # of Screened Applications: 1328
  - Total # of Interviews: 170
  - Total # of Declined Offers: 8 (3 RPO)
  - Total # of RPO Hires: 3

Recruitment Events/Projects in Q2

- Action Items
  - Social Media: Working with marketing to post hiring events and weekly highlighted jobs.
  - RPO Contract with Cross Country has filled 13 positions with more coming.
- April Events
  - 4/3/24 – Tulare Adult School LVN Career Fair
  - 4/10/24 – Visalia Adult School Career Fair
  - 4/16/24 – Porterville College Career Fair
  - 4/16/24 – Bakersfield College Career Fair
- May Events
  - 5/14/24 – COS Clinical Career Fair
  - 5/23/24 – "Welcome to the Big Leagues" Open House Career Event.



Upcoming Recruitment Events/Projects for 2024

- August/September
  1. Meet and Greet with SJVC New Grad RN Students
  2. Meet and Greet with SJVC LVN to RN Bridge Students
  3. Meet and Greet with PC RN Students

- October/November
  1. Porterville College RN Student Luncheon
  2. New Grad Interview Day
  3. Tulare County Workforce Investment Career Fair


EMPLOYEE RELATIONS
SIERRA VIEW
MEDICAL CENTER

Employee Relations

Progressive Disciplinary Actions

- 25 Attendance NOCA's processed
- 21 Performance NOCA's processed
- 50 Terminations processed

Performance Management Activities

- 5 Performance Plans Supported
- 31 investigations conducted

Exit Survey Activity

- 3 in-person exit survey's
- 30 electronic exit survey's launched
- 11 electronic exit survey's received

employersedge

Unemployment Claims Management

- Submitted 22 UI claims
- Attended 10 UI Hearings
- 8 Favorable Hearings
- 2 Unfavorable Hearings

Employee Relations Consultations*

- 14 staff consultations
- 21 management consultations
- 8 policy consultations

**#'s reflect from mid-May to June only*

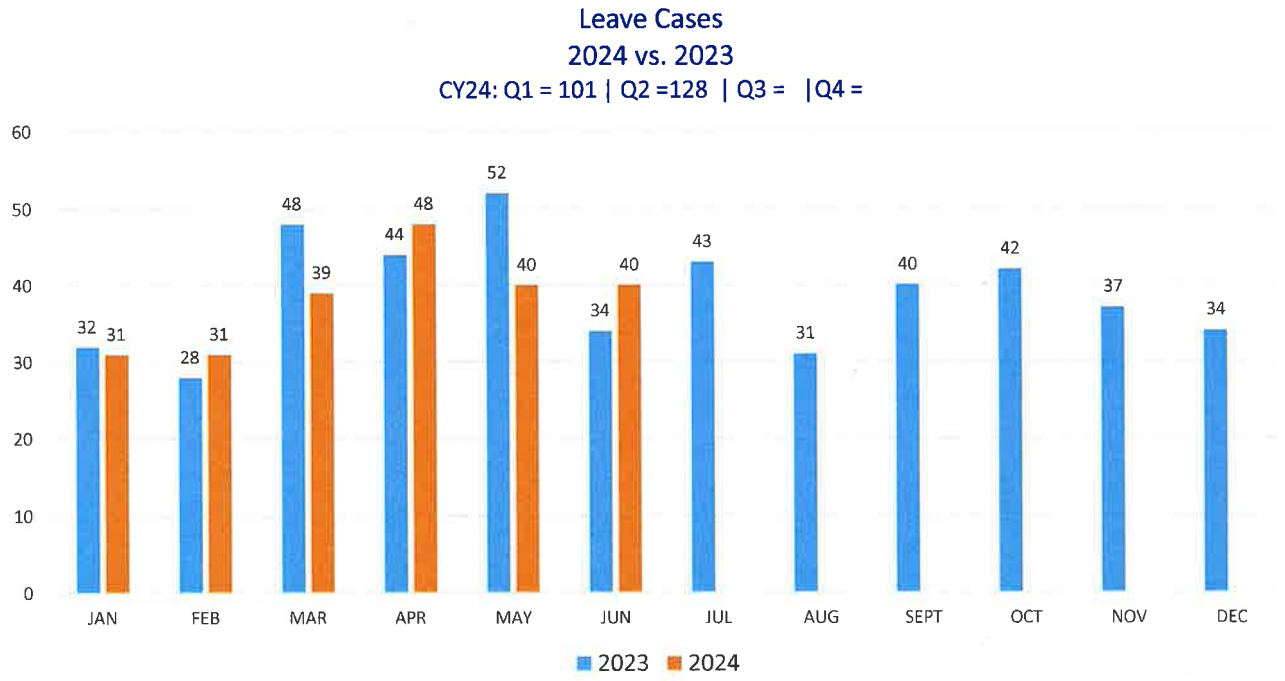
Training & Development

HR Training Sessions

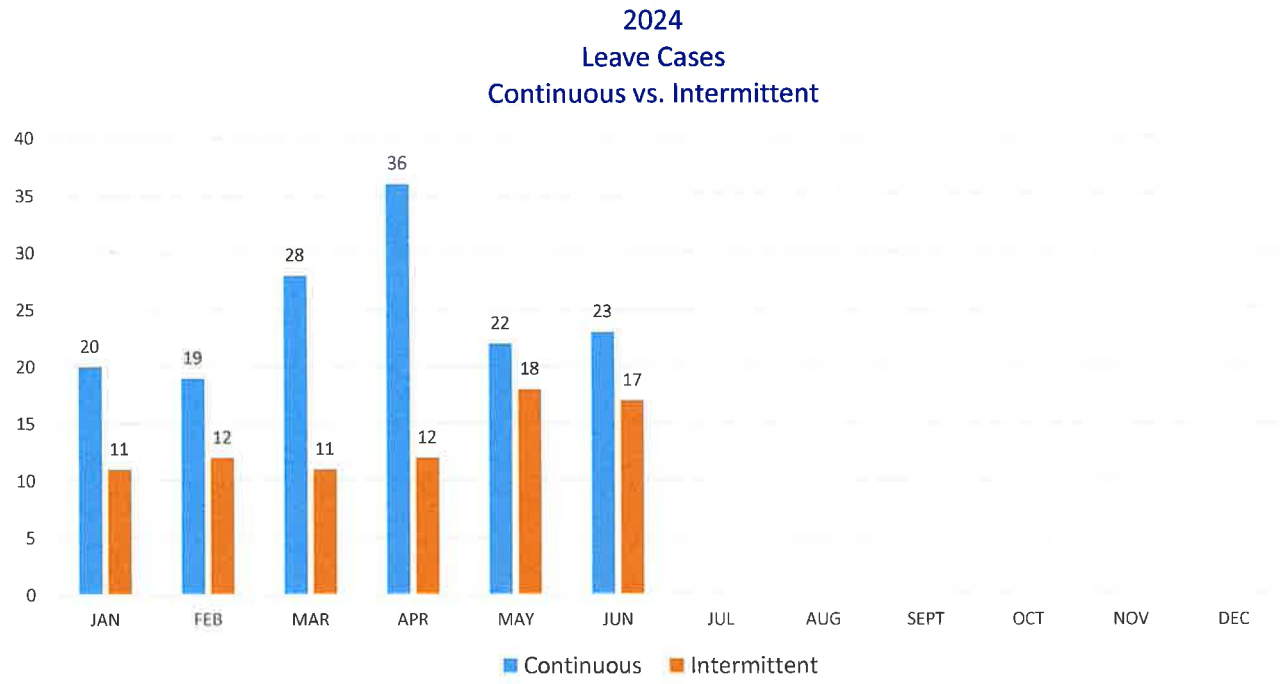
- 4 NHO sessions facilitated
- 50 New hires trained
- 62 Sexual Harassment modules launched
- 26 Leaders Trained on Datix


LEAVE OF ABSENCE
UPDATE
SIERRA VIEW
MEDICAL CENTER

Leave of Absence Update



Leave of Absence Update



Leave of Absences Processed in Q2

Total # of new FMLAs Processed- **58**
Total # of new I-FMLAs Processed- **45**
Total # of new ADAs Processed- **15**
Total # of new Workers Compensation Leaves- **9**
Total # of Extended Leaves Processed-**33**
Total # of Personal Leaves Processed-**2**
Total # of Leaves due to expired licensure/provider cards-**7**
Total # of Return to Work Processed-**74**
Total # of ALL Leaves for this period-**127**

Consultations with Benefits/Leave Coordinator

Consultations with Benefits/Leave Coordinator- **271**

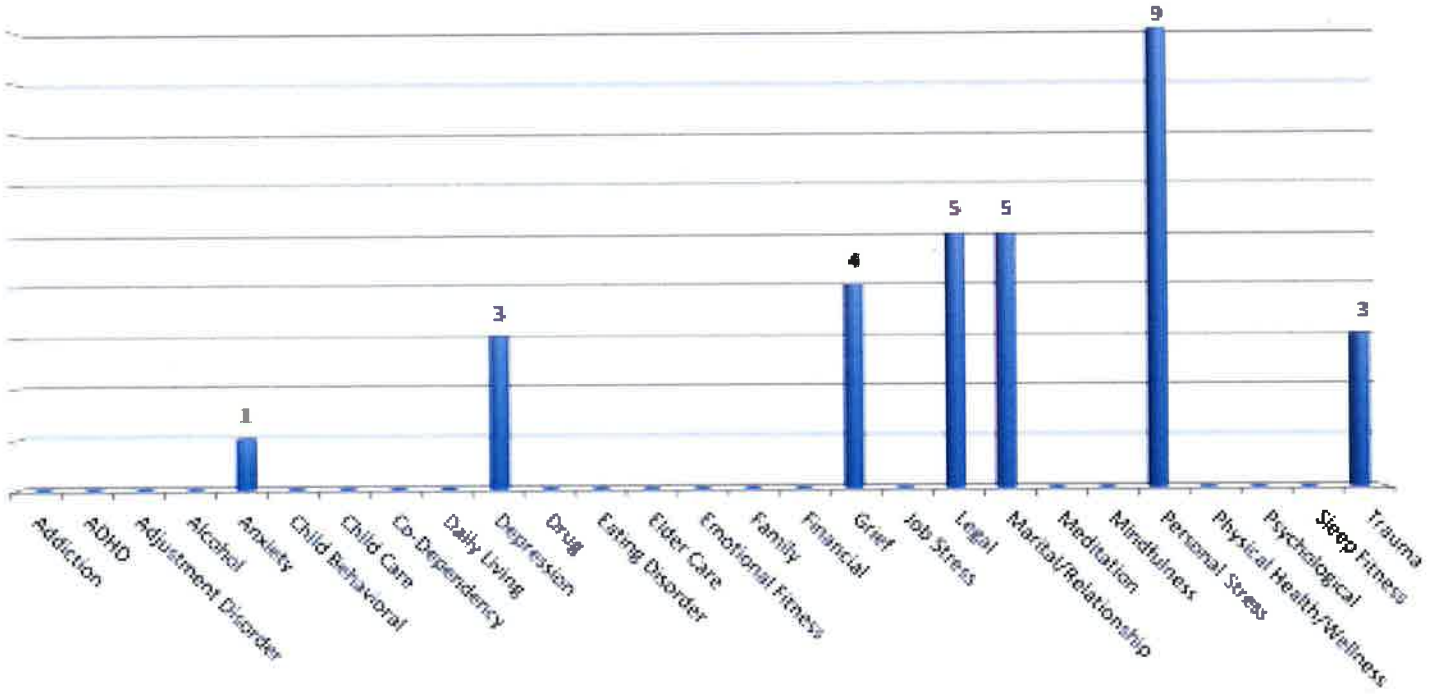
- Benefit consultations- **74**
- LOA consultations - **109**
- SVMC policies clarifications- **34**
- Miscellaneous Consultations - 54


BENEFITS UPDATES
SIERRA VIEW
MEDICAL CENTER

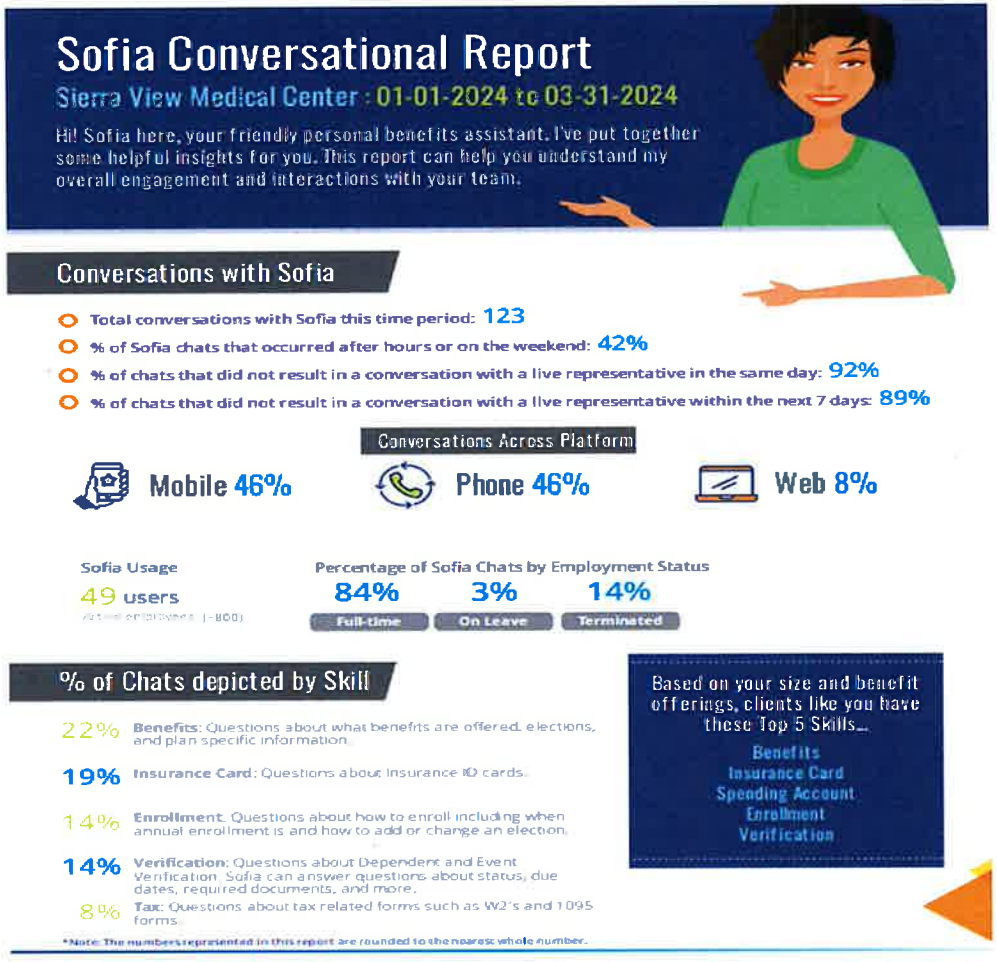
Simple Therapy- EAP

1/1/2024 THRU 3/31/2024

*WILL ALWAYS BE A QTR BEHIND



Benefits Conversational Report



Businessolver/Benefits Center QTRLY Activity- 1/1/2024 thru 3/31/2024

*WILL ALWAYS BE A QTR BEHIND


HR POLICY REVIEW
SIERRA VIEW
MEDICAL CENTER

HR Policy Reviews/Approvals

April

1. Salary Grades and Ranges- NO Changes

May

1. On-Call/Call Back- Changes
2. Paid Sick Leave- Changes
3. Per Diem Protocol- Changes

June

1. Exempt Employee Compensation- Changes
2. Jury Duty and Witness Duty- NO Changes
3. Lactation/Breastfeeding- Changes
4. Referral Bonus- Changes


REGULATORY/COMPLIANCE
UPDATES
SIERRA VIEW
MEDICAL CENTER

Regulatory Compliance/Audits

OF INTERNAL AUDITS CONDUCTED
NONE this Quarter

OF REGULATORY SURVEYS PARTICIPATED IN
1. 5/30/2024- DHS/DP-SNF

Total # of Evaluations processed- **213**
Total # of ECN's processed- **74**


HR PROJECT UPDATES
SIERRA VIEW
MEDICAL CENTER

HRIS Project Update

- UKG Pro WFM
  - Go-live is set for 7/28/2024
  - HR Pending items
    - Benefit import
    - Retirement ER Match
- Leaves
  - Leave History import scheduled for 7/28/2024
- Attendance
  - Attendance History import scheduled for 7/28/2024
- Recruiting
  - Go-live is set for 7/28/2024
  - Pending items
    - E-quest Account Setup
    - Career Web Page Design
- Onboarding
  - Go-live is set for 7/28/2024
  - Pending items
    - Document upload
    - Onboarding processes
- Performance Management
  - Kickoff Call scheduled for Friday, 7/12th

Total number of report requests: 18
Total Analyses: 4
Total number of staff support reports generated: 12

HR Key Accomplishments

- Revised several form stack workflows related to position control, recruitment, and onboarding processes
- Continued implementation phase of UKG PRO conversion with HRIS being key contributor for the project
- Started implementation phase of UKG PRO for Recruitment and Onboarding
- Continuing DUAL ENTRY into UKG PRO and KRONOS
- Implemented PSL Policy changes regarding cash out option and per diem accrual (on hold again until UKG goes live)
- Implemented Retirement change to EE Contribution %, based on earnings with no cap
- Policy changes to Per Diem Protocol and Flexing staff
- Completed projections for 2024-2025 fiscal year budgets
- Updated our Telework Agreement to include notice of moves
- Completed revisions of Employee Handbook for 2024
- Recruited new HR Generalist
- 2024 TB Non-Compliance completed
- Added Outside Declaration Form in Formstack for process efficiency
- Added a method on HR New Hire Welcome Page to upload licenses and certs
- Implemented a notification process to Leaders' Supervisor to provide Leadership orientation checklist
- Added a new indicator on termination notification to include pharmacy red flag
- HR Manager Hosted Friends of the Library Session
- HR Partnered w/Care Continuum Management to launch LCSW Supervisory Training Program (hope to launch soon)
- Re-Launched NODA Program


Marketing Report
2024 Q2
SIERRA VIEW
MEDICAL CENTER


SVMC Marketing
Social Media
SIERRA VIEW
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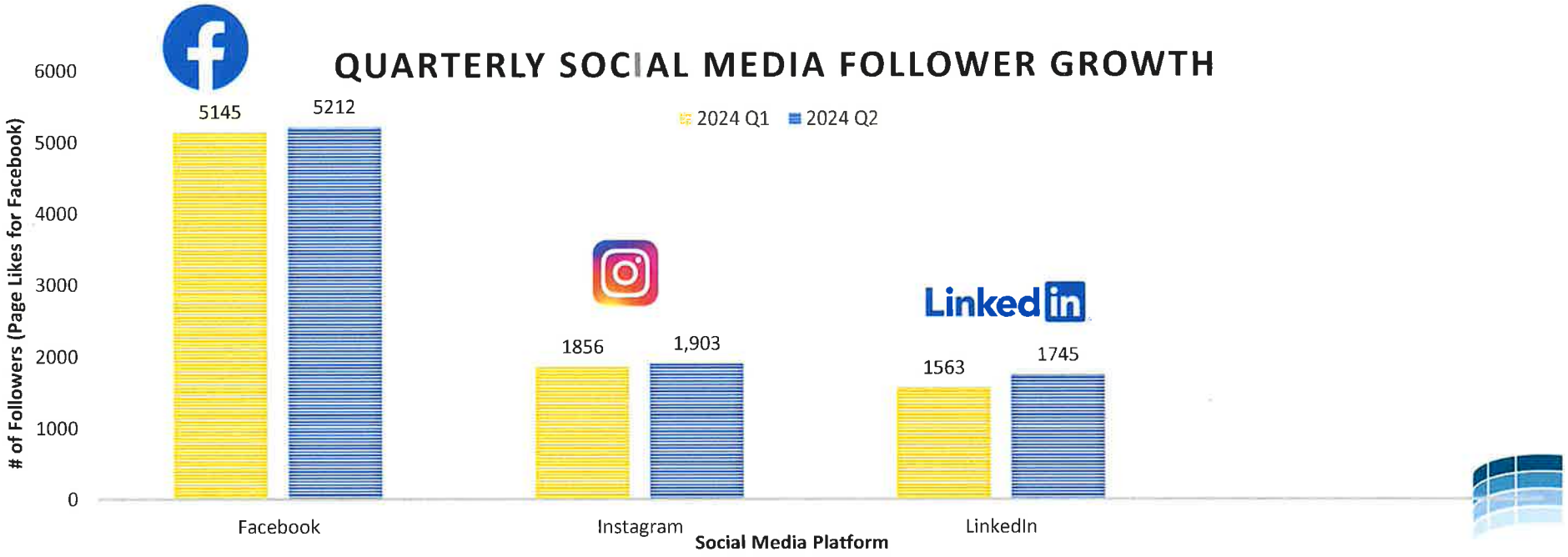
2024 Q2 Social Media Growth

Platform	2024 Q1	2024 Q2	Followers Gained
Facebook	5,145	5,212	67
Instagram	1,856	1,903	47
LinkedIn	1,563	1,745	182

SVMC social media platforms continue to experience a steady growth. Average growth for Q2 was 3.46% in overall audience net gain. A total of 296 new followers was gained across the three platforms.



2024 Social Media Follower Growth Q2

Platform	Follower Growth Q2
Facebook	1.3%
Instagram	2.53%
LinkedIn	11.64%

Mid-year goal: 4% growth
2024 goal: 8% growth

Average growth for Q1-Q2: 5.81%

Q2 Social Media Analytics

	Facebook	Instagram	Linkedin	Overall	Goal (Overall Quarterly Goal)
# of Posts	97	128	49	274	250 per quarter
Impressions	475,081	109,377	23,003	607,461	625,603
Engagements	39,772	4,004	5,262	49,038	48,587
Engagement Rate	8.4%	3.7%	22.9%	8.1%	8.4%

- **# of Posts:** Realistic goal for SVMC that keeps up with industry standards
- **Impressions & Engagements Goals:** 10% growth from previous year-to-date
- **Engagement Rate Goal:** 7.5% growth from previous year-to-date

Top-Performing Stories

Marketing continues to focus on a variety of key categories for social media outreach including: Employees, recruitment, events, partnerships, programs, Board, Foundation, and patient stories.

Top-performing content included our refurbished Little Libraries, Pet Partners Recruitment, a Donate Life story from an SVMC employee, welcoming another Vizient Cohort, and celebrating Java Express's 1st anniversary at SVMC.

Top-Performing Stories By Engagements

Top-performing content by engagements included our first GME Graduation, SVF Golf Classic, welcoming a new Vizient Cohort, Doctor's Day dinner recap, Hospital Week Breakfast, and Wear Blue & Green Day for National Donate Life Month.

Sierra View Medical Ce...
Mon 6/17/2024 1:26 pm PDT

Congratulations to our 2024 Graduate Medical Education Graduates! 🎓 Sierra View Medical Center's inaugur...

Total Engagements	**2,166**
Reactions	59
Comments	3
Shares	2
Post Link Clicks	13
Other Post Clicks	2,089

Sierra View Medical Ce...
Mon 4/29/2024 9:30 am PDT

On Friday, the Sierra View Foundation hosted the 19th Annual Sierra View Golf Classic at Valley Oaks Golf Cours...

Total Engagements	**1,976**
Reactions	59
Comments	1
Shares	2
Post Link Clicks	—
Other Post Clicks	1,914

Sierra View Medical Ce...
Wed 4/24/2024 6:06 pm PDT

Today, we proudly welcomed our Vizier American Association of Colleges of Nu Nurse Residency Cohort #14! 🎉 Our y

Total Engagements	**1,943**
Reactions	300
Comments	7
Shares	5
Post Link Clicks	2
Other Post Clicks	1,629

Sierra View Medical Ce...
Thu 4/4/2024 4:34 pm PDT

Lights, Camera, Appreciation! Last night Sierra View Medical Center rolled out the red carpet for our 2024...

Total Engagements	**1,396**
Reactions	113
Comments	3
Shares	4
Post Link Clicks	—
Other Post Clicks	1,276

Sierra View Medical Ce...
Tue 5/14/2024 12:03 pm PDT

Happy Hospital Week from Sierra View Medical Center! 🎉 We kicked off our 'Around the World' celebration with ...

Total Engagements	**1,383**
Reactions	59
Comments	1
Shares	1
Post Link Clicks	—
Other Post Clicks	1,322

Sierra View Medical Ce...
Fri 4/12/2024 4:34 pm PDT

Today, we're proudly celebrating National Donate Life America Blue & Green Day! 💙💚 It's a day dedicate...

Total Engagements	**1,182**
Reactions	50
Comments	4
Shares	1
Post Link Clicks	—
Other Post Clicks	1,127

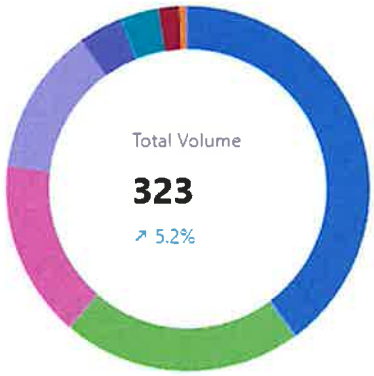
Top-Performing Ads by Reach and Link Clicks

Platform	Post	Date	Link Clicks	Reach
Facebook	Registered Nursing Careers	April 12th - May 27th	589	23,104 reached for $250 over 45 days

Category Breakdown for Social Posts

General

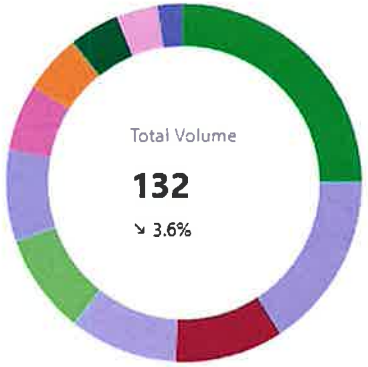
Tagged Published Post Volume



Employees	39.9%
Holiday & Observances	21.4%
events	15.8%
recruitment	13%
Community	4%
Awards	3.4%
Updates	1.9%
Patient Portal	0.6%

Service Line

Tagged Published Post Volume



Nursing Services	25%
Hip & Knee Center	9.8%
SV Foundation	9.8%
DP/SNF	9.1%
GME	8.3%
CTC	6.1%
Emergency Services	5.3%
Maternal Child Health	4.5%
Wound Healing	3.8%
ASD	2.3%
All Other Tags	15.9%

Q2 Competitor Info from Sprout Social (Facebook)

	Kaweah Health	Sierra View Medical Center
Posts	90 posts	94 posts
Follower Growth	Net 42 (Increase of 0.16%)	Net 77 (Increase of 1.50%)
Engagements per post on average	42.17 reactions, comments, and shared	58.21 reactions, comments, and shares
Published Photos	61	88

Q2 Competitor Info from Sprout Social (Instagram)

	Kaweah Health	Sierra View Medical Center
Posts	136 posts	97 posts
Follower Growth	Net 209 (Increase of 2.94%)	Net 48 (Increase of 2.59%)
Engagements per post on average	99.05 reactions, comments, and shared	39.37 reactions, comments, and shares
Published Photos	62	48

SVMC Marketing Reputation Management

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MEDICAL CENTER

Q1 Overall Reputation: All Locations

Platform	Total Reviews in 2024 Q1	Total Reviews in 2024 Q2	Reviews Gained
Google	646	1,030	384

SVMC Google Profiles experienced a large increase in Google Reviews after the launch of Reputation. Average review volume increased by 59.44% in Q2. A total of 384 new reviews were left during this time period.

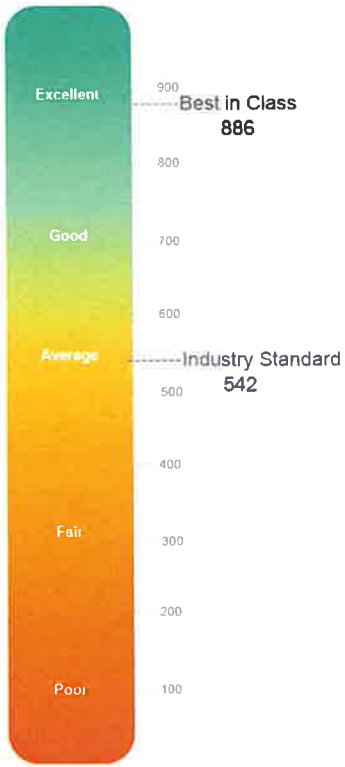
Location	Current Google Rating
Sierra View Medical Center	3.0 Stars
SVMC Medical Office Building	4.5 Stars
Roger S. Good Cancer Treatment Center	4.5 Stars
SVMC Urology Clinic	4.3 Stars
SVMC Physical Therapy	4.9 Stars
SVMC Ambulatory Surgery Center	4.9 Stars
SVMC Wound Healing	5 Stars
Sierra View Community Health Center – Terra Bella	4.7 Stars
SVMC General & Colorectal Surgery Center	4.3 Stars

Sentiment Map

Reviews & Average Rating in Q2

Location (8)	Total Reviews	Average Rating	Reputation Score
Sierra View Community Health Center – Terra Bella (SVMC_Terra_Bella_Clinic)	7 0% | 0% | 100%	5.0 /5	754
Sierra View Medical Center Urology Clinic in alliance with Keck Medicine of USC (SVMC_Urology_Clinic)	7 14% | 0% | 86%	4.4 /5	616
Sierra View Physical Therapy (SVMC_PT)	8 0% | 0% | 100%	5.0 /5	801
SVMC Wound Healing Center (SVMC_Wound_Healing)	9 0% | 0% | 100%	5.0 /5	826
SVMC Ambulatory Surgery Center (SVMC_ASC)	16 0% | 0% | 100%	5.0 /5	832
SVMC Roger S. Good Cancer Treatment Center (SVMC_CTC)	21 0% | 0% | 100%	5.0 /5	817
Sierra View Medical Center (SVMC)	149 28% | 3% | 69%	3.8 /5	590
SVMC Medical Office Building (SVMC_MOB)	167 6% | 2% | 92%	4.7 /5	778

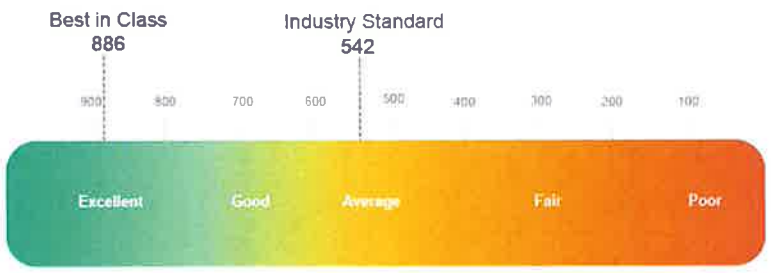
Overall Reputation: All Locations



Location (9)	Reputation Score	Review Sentiment	Review Volume	Review Recency	Review Quality	Review Spread	Review Response	Search Impressions	Listing Completeness
Sierra View Medical Center (SVMC)	598	• 39%	52%	99%	65%	52%	100%	74%	87%
Sierra View Medical Center Urology Clinic in alliance with Keck Medicine of USC (SVMC_Urology_Clinic)	621	• 61%	52%	89%	• 30%	52%	100%	• 31%	77%
SVMC Medical Office Building (SVMC_MOB)	753	82%	52%	86%	53%	52%	100%	74%	73%
Sierra View Community Health Center – Terra Bella (SVMC_Terra_Bella_Clinic)	758	88%	43%	86%	• 32%	52%	100%	• 59%	77%
Sierra View Physical Therapy (SVMC_PT)	803	96%	43%	86%	• 30%	52%	100%	74%	77%
SVMC Roger S. Good Cancer Treatment Center (SVMC_CTC)	815	94%	52%	89%	51%	52%	97%	74%	77%
SVMC Wound Healing Center (SVMC_Wound_Healing)	827	100%	49%	86%	• 21%	52%	100%	74%	77%
SVMC Ambulatory Surgery Center (SVMC_ASC)	833	98%	52%	86%	56%	52%	100%	74%	77%

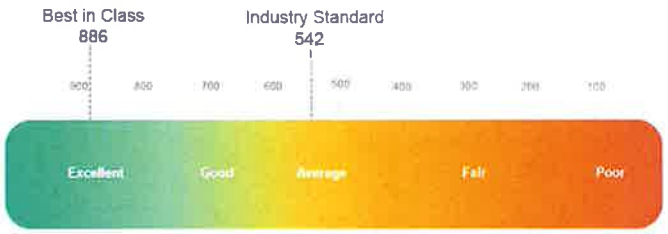
Competitive Analysis: Reviews in Q2

Location (4)	Total Reviews	Average Rating	Reputation Score
Adventist Health Hanford	358 12% | 5% | 83%	4.3 /5	782
Sierra View Medical Center (SVMC)	149 28% | 3% | 69%	3.8 /5	590
Kaweah Health Medical Center	32 38% | 6% | 56%	3.3 /5	565
Dignity Health - Memorial Hospital	12 42% | 16% | 42%	3.1 /5	526



Competitive Analysis: Reputation Scores in Q2

Location (4)	Reputation Score	Review Sentiment	Review Volume	Review Recency	Review Quality	Review Spread	Review Response	Search Impressions	Listing Completeness	Social Score
◆ Best In Class	886	100%	77%	100%	92%	76%	100%	100%	100%	86%
● Industry Average	542	69%	42%	55%	38%	49%	80%	67%	70%	77%
Adventist Health Hanford	782	82%	66%	100%	66%	64%	100%	74%	● 33%	-
Sierra View Medical Center (SVMC)	590	● 37%	52%	97%	65%	52%	100%	74%	87%	◆ 95%
Kaweah Health Medical Center	565	● 37%	66%	100%	68%	64%	100%	74%	● 52%	-
Dignity Health - Memorial Hospital	526	● 35%	66%	100%	● 24%	64%	82%	74%	● 46%	-




SVMC Marketing
Public & Media
Relations
SIERRA VIEW
MEDICAL CENTER

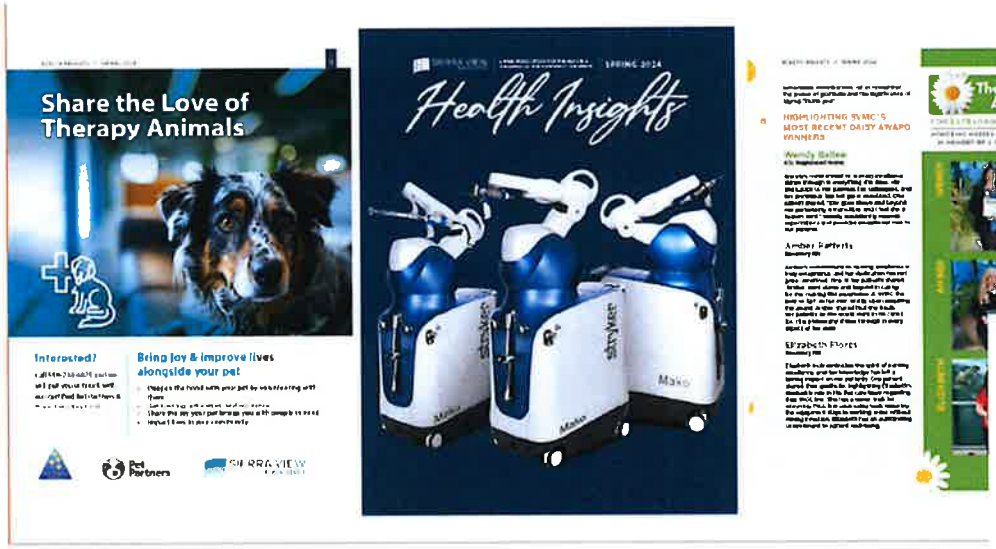
SVMC in the News Making Headlines

In Q2 Sierra View published a total of 5 press releases and was highlighted with a total of 19 press mentions. Some of those highlights include:

1. Spring Health Insights Magazine
2. California Hospital CFO Retirement
3. Leapfrog Group Grades
4. Retirement Story
5. Gift of Life, Donor Story
6. SVMC Graduates first set of resident physicians
7. Sierra View wins four categories in Best of Central California People's Choice Awards

Inside View

Sierra View Medical Center delivered 3 installments of our digital newsletter Inside View to those who sign up through sierra-view.com. This publication gives a monthly recap of everything happening with Sierra View. In addition, the Spring edition of Health Insights was published.




SVMC Marketing
Community Relations,
Events and Fundraising
SIERRA VIEW
MEDICAL CENTER

Community Events

April
Porterville Chamber Business After Hours – Meet Mako
Child Abuse Awareness – Parenting Network
Donor Network West – Organ Donor Flag Raising Ceremony
Sierra View Foundation Golf Tournament
Lunch and Learn with COS Nursing Students
Meet the Pros Career Panel with Porterville Pathways

May
Porterville Chamber Spring Festival
Porterville College Ribbon Cutting
Alta Vista Elementary Health and Resource Fair
Cinco De Mayo Parade
Educational Dinner with Valley Children's Hospital

June
Cancer Treatment Center's Survivor's Day Celebration
Summer Lunch at the Library Series (Every Friday for 8 weeks)
United Way's Power of the Purse

Community Relations Outreach

April
April 5 - First Friday Coffee hosted by REACH Air Medical Services
April 10 - ABC30 Advisory Council Meeting, Fresno CA
April 18 - Adjudicator for the Senior Capstone presentations through MTA Pathway 8:30 a.m. 12:30 @Monache
April 24 - Sun Gazette Paper & Pastries, Lindsay Wellness and Aquatic Center, Lindsay CA 7-9 a.m.

May
May 8: TKHCC Networking Lunch
May 8: Business After Hours hosted by Valley Strong
May 14: Porterville Wellness Center Open House
May 15: Porterville Chamber Coffee with the CEO
May 23 Ribbon Cutting KTIP 101.3FM and 1460 AM

June
6/12: TKHCC Luncheon
6/18: Coffee with the Porterville Chamber CEO
6/27: Government Affairs Meeting (special meeting to review next steps for policy
6/27: Tulare County CEDS Collaborative Meeting


SVMC Marketing
Internal
Communication
SIERRA VIEW
MEDICAL CENTER

Internal Communications:

- Overall our Click-to-Open Rate decreased slightly from Q1 (12.87%). We are at 10.91% for Q2 with a total of 50,155 internal communications delivered.
- Top performing campaign: Leadership Team Bi-Weekly Update with a 93.62% open rate and June Policy Updates for Leadership with a 91.49% open rate.
- SVMC May 8th Chaplaincy Weekly Announcement (5.61% open rate)

59 **Total Campaigns List**

58.10% (Open Rate)

SVMC Click to Open Rate 10.91%

Industry Standard: 28.06% (open rate)
(Approx.. Expected open rate for health care and wellness newsletter. Source: Constant Contact
(Parent company for our vendor, Emma)

Types of Communication

- Weekly Update
- Quality Updates
- Leadership Updates
- Software Updates
- Benefits, HR and Services
- Chaplaincy Services
- Events


SVMC Marketing
Questions? Contact Marketing (MarketingDept@sierra-view.com)
SIERRA VIEW
MEDICAL CENTER

MEDICAL EXECUTIVE COMMITTEE	08/07/2024
BOARD OF DIRECTORS APPROVAL	
	08/27/2024
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
August 27, 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:

	Pages	Action
I. Policies:		**APPROVE**
• Anticoagulation Policy	1-42	
• Aseptic Technique, Utilization of	43-47	
• Assessment of Patients for Surgical/Invasive Procedures	48-49	
• Chemotherapy Competency Policy	50-51	
• Citations/Interviews of Patients by Law Enforcement	52-54	
• Color – Coded Wristband Use	55-58	
• Conduct Methicillin Resistant Staphylococus Aureus (MRSA) Screening	59-61	
• Guidelines for Product Dating	62-66	
• Intravenous Therapy: Potassium Salts	67-68	
• Laryngoscope Blades Processing & Storage	69-70	
• Management of Radiographic Contrast Media	71-73	
• Medical Scribe Policy	74-76	
• Patient Admission Process	77-80	
• Pharmacy Floor Checks	81-82	
• Post Operative Care for Surgical/Invasive Procedure Patients	83-87	
• Qualified Personnel: Arterial Puncture	88	
• R.I.S.E (Response in a Stressful Environment)	89-92	
• Scabies	93-94	
• Scope of Services for the Intensive Care Unit	95-96	
• Seeing/Hearing/Companion Dog (Service Animals)	97-98	
• Sterile Hazardous Drugs Handling	99-118	
• Sterile Products: Sterile Product Quality Assurance	119-132	
• Surgical Hand Scrub	133-135	
• Therapeutic Drug Substitution Protocol	136-146	
• Utilization Review Plan	147-151	

PURPOSE:

To provide a guideline for the safe and effective use of anticoagulation for therapeutic use.

POLICY:

The clinical pharmacist will monitor oral anticoagulation (e.g., warfarin, rivaroxaban, apixaban) and treatment enoxaparin to maintain therapeutic anticoagulation, minimize anticoagulant toxicity, and maximize the use for each hospital stay to achieve the therapeutic goals.

It is the policy of Sierra View Medical Center (SVMC) to use weight-based heparin dosing guidelines for anticoagulation. The therapeutic objective goal of the weight-based heparin continuous infusion is to maintain an aPTT of 50-79.9 seconds.

Guidance provided in this policy is not intended to, and should not, replace clinical judgment of the care provider.

AFFECTED AREAS/PERSONNEL: *NURSING, PHARMACY, PHYSICIANS*

PROTOCOL & PROCEDURE:

1. Dispensing/Administration

    a. To reduce compounding and labeling errors for anticoagulants, SVMC uses only oral unit dose products, pre-filled syringes, or pre-mixed infusion bags for anticoagulants when these types of products are available.

        i. For pediatric patients, if pre-filled syringe products specifically designed for children are not available, Pharmacy will prepare unit dose products, pre-filled syringes, or pre-mixed infusion bags.

        ii. Pharmacists will clarify all anti-coagulation dosing for pediatric patients.

    b. When heparin or argatroban is administered intravenously and continuously, SVMC uses programmable Alaris infusion pumps in order to provide consistent and accurate dosing.

2. Medication Selection

    a. The initiation and maintenance of anticoagulation therapy will be based on guidelines appropriate to the medication used, to the condition being treated, and to potential drug interactions.

        i. The use of direct oral anticoagulants (DOACs) over vitamin K antagonist (VKA) therapy in non-valvular atrial fibrillation is recommended.[1]
        ii. For venous thromboembolism (VTE) without an associated cancer diagnosis, DOACs (dabigatran, rivaroxaban, apixaban, or edoxaban) are recommended over

VKA therapy and VKA therapy is recommended over low molecular weight heparin (LMWH).[2]

iii. For VTE associated with cancer, LMWH is recommended over VKA or any DOACs.[2]

iv. Consider warfarin in cases of severe allergy or contraindication to DOACs or in cases of end-stage renal disease (ESRD).

3. Ordering Labs[3-8]

a. Patients receiving anticoagulants for therapeutic use will have baseline and current laboratory values available for monitoring and adjusting anticoagulant therapy.

b. Pharmacists will have the ability to order lab work as related to the initiation or continuation of anticoagulation for therapeutic use, including but not limited to:

Anticoagulant	Baseline Lab Tests (if not done within last 24 hours)	Ongoing Lab Tests	Recommended Frequency of Current Lab
Warfarin (Appendix A)	PT/INR, CBC	PT/INR, CBC As needed: AST/ALT, albumin	1) PT/INR*: daily until INR is stabilized (i.e., INR therapeutic for 5 days on a consistent dosing regimen) then ok to order every 2-3 days 2) CBC: every 3 days or as needed 3) AST/ALT/albumin: as needed *Additional INR monitoring may be necessary when a patient is started on an interacting drug, enteral feedings or if there is a significant change in diet.
Dabigatran (Appendix B)	CBC, SCr	CBC, SCr	1) CBC: Every 3 days for the first week, then weekly or as needed 2) Scr: Every 3 days or as needed
Apixaban (Appendix B)	CBC, SCr	CBC, SCr	1) CBC: Every 3 days for the first week, then weekly or as needed 1) Scr: Every 3 days or as needed

Anticoagulant	Baseline Lab Tests (if not done within last 24 hours)	Ongoing Lab Tests	Recommended Frequency of Current Lab
Rivaroxaban (Appendix B)	CBC, SCr, AST/ALT	CBC, SCr	1) CBC: Every 3 days for the first week, then weekly or as needed 2) Scr: Every 3 days or as needed
Enoxaparin (Appendix C)	CBC, SCr	CBC, SCr <u>As needed:</u> Anti-Xa	1) CBC, SCr: Every 3 days or as needed 2) Anti-Xa: as needed for >144 kg, renal insufficiency, pregnant patients
Heparin (Appendix D)	aPTT, PT, CBC	CBC, aPTT	1) CBC: the next day after starting Heparin and every 3 days while on Heparin or as needed 2) aPTT will be ordered by nursing staff every 6 hours per protocol during the first 24 hours of treatment. If over 24 hours of therapy & PTT at goal, next lab draw in AM of following day.
Argatroban (Appendix E)	PT/INR, aPTT, CBC, AST/ALT	aPTT, CBC, ACT (for PCI)	For the argatroban HIT protocol, aPTT to be ordered by nursing 1) Order aPTT 2 hours after initiation and 2 hours after each change in rate 2) If aPTT level at goal, continue current rate, re-order aPTT level every 2 hours x 2 times. 3) If aPTT stays within therapeutic range, check aPTT daily in AM 4) Order aPTT if hemorrage/ thromboembolism suspected

Anticoagulant	Baseline Lab Tests (if not done within last 24 hours)	Ongoing Lab Tests	Recommended Frequency of Current Lab
			5) CBC daily For the argatroban PCI protocol, ACT to be ordered by nursing 1) ACT (activated clotting time) to be drawn every 5-10 minutes after bolus infusion or a change in rate if argatroban used for PCI (percutaneous coronary intervention). 2) Proceed with procedure if ACT > 300 seconds.

c. If dose adjustment is required or if the patient becomes sub/supra-therapeutic, the cycle of more frequent monitoring should be repeated until a stable dose response can again be achieved. Pharmacists may order laboratory work as required by anticoagulation protocol.

4. Dosing Guidance

a. Initiation (e.g., dosing, adjustment, drug-drug interaction, drug-food interaction), management and monitoring of therapeutic anticoagulation is detailed below:

i. Warfarin (Appendix A)
ii. Direct oral anticoagulants (dabigatran, rivaroxaban, apixaban, or edoxaban) (Appendix B)
iii. Enoxaparin (Appendix C)
iv. Heparin Titration Protocol (DVT/PE and ACS) (Appendix D)
v. Argatroban Protocol (Appendix E)
vi. Perioperative Management of Anticoagulation (Appendix F)

b. Pharmacist will routinely check patients on therapeutic anticoagulation for drug-drug interactions, concomitant anticoagulation medication (e.g., NSAIDs, clopidogrel, aspirin >81mg) and relevant labs.

i. Ketorolac will not be administered to any patient on therapeutic anticoagulation therapy. The pharmacy will automatically discontinue ketorolac orders and notify the physician.

ii. While on heparin continuous infusion, patients should not receive any non-steroidal anti-inflammatory drugs (NSAIDs), aspirin or aspirin-containing medications.

c. Appropriate objective measures (e.g., Fecal Occult Samples, UA, CBC, etc.) will be monitored as necessary to assess the safety of anticoagulant therapy.

5. Management of bleeding and reversal of anticoagulation

   a. When bleeding is suspected, hold anticoagulation and discuss with primary physician for patient management.
   b. Assess and/or repeat appropriate objective measures (e.g., Fecal Occult Samples, UA, CBC, etc.) as needed.
   c. Review anticoagulation appendices for steps to reverse anticoagulation (Appendix A-D).
   d. A summary of reversal dosing for each anticoagulant is provided in Appendix G: Emergent reversal for life-threatening bleeding due to anticoagulant.

6. Safety and Reporting

   a. Evaluation of safety practices related to anticoagulation use will be conducted annually by the Medication Safety Committee to identify potential improvement opportunities, and to monitor and measure the effectiveness of improvement actions. This evaluation will include:
      i. Outcome Measures – i.e. Adverse Drug Events Related to Anticoagulants per 100 Admissions with Anticoagulant Administered.
      ii. Process Measures – i.e. Percent of anticoagulant administrations with appropriate laboratory monitoring according to protocol, percent of anticoagulant discharges with appropriate patient/family discharge instructions.
   b. Nursing, physicians, pharmacists are to report adverse drug events (e.g., bleeding) with anticoagulation promptly in the electronic incident reporting system.
   c. Pharmacy is to review trigger medication (e.g., protamine, vitamin K) report to identify potential adverse drug reaction with anticoagulation. If an adverse drug reaction is present, pharmacy will report the case in the electronic incident reporting system.

7. Discharge Education

   a. Nursing will provide education to patients/families specific to the anticoagulant medication that the patient will be discharged on. Discharge education will include:

      i. adherence to medication dose and schedule
      ii. importance of follow-up appointments and laboratory testing (if applicable)
      iii. potential drug–drug and drug–food interactions
      iv. the potential for adverse drug reactions.

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Appendix A: Warfarin

Individual patient responses to warfarin are highly variable. The guideline that follows is not a substitute for good clinical judgment.

The individual doses recommended below will commonly require modification for situations that include:

- Baseline INR value > 1.2
- Age greater than 65
- Poor nutritional status
- Liver disease
- Otherwise debilitated
- Presence of interacting medications (Table 1)

Upon the request of the physician, the pharmacist will initiate the monitoring process.

1. The pharmacist will monitor for adjustments to the warfarin dose according to:
    a. Desired INR of 2-3 for:
        i. Deep vein thrombosis (DVT)
        ii. Pulmonary embolism (PE)
        iii. Prophylaxis of venous thromboembolism (VTE)
        iv. Prevention of systemic embolism
    b. Desired INR of 2.5-3.5 for:
        i. mechanical prosthetic valve in the mitral position
        ii. mechanical prosthetic value in the aortic position with additional risk factors
    c. Desired INR as specified by physician order

2. The pharmacist will monitor the INR daily when the patient is on warfarin. If the INR is not ordered, the pharmacist will order the INR. No warfarin will be dispensed without the baseline INR.

3. The following guidelines are to achieve an INR of 2 to 3. If different INR range is desired, adjust the dose accordingly.
    a. Initiation
        i. For patients on unfractionated heparin:
            1. Start at 5 mg on day #1 and day #2, then adjust subsequent daily dose according to INR (see "Maintenance").
                a. Consider **higher dose (7.5mg)** for patients
                    i. weighing greater than 85kg,
                    ii. on medications that can significantly decrease warfarin, response such as rifampin, phenytoin, phenobarbital (see Table 1), or
                    iii. hypothyroidism (does NOT include levothyroxine-treated patient who is currently euthyroid)
            2. Consider **lower dose (2.5 mg)** for:
                i. elderly (> 70 years),
                ii. poor nutrition,
                iii. liver disease,

iv. debilitated patient,
v. patient with elevated initial INR, or
vi. on medications that can significantly increase warfarin response such as metronidazole, azole antifungals, sulfonamides, and amiodarone (see Table 1).

ii. For patients on low molecular weight heparin (LMWH):

1. **Start at 10 mg** on day #1 and day #2, then adjust subsequent daily dose according to INR (see "Maintenance").
2. Consider **lower dose (5-7.5 mg)** for:
   a. elderly (> 70 years),
   b. poor nutrition,
   c. liver disease,
   d. debilitated patient,
   e. patient with elevated initial INR, or
   f. on medications that can significantly increase warfarin response such as metronidazole, antifungals, sulfonamides, and amiodarone (see Table 1).

b. Maintenance

i. Pharmacist will adjust the dose of warfarin based on the INR

Day	INR	Dosage
3	< 1.5 1.5 – 1.9 2 – 3 > 3	5 – 10 mg 2.5 – 5 mg 0 – 5 mg 0
4	< 1.5 1.5 – 1.9 2 – 3 > 3	10 mg 5 – 7.5 mg 0 – 5 mg 0
5	< 1.5 1.5 – 1.9 2 – 3 > 3	10 mg 7.5 – 10 mg 0 – 5 mg 0
6	< 1.5 1.5 – 1.9 2 – 3 > 3	7.5 – 12.5 mg 5 – 10 mg 0 – 7.5 mg 0

c. Patients on warfarin prior to admission

i. If the patient is currently on a stable home warfarin dose and the INR is within the target range, evaluate the patient for any changes in co-morbidities, warfarin sensitivity, warfarin clearance and potential drug interactions.
   1. If there are no changes, continue the home dose and monitor the patient daily.
   2. If there are changes, evaluate the patient for a dosage change.

TABLE 1: WARFARIN DRUG INTERACTION TABLE

Drug that can INCREASE effects of warfarin	Drug that can DECREASE

			effects of warfarin	
Severe	Moderate to mild	Herbals/Dietary supplements	Severe to moderate	Herbals/Dietary supplements
Amiodarone§	Allopurinol	Alcohol (acute)	Azathioprine	Alcohol (chronic)
Fenofibrate and derivatives	Azole antifungals (fluconazole§, ketoconazole§, miconazole§, voriconazole, itraconazole, etc.)	Dong Quai	Bosentan	Ginseng (American)
Metronidazole§	Cephalosporins	Fish oil	Carbamazepine	St. John's Wart
Sulfamethoxazole§	Cimetidine	Garlic	Cholestyramine	Vitamin K
Tamoxifen-concurrent use with warfarin contraindicated	Colchicine	Gingko	Griseofulvin	
Ginseng (Panax and Siberian)-avoid concurrent use	Corticosteroids	Grapefruit or grapefruit juice	Isotretinoin	
	Fluoroquinolones	Vitamin E	Mesalamine	
	Gemfibrozil		Mercaptopurine	
	Glyburide		Methimazole	
	Isoniazid		Phenobarbital¥	
	Levothyroxine		Phenytoin (chronic use)¥	
	Macrolides (Erythromycin, Clarithromycin, Azithromycin)		Propylthiouracil	
	NSAIDs (increase risk of bleed)		Ribavirin	
	Propafenone		Rifabutin	
	Proton pump inhibitors (e.g., pantoprazole, omeprazole, etc.)		Rifampin¥	
	Quetiapine		Sucralfate	
	Quinidine		Sulfasalazine	
	Ranitidine			
	SSRIs (paroxetine, escitalopram, fluoxetine, etc.)			
	Statins			
	Tetracyclines			

	(doxycycline, etc.)			
	Tramadol			

Note: *These are common warfarin interactions only, NOT an all-inclusive list.*
¥Consider empirically increasing warfarin dose with concurrent use
§Consider empirically reducing warfarin dose with concurrent use

4. Reversal of Warfarin
   a. If INR >4.5, assess for possible lab error. If lab error is possible (i.e., short draw or hard draw), repeat INR ASAP.
   b. If the patient has any signs or symptoms of bleeding, or if INR > 6, discuss with the primary physician for patient management.
   c. To reverse warfarin, use of 5-10 mg intravenous vitamin K is appropriate for major bleeding events, while 2-5 mg of oral or intravenous vitamin K can be used for non-major bleeding events that require hospitalization.

INR	CLINICAL SCENARIO	MANAGEMENT
< 4.5	No bleeding	• Hold warfarin until INR in therapeutic range then resume warfarin at a lower dose
	Rapid reversal required	• Hold warfarin • Consider vitamin K 2.5mg oral
4.5-10	No bleeding	• Hold warfarin until INR in therapeutic range • Consider vitamin K 2.5mg oral
	Rapid reversal required	• Hold warfarin • Give vitamin K 2.5mg oral or 1mg IV infusion
>10	No bleeding	• Hold warfarin until INR in therapeutic range • Give vitamin K 2.5mg oral or 1-2mg IV infusion over 30 minutes, and repeat q24h as needed
	Rapid reversal required	• Hold warfarin • Give vitamin K 1-2mg IV infusion over 30 minutes, and repeat q6- 24h as needed
Any INR	Serious or life-threatening bleeding	• Hold Warfarin • Give vitamin K 10mg IV infusion over 30 minutes • Give 4F-PCC (see below)

Note: If patient is unable to tolerate PO Vitamin K, IV route may be substituted. IV administration of vitamin K has faster onset of action.

   d. Use of 4 factor prothrombin complex concentrate (4F-PCC) is recommended for major bleeding in patients taking warfarin.
      i. Administer 4F-PCC based on INR or low fixed dose
         1. Based on INR or
            a. INR 2-3.9, 25 units/kg (max 2,500 units)

b. INR 4-6, 35 units/kg (max 3,500 units)
c. INR >6, 50 units/kg(max 5,000 units)
d. INR unavailable, use low fixed dose option

2. Based on Low Fixed Dose
   a. 1,000 units for any major bleed
   b. 1,500 units for intracranial hemorrhage

ii. If 4F-PCC not available, use plasma 10-15 mL/kg

e. After the bleeding has been controlled, a shared decision-making discussion is needed to determine if and when warfarin should be restarted. A delayed restart is recommended when the bleed occurred in a critical site, the patient has a high risk of re-bleeding or of death from a re-bleed, the source of the bleed cannot be identified, or future surgical interventions are planned.
   i. For patients with gastrointestinal bleeds, restarting oral anticoagulants after ≥7 days has been associated with better outcomes, including improved survival and reduced thromboembolism risk.
   ii. For patients with intracranial hemorrhage, restarting oral antithrombotic agents should usually be delayed for approximately 4 weeks.

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Appendix B: Direct oral anticoagulants (dabigatran, rivaroxaban, apixaban, or edoxaban)

The guideline that follows is not a substitute for good clinical judgment. Upon the request of the physician, the pharmacist will initiate the monitoring process.

1. Background

    a. Several direct oral anticoagulants (DOACs) have been approved by the FDA since 2010. Unlike warfarin, these drugs do not require regular blood monitoring. These medications directly inhibit the blood's ability to form blood clots.
    b. DOACs are both rapid and short-acting agents with relatively low bleeding risks and good overall safety profiles. They are considered to be at least as effective as warfarin. Available medications in this category include apixaban (Eliquis), dabigatran (Pradaxa), edoxaban (Savaysa) and rivaroxaban (Xarelto).
    c. Use of DOACs is common for conditions such as non-valvular atrial fibrillation and venous thromboembolism (VTE).

2. Initiation/Monitoring:

    a. Prior to initiating, pharmacist will assess for appropriate indication, baseline renal function (e.g., CrCl), and hepatic function (e.g. ,Child-Pugh) as needed.
    b. Drug-drug interactions will be assessed throughout duration of therapy / hospital stay (Table 2).

3. Indication and Dosing (including renal and hepatic adjustment):[1-5]

Indication	Dabigatran	Rivaroxaban	Apixaban	Edoxaban
Non-valvular AF	CrCl >30 mL/min: 150 mg BID	CrCl >50 mL/min: 20 mg daily with evening meal	5 mg BID	CrCl >50 to ≤95 mL/min: 60 mg daily
	CrCl 15–30 mL/min: 75 mg BID *Per ACCP, C/I in CrCl <30*[5]	CrCl 15–50 mL/min: 15 mg daily with evening meal	2.5 mg BID, if 2 of 3 characteristics: SCr ≥1.5 mg/dL, age ≥80 yo, weight ≤60 kg	CrCl 15–50 mL/min: 30 mg daily
	CrCl <15 mL/min or on dialysis: Not recommended *Per ACCP, C/I in CrCl <30*[5]	CrCl <15 mL/min or on dialysis: Not recommended		CrCl <15 mL/min: Not recommended
	CrCl 30–50 mL/min with concomitant P-gp inhibitors (e.g., Dronedarone,			NOT recommended for CrCl >95 mL/min due to increased risk of ischemic

Indication	Dabigatran	Rivaroxaban	Apixaban	Edoxaban
	ketoconazole PO): 75 mg BID			stroke
	CrCl <30 mL/min with concomitant P-gp inhibitors: Avoid co-administration			Avoid use with rifampin
DVT or PE treatment	CrCl >30 mL/min: 150 mg BID after at least 5 days of parenteral anticoagulation	15 mg BID with food x 21 days for initial treatment, then 20 mg once daily with food	10 mg BID x 7 days, then 5 mg BID	CrCl >30 mL/min: Start after at least 5 days of parenteral anticoagulation >60kg: 60 mg daily ≤ 60kg: 30 mg daily
	CrCl ≤30 mL/min or on dialysis: Not recommended	CrCl <30 mL/min: Not recommended	*Not studied in CrCl ≤ 25 or SCr > 2.5*	CrCl 15–50 mL/min or on certain P-gp inhibitors: 30 mg once daily Avoid use with rifampin
↓ in recurrent DVT/PE	CrCl >30 mL/min: 150 mg BID after at least 5 days of parenteral anticoagulation	20 mg daily with food	2.5 mg BID	
	CrCl ≤30 mL/min or on dialysis: Not recommended	CrCl <30 mL/min: Not recommended	*Not studied in CrCl ≤ 25 or SCr > 2.5*	
DVT, PE prophylaxis after hip or knee replacement	CrCl >30 mL/min after achievement of hemostasis: If given day of surgery, 110 mg 1–4 h postop; after day of surgery 220 mg once daily x 10-14 days (max 35 days)	Initial dose 6–10 h after surgery provided hemostasis established: 10 mg daily x 10-14 days (max 35 days)	2.5 mg BID x 10-14 days (max 35 days)	
	CrCl ≤30 mL/min	CrCl <30 mL/min:	*Not studied in*	

Indication	Dabigatran	Rivaroxaban	Apixaban	Edoxaban
	or on dialysis: Not recommended	Not recommended	*CrCl ≤ 25 or SCr > 2.5*	
	CrCl <50 mL/min with concomitant P-gp inhibitors: Avoid co-administration			
Acute Medically Ill patient: VTE prophylaxis		10 mg once daily for 31 to 39 days Avoid use with CrCl <30 mL /min		
Acute Coronary Syndrome & Coronary Artery Disease		Off Label: 2.5 mg twice daily, in combo w/aspirin Avoid use with CrCl <30 mL/min		
Postpercutaneous coronary intervention w/stent placement & Nonvalvular afib.		Off Label: CrCl >50 mL/minute 15 mg once daily with food CrCl 30 to 50mL/min: 10 mg once daily Avoid use with CrCl <30 mL/min	5 mg twice daily Unless patient has any 2 of the following: Age ≥80 years, body weight ≤60kg, or serum creatinine ≥1.5 mg/dL, then reduce to 2.5mg twice daily	
Superficial Vein thrombosis, acute symptomatic		Off label: 10 mg once daily for 45 days Avoid use with CrCl <30 mL/min		
Indefinite Anticoagulation *If patient at risk for recurrent VTE following >6 months of therapeutic anticoagulation		10 mg once daily	2.5 mg twice daily	
Hepatic Function Dosing		Not recommended in moderate-severe	Not recommended in patients with	Not recommended in moderate-severe

Indication	Dabigatran	Rivaroxaban	Apixaban	Edoxaban
Considerations		hepatic impairment (Child-Pugh class B/C) or hepatic disease with coagulopathy	severe hepatic impairment (Child-Pugh class C)	hepatic impairment (Child-Pugh class B/C) or hepatic disease with coagulopathy

Table 2: Direct Oral Anticoagulants Drug Interactions Table[1-4,6]

DOAC	Interacting Medication	Effect on DOAC	Labeled Guidance; Comments
Dabigatran	P-gp inducer: rifampin	↓ Dabigatran exposure	Concomitant use should generally be avoided.
	P-gp inhibitors: ketoconazole, dronedarone	↑ Dabigatran exposure if concomitant severe renal impairment	If CrCl 30–50 mL/min: ↓ to 75 mg BID during concomitant use
	P-gp inhibitors: ketoconazole, dronedarone, verapamil, amiodarone, quinidine, clarithromycin, ticagrelor		If CrCl 15–30 mL/min: avoid concomitant use
Apixaban	Strong dual P-gp and CYP3A4 inducers: rifampin, carbamazepine, phenytoin, St. John's wort	↓ Apixaban exposure	Avoid concomitant use
	Strong dual P-gp and CYP3A4 inhibitors: ketoconazole, itraconazole, ritonavir, clarithromycin	↑ Apixaban exposure	In patients on 5 mg or 10 mg BID, ↓ dose by 50% when co-administered. Avoid co-administration with 2.5 mg BID
Rivaroxaban	Combined P-gp and strong CYP3A4 inducers: rifampin, carbamazepine, phenytoin, St. John's wort	↓ Rivaroxaban exposure	Avoid concomitant use; may decrease rivaroxaban efficacy
	Combined P-gp and strong CYP3A4 inhibitors: ketoconazole, itraconazole, HIV protease inhibitors (ritonavir, lopinavir/ritonavir, indinavir), conivaptan	↑ Rivaroxaban exposure	Avoid concomitant use
	Combined P-gp and moderate CYP3A4 inhibitors: diltiazem, verapamil, amiodarone, dronedarone, erythromycin	↑ Rivaroxaban exposure in patients with renal impairment	In CrCl 15 to <80 mL/min, rivaroxaban should not be used concomitantly unless the potential benefit justifies the potential risks

			No evidence of interaction observed in ROCKET AF between treatment assignment and outcomes in patients using ≥1 combined P-gp and moderate 3A4 inhibitors (including amiodarone, diltiazem, and verapamil)
Edoxaban	P-gp inducer: rifampin	↓ Edoxaban exposure	Avoid concomitant use
	Strong P-gp inhibitors: ritonavir, nelfinavir, saquinavir, indinavir, cyclosporine	↑ Edoxaban exposure	Avoid concomitant use in patients taking edoxaban for treatment of VTE
	P-gp inhibitors: verapamil, quinidine, azithromycin, clarithromycin, itraconazole, ketoconazole	↑ Edoxaban exposure	↓ to 30 mg daily during concomitant administration for patients taking edoxaban for the treatment of VTE. Dose reduction is not recommended for AF indications. *In ENGAGE AF, a ↓ dose of edoxaban as a result of concomitant P-gp inhibitor use (verapamil, quinidine, dronedarone) was associated with ↓ edoxaban exposure and a relative ↑ in risk of stroke or systemic embolism with edoxaban relative to warfarin*

AF, atrial fibrillation; BID, twice daily; CrCl, creatinine clearance; ENGAGE AF, Effective Anticoagulation With Factor Xa Next Generation in Atrial Fibrillation trial; P-gp, P-glycoprotein; ROCKET AF, Rivaroxaban Once Daily Oral Direct Factor Xa Inhibition Compared with Vitamin K Antagonism for Prevention of Stroke and Embolism Trial in Atrial Fibrillation; and VTE, venous thromboembolism.

4. Reversal of DOACs[7]
    a. When bleeding is suspected, hold anticoagulation and discuss with primary physician for patient management.
    b. Use of a reversal agent should be reserved only for patients with a life-threatening bleed or a major bleed in a critical site. Recommended reversal agents for DOACs include:

	First line	Second line	Not indicated	Notes
Dabigatran	Administer 5g idarucizumab IV* (typically provided as	If idarucizumab* not available, administer 4F-PCC or aPCC 50	Plasma	Consider activated charcoal for known recent

	two separate vials each containing 2.5 g/50 mL)	units/kg IV		ingestion (within 2-4 hours)
Edoxaban	Administer 4F-PCC 50 units/kg IV	If 4F-PCC not available, administer aPCC 50 units/kg IV	Idarucizumab*, Plasma	Consider activated charcoal for known recent ingestion (within 2-4 hours)
Rivaroxaban or Apixaban	Administer andexanet alfa*	If andexanet alpha* not available, administer 4F-PCC 50 units/kg IV or aPCC 50 units/kg IV	Idarucizumab*, Plasma	Consider activated charcoal for known recent ingestion (within 2-4 hours)
	Timing of Last Rivaroxaban or Apixaban Dose before Andexanet Alfa Initiation			
	< 8 hrs ago or unknown		**≥ 8 hrs ago**	
Rivaroxaban >10 mg or unknown **Or Apixaban** > 5 mg or unknown	**High dose andexanet alfa*:** Initial IV Bolus: 800 mg at a target rate of 30 mg/min Follow-on IV Infusion: 8 mg/min for up to 120 minutes		**Low dose andexanet alfa*:** Initial IV Bolus: 400 mg at a target rate of 30 mg/min Follow-on IV Infusion: 4 mg/min for up to 120 minutes	
Rivaroxaban ≤ 10 mg **Or Apixaban** ≤ 5 mg	**Low dose of andexanet alfa*** Initial IV Bolus: 400 mg at a target rate of 30 mg/min Follow-on IV Infusion: 4 mg/min for up to 120 minutes			

4F-PCC, 4 factor prothrombin complex concentrate; aPCC, activated PCC
**Idarucizumab and andexanet is non-formulary and not in stock at SVMC*

c. After the bleeding has been controlled, a shared decision making discussion is needed to determine if and when the DOAC medication should be restarted. A delayed restart is recommended when the bleed occurred in a critical site, the patient has a high risk of re-bleeding or of death from a re-bleed, the source of the bleed cannot be identified, or future surgical interventions are planned.
   i. For patients with gastrointestinal bleeds, restarting oral anticoagulants after ≥7 days has been associated with better outcomes, including improved survival and reduced thromboembolism risk.
   ii. For patients with intracranial hemorrhage, restarting oral antithrombotic agents should usually be delayed for approximately 4 weeks.

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Appendix C: Enoxaparin

The clinical pharmacist will monitor enoxaparin to maintain therapeutic anticoagulation, minimize anticoagulant toxicity, monitor laboratory trends, and maximize the use of each hospital stay to achieve the therapeutic goals.

The guideline that follows is not a substitute for good clinical judgment. Upon the request of the physician, the pharmacist will initiate the monitoring process.

1. Background[1-2]:
    a. Enoxaparin is a low molecular weight heparin (LMWH) derived from porcine heparin. Enoxaparin must be administered parenterally by the subcutaneous route (about 90% bioavailability), and may also be administered by IV. Enoxaparin binds to Anti-thrombin III to inhibit coagulation factors Xa and IIa at a ratio of between 2:1 and 4:1, whereas unfractionated heparin inhibits these factors at a 1:1 ratio.
    b. Time to peak plasma availability is 3 – 5 hours with a half-life of 3 – 6 hours in patients with normal renal function. Enoxaparin is metabolized in the liver and excreted renally.
2. Indications[1]
    a. Prophylaxis of DVT in abdominal surgery, hip replacement surgery, knee replacement surgery, or medical patients with severely restricted mobility during acute illness.
    b. Outpatient treatment of acute DVT without pulmonary embolism.
    c. Inpatient treatment of acute DVT with or without pulmonary embolism.
    d. Prophylaxis of ischemic complications of unstable angina and non-Q-wave myocardial infarction [MI].
    e. Treatment of acute ST-segment elevation myocardial infarction [STEMI] managed medically of with subsequent percutaneous coronary intervention [PCI].
3. Monitoring
    a. BLACK BOX WARNING: Epidural or spinal hematomas may occur in patients receiving enoxaparin and are receiving neuraxial anesthesia or undergoing spinal puncture, which results in long-term or permanent paralysis. Consider the benefits and risks before neuraxial intervention in patients who are or will be taking enoxaparin for thromboprophylaxis. Nursing and Physicians to monitor patients frequently for signs and symptoms of neurological impairment, and treat urgently if neurological compromise is noted.[1]
    b. Drug-drug, drug-disease, & drug-procedure interactions will be assessed throughout duration of therapy / hospital stay. [2-3]
    c. Anti-factor Xa activity is the most accurate measure anticoagulation with enoxaparin, however ordering this lab is both expensive and time-consuming (3-5 day turn-around time), so it is not useful in most situations. However, it should be considered in high risk patients (morbid obesity over 144 kg, pregnancy, and renal dysfunction) who will be on enoxaparin long term. [1-2]
        a. Anti-Xa activity should be measured 4 to 6 hours after the dose.[6-11]

Indication	Patient Population	Anti-Xa activity target	Notes
Mechanical heart valve (bridging	Non-pregnant high-risk patients	0.5 to 1 units/mL	Monitoring anti-Xa activity is not necessary. However, some experts

anticoagulation)			recommend monitoring, if possible.[9]
	Pregnant patients	0.8 to 1.2 units/mL[8]	Some experts recommend higher anti-Xa targets (e.g., 1 to 1.2 units/mL) for mechanical mitral valves and lower targets (0.8 to 1 units/mL) for mechanical aortic valves.[10]
VTE treatment	High-risk patients	Once-daily dosing: >1 units/mL [6] Twice-daily dosing: 0.6 to 1 units/mL	Note: Twice-daily dosing is recommended in pregnant patients [6-7]
VTE prophylaxis	Pregnant women	0.2 to 0.6 units/mL[11]	

4. Dosing [1-3]

Indication	Dosage Regimen	Comments
DVT prophylaxis in abdominal surgery	40 mg once a day subcutaneously for 7 to 10 days.	* Start 2 hours prior to surgery * Adjust dose for patients with severe renal impairment (CrCl <30 mL/min)
DVT prophylaxis in hip or knee replacement surgery	30 mg every 12 hours subcutaneously for 7 to 10 days. For hip replacement, 40 mg once a day for 7 to 10 days may be considered.	* For 30 mg dose, start 12 to 24 hours after surgery providing hemostasis has been established. * For 40 mg dose, start 12 hours prior to surgery. * Continued prophylaxis of 40 mg once a day for an additional 3 weeks is recommended. * Adjust dose for patients with severe renal impairment (CrCl <30 mL/min)
Medical patients during acute illness with severe mobility restriction	40 mg once a day subcutaneously for 6 to 11 days.	* Adjust dose for patients with severe renal impairment (CrCl <30 mL/min)
Treatment of DVT without PE (outpatient)	1 mg/kg subcutaneously every 12 hours for at least 5 days until a therapeutic oral anticoagulant effect with warfarin has	* Start warfarin therapy when appropriate (usually within 72 hours). * Adjust dose for patients with severe renal impairment (CrCl <30 mL/min) * Round doses to the nearest 10 mg.

	been achieved (INR 2.0-3.0)	
Treatment of DVT with or without PE (inpatient)	1 mg/kg subcutaneously every 12 hours or 1.5 mg/kg once a day for at least 5 days until a therapeutic oral anticoagulant effect with warfarin has been achieved (INR 2.0-3.0)	* Start warfarin therapy when appropriate (usually within 72 hours). * Adjust dose for patients with severe renal impairment (CrCl <30 mL/min) * Round doses to the nearest 10 mg.
Unstable angina and non-Q-wave myocardial infarction [MI]	1 mg/kg subcutaneously every 12 hours in conjunction with aspirin therapy (100 to 325 mg daily) for at least 2 days and continued until clinical stabilization.	* Adjust dose for patients with severe renal impairment (CrCl <30 mL/min) * Round doses to the nearest 10 mg.
Acute ST-segment elevation myocardial infarction [STEMI]	A single IV bolus of 30 mg plus a 1 mg/kg subcutaneous dose, then 1 mg/kg subcutaneously every 12 hours.	* Max 100 mg for first two doses, then 1 mg/kg for remaining doses. * Dosage adjustments are recommended for patients 75 years of age and older. (see below) * All patients with confirmed STEMI should receive aspirin therapy 75 to 325 mg per day unless contraindicated. * Adjust dose for patients with severe renal impairment (CrCl <30 mL/min) * Round doses to the nearest 10 mg.
Acute ST-segment elevation myocardial infarction [STEMI] (geriatric patients aged 75 and older)	DO NOT use IV bolus. 0.75 mg/kg subcutaneously every 12 hours.	* Max 75 mg for first two doses, then 0.75 mg/kg for remaining doses. * All patients with confirmed STEMI should receive aspirin therapy 75 to 325 mg per day unless contraindicated. * Adjust dose for patients with severe renal impairment (CrCl <30 mL/min) * No dose adjustments are needed for other indications in geriatric patients unless there is renal impairment. * Round doses to the nearest 10 mg.

Note: Patients dosed by weight should be dosed using actual body weight (up to 144 kg).[2] Round all doses to the nearest 10 mg.

5. Renal Adjustment [1]
   a. No dose adjustment is recommended for patient with mild (CrCl 50-80 mL/min) and moderate (CrCl 30-50 mL/min) renal impairment, all these patients should be closely monitored for signs and symptoms of bleeding.
   b. For patients with severe renal impairment (CrCl <30 mL/min), the pharmacist will automatically perform a renal dose adjustment, and document their action in the patient's EHR.
   c. Enoxaparin should not be used for patients with renal dysfunction on dialysis for the following reasons:
      a. There is no FDA indication for enoxaparin use in dialysis patients.
      b. Patients with severe renal impairment (CrCl <30 mL/min) have a 65% increase in AUC over patients with normal renal function, however, in one study, hemodialysis patients had a two-fold higher AUC than the control population.
      c. Enoxaparin has been associated with hyperkalemia in patients with renal failure.

LOVENOX (ENOXAPARIN) RENAL DOSE ADJUSTMENTS PER INDICATION

Indication	**Dosage Regimen for CrCl < 30 mL/min**
DVT prophylaxis in abdominal surgery	30 mg administered subcutaneously once daily
DVT prophylaxis in hip or knee replacement surgery	30 mg administered subcutaneously once daily
Medical patients during acute illness with severe mobility restriction	30 mg administered subcutaneously once daily
Treatment of DVT with or without PE (outpatient)	1 mg/kg administered once daily (rounded to the nearest 10 mg)
Treatment of DVT with or without PE (inpatient)	1 mg/kg administered once daily (rounded to the nearest 10 mg)
Unstable angina and non-Q-wave myocardial infarction [MI]	1 mg/kg administered once daily (rounded to the nearest 10 mg)
Acute ST-segment elevation myocardial infarction [STEMI]	30 mg single IV bolus plus a 1 mg/kg subcutaneous dose followed by 1 mg/kg administered once daily (rounded to the nearest 10 mg)
Acute ST-segment elevation myocardial infarction [STEMI] (geriatric patients aged 75 and older)	1 mg/kg administered subcutaneously once daily (no initial bolus) (rounded to the nearest 10 mg)

6. Guideline for converting from enoxaparin to oral anticoagulants
   a. Bridging enoxaparin to warfarin: When warfarin therapy is appropriate, initiate within 72 hours of starting enoxaparin, and continue concomitant administration for at least 5 days. Discontinue enoxaparin only after INR is above 2.0 for two consecutive days. [1,5]
   b. Conversion from enoxaparin to rivaroxaban/apixaban: Discontinue enoxaparin and initiate rivaroxaban ≤2 hours prior to the next regularly scheduled evening dose of enoxaparin.

7. Management of enoxaparin for invasive surgical procedures[1]
    a. Refer to the dosing chart above for surgical treatment.
8. Reversal of enoxaparin
    a. Protamine partially reverses the anticoagulant effect of LMWHs (~60%)
    b. Administer protamine; do not exceed rate of 5 mg/min, max dose 50 mg
    c. If enoxaparin was given within the last 8 hours, give 1 mg of protamine for every 1 mg of enoxaparin given.
    d. If enoxaparin administered within 8-12 hrs or if bleeding continues or patient has renal impairment, give a second dose of 0.5 mg of protamine for every 1 mg of enoxaparin given.
    e. Administer by slow IV injection over ~10 minutes; **maximum single dose: 50 mg.**
    f. If enoxaparin administered >12 hrs, protamine is unlikely to be helpful.
    g. Note: In patients receiving enoxaparin (LMWH) for prophylaxis (i.e., not a full therapeutic dose), the NCS/SCCM guidelines suggest against reversal.[12]

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Appendix D: Heparin Titration Protocol (DVT/PE and ACS)

PURPOSE:

To outline the procedure to safely administer IV heparin in therapeutic doses to delay clotting and prevent formation or extension of a thrombus. The institution utilizes indication-specific heparinization, ordered via computerized physician order entry (CPOE.) There are two distinct dosing order sets which are respective to the following two indications: non-cardiac (Deep Vein Thrombosis and Pulmonary Embolism (DVT/PE)) and cardiac (Acute Coronary Syndromes (ACS)).

POLICY:

1. It is the policy of Sierra View Medical Center to use weight-based heparin dosing guidelines for anticoagulation.
    a. All bolus doses are to be calculated and administered in UNITS/KG.
    b. All constant infusions and intra-infusion titrations will be in UNITS/KG/HR.
2. The therapeutic objective goal of the weight-based Heparin continuous infusion is to maintain an aPTT of 50-79.9 seconds.

AFFECTED PERSONNEL/AREAS: *NURSING, PHARMACY, PHYSICIANS*

EQUIPMENT:

- Alaris IV Infusion Smart Pump
- Heparin for bolus (1000units/mL vial)(from Pyxis)
- Pre-Mixed bag of heparin (heparin 25,000 units in 500ml (50units/mL) of D5W) available from Pyxis.
- Dedicated IV tubing and access.
- IV bag label

PROCEDURE:

1. The following three baseline labs should be obtained immediately (STAT) if they have not been ordered in last 24 hours. They may be ordered by the RN, per this protocol, in the first 24 hours of treatment.
    a. CBC (auto diff)
    b. Prothrombin Time (PT)
    c. Partial Thromboplastin Time (aPTT)
        i. aPTT will be ordered by nursing staff every 6 hours per protocol during the first 24 hours of treatment, or until the Heparin infusion results in a therapeutically stable aPTT for 12 consecutive hours.
2. Identify the patient using TWO identifiers as outlined in the policy Medication Administration Principles and Procedures.
3. Verify the physician's order and dose using TWO licensed staff members.

a. Check that the indication corresponds to the ordered set and follow the directions within the set. (The major difference between the two order sets/indications is that ACS (cardiac) patients are also receiving antiplatelet medications and therefore are at a higher risk for bleeds, requiring a lower heparin bolus and initial continuous infusion rate.) Protocol detailed at the end of this section.

4. Preparation and administration of Heparin bolus dose:
   a. Obtain appropriate Heparin vial from Pyxis
   b. Pull appropriate Heparin bolus dose from vial.
      i. 80 units/kg (non-cardiac) **not to exceed 8,000 units**
      ii. 60 units/kg (cardiac) **not to exceed 4,000 units**
   c. Have second RN or Pharmacist verify the "5 Rights."
   d. Administer via IV push over 1 minute via cannula at IV site.
   e. Document administration.
5. Preparation and administration of Heparin continuous infusion:
   a. Obtain the premix Heparin bag (25,000units/500mL of D5W) from Pyxis.
   b. Appropriately label the premixed Heparin bag.
   c. Connect tubing to Heparin solution bag, through Alaris infusion pump and attach directly to cannula at IV site.
   d. Use a dedicated line.
   e. "Power on" the Alaris infusion pump, and select the appropriate indication-specific weight-based guardrails (i.e. DVT/PE or ACS.)
   f. Enter patient's total/actual body weight (Kg) into the smart pump and confirm that the rate correctly corresponds with the appropriately ordered set.
      i. 18 units/kg/hr (non-cardiac)
      ii. 12 units/kg/hr (cardiac)
   g. The infusion rate is not to exceed 1800 units/hr (36mL/hr) unless authorized by prescriber.
   h. Have second RN or Pharmacist verify the "5 Rights."
   i. "Start" the continuous infusion.
   j. Immediately after bolus administration and initiation of continuous infusion RN is to place lab orders for Q6HR Partial Thromboplastin STAT Timed (aPTT) for the next 24 hours, "per protocol."
6. Lab monitoring:
   a. In between each Q6HR aPTT lab result, and corresponding rate titrations, observe patient for signs and symptoms of bleeding (notify physician if any of the following occur)
      i. Observe urine for blood
      ii. Check gums for bleeding (use soft toothbrush)
      iii. Check for bruises
7. Q6HR aPTT Lab Results:
   a. During on-site pharmacy hours, Pharmacist's will help manage bolus/rate adjustments as needed per protocol. Pharmacists will receive calls from nursing to help with recommendations & enter pertinent labs into the system as needed per protocol.
   b. Titrate Heparin continuous infusion rate (or administer additional bolus as outlined above, if protocol directs) according to the patient's most recent aPTT as outlined in the appropriate Heparin-weight based titration protocol in the addendums below.
   c. The therapeutic objective goal of the Heparin continuous infusion is an aPTT of 50-79.9 seconds

d. Once two consecutive Q6HR labs report aPTTs that are between 50-79.9 seconds, then hold at current infusion rate and monitor next default ordered 0500 aPTT. (place aPTT order for next day at 0500 if it currently is not placed, per protocol)
e. Continue Heparin continuous infusion at therapeutic rate until physician gives order for transition to outpatient therapy. Contact physician if duration has exceeded 48 hours.
f. If aPTT returns >100 seconds, then stop infusion for 60 minutes. Consult physician, and decrease rate by 3 units/kg/hr if/when infusion is started again. Order aPTT for 6 hours from re-initiation of infusion.

8. Transitioning to outpatient anticoagulants:
   a. Low Molecular Weight Heparin (Enoxaparin)
      i. Discontinue Heparin and initiate Enoxaparin within 1 hour.
   b. Direct Oral Anticoagulants (Apixaban (Eliquis), Rivaroxaban (Xarelto))
      i. Discontinue Heparin and immediately give first dose of Apixaban or Rivaroxaban.
9. Contraindications to Heparin continuous infusion:
   a. Patients should not receive any non-steroidal anti-inflammatory drugs (NSAIDS), aspirin or aspirin containing medications.
   b. Patients with epidural catheters should not receive anticoagulant therapy during infusion and until four hours post-catheter removal.
   c. Do not administer IM.
   d. Primary IV lines should not be used for blood draws.
10. Reversal of Heparin IV
   a. **Heparin overdosage, following IV administration:** As blood heparin concentrations decrease rapidly after heparin administration, adjust the protamine dosage depending upon the duration of time since heparin administration as follows:

Neutralization Dose of Protamine for IV Heparin Overdosage	
Time Elapsed	Dose of Protamine (mg) to Neutralize 100 units of Heparin
Immediate	1 to1.5
30 to 60 min	0.5 to 0.75
>2 h	0.25 o 0.375

      i. 1 mg of protamine neutralizes ~100 units of heparin; **maximum single dose: 50 mg.** If the aPTT remains elevated, may repeat dose at 0.5 mg of protamine for every 100 units of heparin.
      ii. When heparin is given as a continuous IV infusion, only heparin given in the preceding 2 to 3 hours should be considered when administering protamine. For example, a patient receiving heparin 1,250 units/hour will require ~30 mg of protamine for reversal of heparin given in the last 2 to 2.5 hours
   b. Intracranial hemorrhage associated with heparin
      i. Heparin-mediated (full dose infusions): 1 mg protamine for every 100 units of heparin administered in the previous 2 to 3 hours; administer by slow IV injection over ~10 minutes; **maximum single dose: 50 mg.** If the aPTT remains elevated, consider administering 0.5 mg protamine for every 100 units of heparin.
11. Reversal of Heparin SQ
   a. Consider reversal for prophylactic subcutaneous doses of heparin when aPTT is significantly prolonged.

b. **Heparin overdosage, following SubQ injection:** IV: 1 to 1.5 mg protamine per 100 units heparin; this may be done by a portion of the dose (e.g., 25 to 50 mg) given slowly IV followed by the remaining portion as a continuous infusion over 8 to 16 hours (the expected absorption time of the SubQ heparin dose).

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CROSS REFERENCES:

- MEDICATION ADMINISTRATION – SVMC Policy and Procedure

HEPARIN DEEP VEIN THROMBOSIS AND PULMONARY EMBOLISM WEIGHT BASED TITRATION PROTOCOL

Heparin Infusion – DVT/PE (Non-cardiac)	
Bolus:	80 units/kg (Max 8,000 units)
Starting Rate:	18 units/kg/hr
Titration:	q6hrs determined by aPTT as described below:

Heparin Infusion (DVT/PE) TITRATE Per Protocol

PROTOCOL:		
Condition	**Dose/Route**	**Instructions**
Starting Rate	18 Units/Kg/Hr Not to exceed 36 mL/Hr (1,800 Units/Hr) unless Dr. Authorized	Bag: 25,000 Units/500 mL Concentration: 50 Units/mL STAT aPTT in 6 hours to be ordered by the nurse after start of infusion. Then follow table below.
aPTT (Seconds)	Bolus: Infuse over 1 min	Infusion Rate Adjustment/Labs
35.9 or less	Give IV Bolus of 80 Units/Kg *Not to exceed 8,000 Units	Increase Rate By 4 Units/Kg/Hr STAT aPTT in 6 hours to be ordered by the nurse.
36-49.9	Give IV Bolus of 40 Units/Kg *Not to exceed 4,000 Units	Increase Rate By 2 Units/Kg/Hr STAT aPTT in 6 hours to be ordered by the nurse.
50-79.9	No Bolus	Maintain current infusion rate if during initial 24 Hr therapy. STAT aPTT in 6 hours to be ordered by the nurse. If over 24 hrs of therpay aPTT in AM.
80-99.9	No Bolus	Decrease infusion rate by 2 Units/Kg/Hr. STAT aPTT in 6 hr to be ordered by the nurse.
100 or greater	No Bolus	Stop infusion for 60 minutes. (Clarify with MD if less than 24 hrs of therpay). Then decrease rate by 3 Units/Kg/Hr. STAT aPTT in 6 hrs to be ordered by the nurse after restart of infusion.
Signifcant Bleeding		Stop infusion immediately; STAT CBC and aPTT
Starting Rate: 18 Units/Kg/Hr		
If aPTT 100 or greater: Stop infusion x60 minutes, (Clarify with MD if less than 24 hours post thrombolytic….)		

HEPARIN ACUTE CORONARY SYNDROME WEIGHT BASED TITRATION PROTOCOL

Heparin Infusion – ACS (cardiac)	
Bolus:	60 units/kg (Max 4,000 units)
Starting Rate:	12 units/kg/hr
Titration:	q6hrs determined by aPTT as described below:

Heparin Infusion (ACS) TITRATE Per Protocol

PROTOCOL:		
Condition	**Dose/Route**	**Instructions**
Starting Rate	12 Units/Kg/Hr Not to exceed 20 mL/Hr (1,000 Units/Hr) unless Dr. Authorized	Bag: 25,000 Units/500 mL Concentration: 50 Units/mL STAT aPTT in 6 hours to be ordered by the nurse after start of infusion. Then follow table below.
aPTT (Seconds)	Bolus: Infuse over 1 min	Infusion Rate Adjustment/Labs
35.9 or less	Give IV Bolus of 60 Units/Kg *Not to exceed 4,000 Units	Increase Rate By 4 Units/Kg/Hr STAT aPTT in 6 hours to be ordered by the nurse.
36-49.9	Give IV Bolus of 30 Units/Kg *Not to exceed 2,000 Units	Increase Rate By 2 Units/Kg/Hr STAT aPTT in 6 hours to be ordered by the nurse.
50-79.9	No Bolus	Maintain current infusion rate if during initial 24 Hr therapy. STAT aPTT in 6 hours to be ordered by the nurse. If over 24 hrs of therpay aPTT in AM.
80-99.9	No Bolus	Decrease infusion rate by 2 Units/Kg/Hr. STAT aPTT in 6 hr to be ordered by the nurse.
100 or greater	No Bolus	Stop infusion for 60 minutes. (Clarify with MD if less than 24 hrs of therpay). Then decrease rate by 3 Units/Kg/Hr. STAT aPTT in 6 hrs to be ordered by the nurse after restart of infusion.
Signifcant Bleeding		Stop infusion immediately; STAT CBC and aPTT
Titrate to: aPTT 50-79.9		
Starting Rate: 12 Units/Kg/Hr		
If aPTT 100 or greater: Stop infusion for 60 minutes. (Clarify with MD if less than 24 hrs of therpay). Then decrease rate by 3 Units/Kg/Hr. STAT aPTT in 6 hrs to be ordered by the nurse after restart of infusion.		

Appendix E: Argatroban Protocol

PROTOCOL EXCLUSION:

- Use immediately preceding or during surgical/invasive procedures
- If patient has indwelling epidural/intrathecal catheter, consult anesthesia

GENERAL CONSIDERATIONS:

1. Indication: Anticoagulation for patients with Heparin-Induced Thrombocytopenia (HIT) or history of HIT.
2. Contraindications:
    a. Hypersensitivity to argatroban or any component of the formulation
    b. Overt major bleeding
    c. Suspected intracranial hemorrhage
3. Cautions:
    a. Uncontrolled hypertension
    b. Hepatically impaired (total serum bilirubin greater than 1.5 mg/dL, AST/ALT greater than or equal to 3x of upper normal limit)
    c. Heart failure/severe anasarca
    d. multi-organ dysfunction (MODS)

INITIATING ARGATROBAN

1. Must be ordered under approval of Critical Care Intensivist, Cardiologist, or Hematologist.
2. Stop all heparin or low-molecular weight heparin, including flushes or locks.
3. Label all IV sites or catheters as "NO HEPARIN."
4. Draw baseline labs listed below prior to starting argatroban infusion.
5. Initial argatroban infusion dose based on patient status (choose one):
    a. For non-critically ill patients with normal hepatic function:
        i. Initiate argatroban infusion at 2 mcg/kg/min
    b. For critically ill patients with heart failure, MODS, severe anasarca, post-cardiac surgery or hepatic insufficiency (Child-Pugh Class B and C):
        i. Initiate argatroban infusion at a reduced rate of 0.2 mcg/kg/min. Rate set at physician's discretion.
    c. For patients with or at risk of heparin induced thrombocytopenia (HIT) undergoing percutaneous coronary intervention (PCI):
        i. Initiate argatroban at 25 mcg/kg/min and administer a bolus of 350 mcg/kg via a large bore intravenous line over 3 to 5 minutes
        ii. Avoid use in patients with clinically significant hepatic impairment or elevations of ALT/AST $\geq 3 \times$ ULN (has not been studied).
6. Adjust rate of infusion based on Argatroban Protocols Below. Two RN signatures required.
7. Laboratory Monitoring:
    a. Draw Baseline PT/INR, aPTT, CBC, and Hepatic Panel if not done within last 24 hours.
    b. aPTT two hours after the start of the argatroban infusion for HIT. Adjust rate to aPTT results according to the Argatroban Protocol for HIT below.
    c. Repeat aPTT as indicated in the Argatroban Protocol for HIT below.
    d. CBC daily while on Argatroban.

e. ACT (activated clotting time) to be drawn every 5-10 minutes after bolus infusion or a change in rate if Argatroban used for PCI (percutaneous coronary intervention). Proceed with procedure if ACT > 300 seconds.

8. Monitoring and adjusting argatroban infusion:
   a. Adjust infusion rate of argatroban based on the Argatroban Protocol
   b. Monitor for signs/symptoms of bleeding. Notify MD if noted.

EPIDURAL MANAGEMENT: (exception: anticoagulation and epidural management are part of the invasive procedure)

1. It is recommended that epidural catheter is removed if argatroban IV treatment is desired.
2. Argatroban infusion should be discontinued a minimum of 4 hours before epidural placement to allow aPTT to normalize.
3. Argatroban infusion should not be started until 24 hours after catheter removal or administration of single dose epidural/spinal anesthesia, unless approved by anesthesiologist.

SURGICAL MANAGEMENT:

1. Argatroban should be discontinued a minimum of 4 hours before procedures to allow aPTT to normalize (unless it is part of the procedure).
2. Surgeons should decide when it is safe to resume anticoagulation after surgery. Argatroban can usually be resumed when hemostasis is achieved (approximately 12 hours), unless it is a standard part of post-operative care.

CONVERSION TO OTHER ANTICOAGULANT

1. **Conversion to warfarin:** Because there may be a combined effect on the INR when argatroban is combined with warfarin, loading doses of warfarin should not be used.
   a. Warfarin therapy should be started at the expected daily dose.
   b. Minimum of 5 days overlap with argatroban and warfarin until INR is within target range. NOTE: Argatroban prolongs the INR, therefore it must overlap with warfarin until INR > 4. When INR is > 4 and warfarin therapy has overlapped for 5 days and:
      i. If rate is ≤ 2 mcg/kg/min stop infusion
         1. Obtain INR 4-6 hours, after stopping argatroban infusion
         2. If INR 2-3 (therapeutic), continue with warfarin monotherapy
         3. If INR < 2 (sub-therapeutic), resume argatroban at previous rate & repeat procedure the following day
      ii. If rate is > 2 mcg/kg/min reduce rate to 2 mcg/kg/min
         1. Obtain INR in 4-6 hours, if INR >4, stop argatroban
         2. Obtain INR 4-6 hours, after stopping argatroban infusion
         3. If INR 2-3 (therapeutic), continue with warfarin monotherapy
         4. If INR < 2 (sub-therapeutic), resume argatroban at previous rate & repeat procedure the following day
2. If starting enoxaparin after an argatroban drip is discontinued (i.e., if HIT is ruled out), give the 1st dose of enoxaparin 1 hour after shutting off the argatroban. Timing of initiation of argatroban after enoxaparin injection will be determined by patient's clinical status.
3. If starting fondaparinux after an argatroban drip is discontinued, give the 1st dose of fondaparinux 1 hour after shutting off the argatroban. If starting argatroban drip after therapeutic fondaparinux is discontinued, start the argatroban drip 22 hours after the last fondaparinux dose.
3. No IM injections if possible when the patient is on an anticoagulant.

ARGATROBAN PROTOCOL

ARGATROBAN PROTOCOL: HEPARIN INDUCED THROMBOCYTOPENIA

Stop all heparin containing products, then follow the protocol below:

PROTOCOL:		
Condition	**Dose/Route**	**Instructions**
Starting Rate*	2 mcg/kg/min	
After Initiation	Order aPTT level	2 hours later
Goal aPTT	45-90 seconds	Not to exceed 100 seconds without physician approval
If aPTT level < 45 seconds	Increase rate by 20% (ml/hr x 1.2)	Re-order aPTT level in 2 hours
If aPTT level 45-90 seconds	Continue at same rate	If aPTT within range, continue current rate, re-order aPTT levels every 2 hours x 2 times. If aPTT stays within therapeutic range, order aPTT level the following morning.
If aPTT level > 90 seconds	Hold for 2 Hours, then	Restart at 50% previous rate New rate = ml/hr x 0.5 Recheck aPTT in 2 hours
Order aPTT levels		1. Every morning 2. Two hours after any change with dose immediately prior to resuming infusion 3. Hemorrage/thromboembolism suspected 4. Or at additioanl checks at MD discretion
Max Rate	10 mcg/kg/min	
STOP IMMEDIATELY	Any sign of bleeding	

Adverse reactions (>10%)

- Chest pain
- Hypotension
- Genitourinary tract hemorrhage.

***For Critically-ill patients (e.g., heart failure, MODS, severe anasarca, post-cardiac surgery or hepatic insufficiency):**

Stop all heparin containing products, then follow the protocol below:

PROTOCOL:		
Condition	**Dose/Route**	**Instructions**
Starting Rate*	0.2 mcg/kg/min	
After Initiation	Order aPTT level	2 hours later
Goal aPTT	50-100 seconds	Not to exceed 100 seconds without physician approval
If aPTT level < 50 seconds	Increase rate by 20% (ml/hr x 1.2)	Re-order aPTT level in 2 hours
If aPTT level 50-100 seconds	Continue at same rate	If aPTT within range, continue current rate, re-order aPTT levels every 2 hours x 2 times. If

		aPTT stays within therapeutic range, order aPTT level the following morning.
If aPTT level > 100 seconds	Hold for 2 Hours, then	Restart at 50% previous rate New rate = ml/hr x 0.5 Recheck aPTT in 2 hours
Order aPTT levels		1. Every morning 2. Two hours after any change with dose immediately prior to resuming infusion 3. Hemorrage/thromboembolism suspected 4. Or at additioanl checks at MD discretion
Max Rate	10 mcg/kg/min	
STOP IMMEDIATELY	Any sign of bleeding	

ARGATROBAN PROTOCOL: PERCUTANEOUS CORONARY INTERVENTION

Avoid use in patients with clinically significant hepatic impairment or elevations of ALT/AST ≥3 × ULN (has not been studied).

Stop all heparin containing products, then follow the protocol below:

PROTOCOL:		
Condition	**Dose/Route**	**Instructions**
Starting Rate	25 mcg/kg/min and adminiser a bolus of 350mcg/kg over 3-5 minutes	Check ACT 5-10 minutes after bolus infusion Proceed with procedure if ACT > 300 seconds
After Initiation	Order aPTT level	5-10 minutes
If ACT < 300 seconds	Give an additional 150 mcg/kg bolus, and increase infusion rate to 30 mcg/kg/minute	Recheck ACT in 5 to 10 minutes
If ACT 300-450 seconds	Continue rate during the procedure	
If ACT > 450 seconds	Decrease infusion rate to 15 mcg/kg/minute	Recheck ACT in 5 to 10 minutes
If dissection, impending abrupt closure, thrombus formation during PCI, or inability to achieve ACT >300 seconds	Give an additional bolus of 150 mcg/kg, and increase rate to 40 mcg/kg/minute	Recheck ACT in 5 to 10 minutes after each additional bolus or change in infusion rate
Post-PCI anticoagulation	If required, see HIT protocol.	

REFERENCES:

- Package Insert Argatroban. Sandoz, Inc. Princeton, NJ 08540. Jan 2011.

- Garcia DA, Baglin TP, Weitz JI, et al. Parenteral Anticoagulants: Antithrombotic Therapy and Prevention of Thrombosis, 9th ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines. Chest, 2012, 141(2 Suppl):24-43.

- Guyatt GH, Akl EA, Crowther M, et al. Executive Summary: Antithrombotic Therapy and Prevention of Thrombosis, 9th ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines. Chest, 2012, 141(2 Suppl):7-47.

Appendix F: Perioperative Management of Anticoagulation

1. Many surgical procedures can be safely performed without interrupting systemic anticoagulation. Please review most current guideline recommendations, assess thromboembolic and bleeding risk before interrupting systemic anticoagulation for procedures.

2. Bridging preoperatively is generally reserved for individuals considered at high risk of thromboembolism (e.g., recent embolic stroke or systemic embolic event in the last 3 months, mechanical mitral valve, mechanical aortic valve and additional stroke risk factors, atrial fibrillation and very high stroke risk (CHADS2 score of 5 or 6), venous thromboembolism (VTE) within the previous 3 months, coronary stenting within the previous 12 weeks, previous thromboembolism during interruption of chronic anticoagulation). [1]

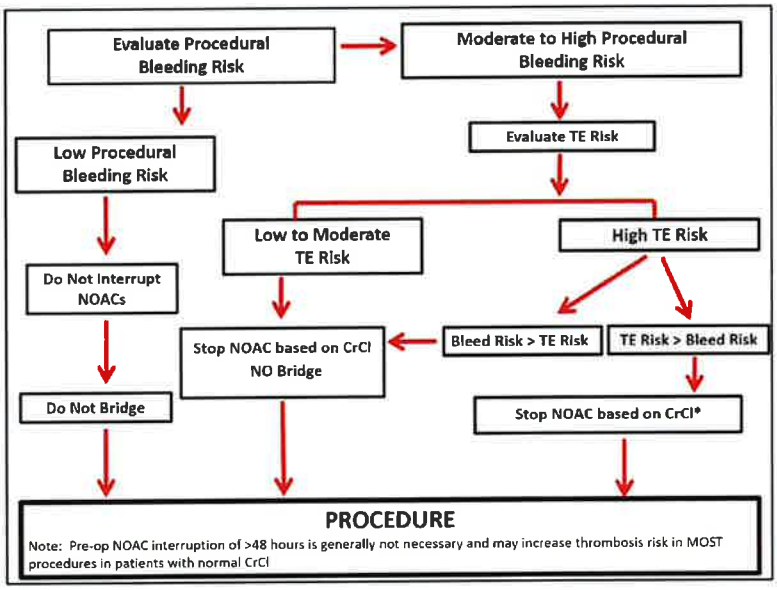
3. If anticoagulation needs to be stopped before procedure follow the below steps for patients on:
   a. Warfarin [2]

Day (Around Procedure)	Protocol
−5	Stop warfarin
−3	Start bridging* agent (e.g., LMWH)
−1	Stop bridging* agent 24 hr prior to procedure If INR > 1.5, administer oral vitamin K (1 – 2mg), INR should be ≤ 1.4 before procedure.
0	Day of procedure
1	Resume warfarin within 24 hr. Resume bridging agent within 24 hr for low bleed risk.
2–3	Resume bridging agent within 48 to 72 hr for high bleed risk procedures
5–10	Stop bridging agent when INR reaches ≥2.0

* Bridging preoperatively is generally reserved for patients with high risk of thromboembolism. Bridging is not recommended for patients with atrial fibrillation without high risk of thromboembolism.

   b. Direct oral anticoagulants (dabigatran, rivaroxaban, apixaban, or edoxaban)[3]

Periprocedural management of patients on DOACs



Peri-Procedural Bleeding Risk

Low	Moderate	High
Minor Dental	SVT ablation	Cardiovascular/Thoracic Surgery
Minor Dermatologic	ICD Implant	Intra-abdominal/Pelvic surgery
Opthalmologic	Endoscopy with Biopsy	Major Orthopedic Surgery
Endoscopy without Biopsy	Prostate Biopsy	Neurosurgery
	Cardiac catheterization via radial artery	Cardiac catheterization via femoral artery

Peri-Procedural Thromboembolic Risk

Low	Moderate to High
$CHA_2DS_2VASc \leq 1$	$CHA_2DS_2VASc > 2$
No Stroke/TIA, VTE within 3 months	Stroke/TIA, VTE within 3 months
Heterozygous Factor V Leiden Heterozygous PT gene mutation	Protein C or S Deficiency Antithrombin Deficiency Antiphospholipid Syndrome

CrCl indicates creatinine clearance; ICD, implantable cardioverter-defibrillator; PT, prothrombin time; SVT, supraventricular tachycardia; TE, thromboembolic event; TIA, transient ischemic attack; and VTE, venous thromboembolism.
**Bridging with low molecular weight heparin (LMWH) may be considered in patients with a history of systemic embolus in the last 6 weeks.*

If DOACs need to be interrupted for procedure:

	Renal Function	Interval between last dose and procedure	Procedure
Dabigatran	CrCl ≥50 mL/min	Last dose 24 hrs before procedure	Cardiac Catheterization and PCI
	CrCL <50 mL/min	Last dose 72 hrs before procedure	
Dabigatran	CrCl ≥80 mL/min	Last dose 24 hrs before procedure	Electronic Device Implantation
	CrCl 50-79 mL/min	Last dose 36 hrs before procedure	
	CrCl <50 mL/min	Last dose 48 hrs before procedure	
Rivaroxaban, apixaban and edoxaban	All CrCl	Last dose 24 hrs before procedure	Any Procedure

NOTE: No anticoagulant is administered the day of the procedure.

4. The decision to resume antithrombotic therapy after the procedure should be guided by thromboembolic risk.[3]
   a. For procedures with low bleeding risk: resume anticoagulation 24 hours after surgery[1]
   b. For procedures with high bleeding risk: resume anticoagulation 48-72 hrs after surgery[1]

REFERENCES:

- Douketis JD, Lip GYH. Perioperative management of patients receiving anticoagulants. Leung LLK, ed. UpToDate. Waltham, MA: UpToDate Inc. http://www.uptodate.com. Accessed January 26, 2019.

- Douketis JD, Spyropoulos AC, Kaatz S, Becker RC, Caprini JA, et al. Perioperative Bridging Anticoagulation in Patients with Atrial Fibrillation. N Engl J Med. 2015;373(9):823-33. doi: 10.1056/NEJMoa1501035.

- Raval AN, Cigarroa JE, Chung MK, Diaz-Sandoval LJ, Diercks D, et al. Management of Patients on Non-Vitamin K Antagonist Oral Anticoagulants in the Acute Care and Periprocedural Setting: A Scientific Statement From the American Heart Association. Circulation. 2017;135(10):e604-e633. doi: 10.1161/CIR.0000000000000477.

Appendix G: Emergent reversal for life-threatening bleeding due to anticoagulant.

Drug	*Trade Name*	*Elimination Half-life*	*Removed by dialysis*	*Emergent reversal for life-threatening bleeding*
		Vitamin K Antagonist		
Warfarin	Coumadin Jantoven	20-60 hours Peak effect: 5-7 days Duration: 2-5 days	No	Reversal strategies are INR-based (see Appendix A)
		Direct Oral Anticoagulants (DOACs): Xa inhibitors		
Apixaban	Eliquis	12 hours Longer in renal impairment	No	If ingested within 2 hours, give activated charcoal 1 g/kg (max 50 g). Consider 4F-PCC at 50 units/kg x 1 (one dose only; do not re-dose) Some experts recommend andexanet alfa for life-threatening bleeding only after other hemostatic measures (e.g., antifibrinolytic therapy and drug removal with activated charcoal) have been shown to be ineffective.
Edoxaban	Savaysa	10-14 hours Longer in renal impairment	No	
Rivaroxaban	Xarelto	Healthy: 5-9 hours Elderly: 11-13 hours Longer in renal impairment	No	
		Direct Thrombin Inhibitors		
Argatroban		39-51 minutes Longer in hepatic impairment (181 min)	20%	Turn off infusion. Consider 4F-PCC at 50 units/kg x 1 (one dose only; do not re-dose)
Dabigatran	Pradaxa	12-17 hours Up to 28 hours in severe renal impairment	57%	If ingested within 2 hours, give activated charcoal 1 g/kg (max 50 g). Consider idarucizumab, administered as 2 consecutive IV infusions of 2.5 g vials over 5 minutes each. The second 2.5 g vial must be administered within 15 minutes of the first vial. If idarucizumab not available, consider 4F-PCC at 50 units/kg x 1 (one dose only; do not re-dose)
Bivalirudin	Angiomax	25 minutes Up to 3.5 hour in severe renal impairment	25%	Turn off infusion. Consider 4F-PCC at 50 units/kg x 1 (one dose only; do not re-dose)
		Heparins		

Enoxaparin	Lovenox	4.5-7 hours Longer in severe renal impairment	No	Protamine partially reverses the anticoagulant effect of LMWHs (~60%) Administer protamine; do not exceed rate of 5 mg/min, max dose 50 mg If last dose was within 8 hours PTA, for each 1mg of enoxaparin, administer 1 mg of protamine If last dose was 8-12 hours PTA, for each 1 mg of enoxaparin administer 0.5 mg of protamine If last dose was >12 hours PTA, protamine is unlikely to be beneficial
Heparin, unfractionated (UFH) IV		1-2 hours (dose-dependent)	No	Turn off infusion Protamine neutralizes heparin. Use the preceding 2-3h rate of UFH to dose protamine. For each 100 units of UFH, administer 1 mg of protamine. Do not exceed rate of 5 mg/min (max 50 mg). Reversal of heparin given within last 3 hours a)Dose immediately after UFH dose: 1 mg of protamine for each 100 units of UFH b) Dose within 60min after UFH dose: 0.5 mg of protamine for each 100 units of UFH is 0.5 c)Dose ≥ 2-3 hours after UHF dose: 0.25 mg of protamine to each 100 units of UFH If aPTT remains elevated, can repeat protamine - for each 100 units of UFH, administer 0.5mg of protamine.
Pentasaccharide				
Fondaparinux	Arixtra	17-21 hours Prolonged in renal impairment and elderly	20%	Consider 4F-PCC at 50 units/kg x 1 (one dose only; do not re-dose)

4F-PCC, 4 factor prothrombin complex concentrate; PTA, prior to admission

REFERENCES:

- Warfarin. Lexi-Drugs. Accessed 2/1/2019.
- Apixaban. Lexidrugs. Accessed 2/1/2019.
- Frontera JA, Lewin JJ 3rd, Rabinstein AA, Aisiku IP, Alexandrov AW, et al. Guideline for Reversal of Antithrombotics in Intracranial Hemorrhage: A Statement for Healthcare Professionals from the Neurocritical Care Society and Society of Critical Care Medicine. Neurocrit Care. 2016 Feb;24(1):6-46. doi: 10.1007/s12028-015-0222-x.
- Minocha A, Krenzelok EP, Spyker DA. Dosage recommendations for activated charcoal-sorbitol treatment. J Toxicol Clin Toxicol. 1985-1986;23(7-8):579-87.
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- Bivalirudin. Lexidrugs. Accessed 2/1/2019.
- Enoxaparin. Lexidrugs. Accessed 2/1/2019.
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- Fondaparinux. Lexidrugs. Accessed 2/1/2019.

SUBJECT: **ASEPTIC TECHNIQUE, UTILIZATION OF**	SECTION: **Page 1 of 5**

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

PURPOSE:

To define the procedures to maintain a sterile field for a safe environment and to minimize wound contamination for all surgical patients and Interventional Radiology (IR)/Cath Lab patients.

POLICY:

All Members of the surgical team will adhere to aseptic principles and techniques providing and maintaining a safe environment.

AFFECTED AREAS/ PERSONNEL: *MAIN OPERATING ROOM (OR)-MATERNAL CHILD HEALTH (MCH) OR/ALL SURGICAL TEAM MEMBERS, INTERVENTIONAL RADIOLOGY AND CARDIAC CATH LAB TEAM MEMBERS*

PROCEDURE:

1. **Scrubbed person shall have all necessary instruments, supplies, and equipment needed to prepare the sterile field for surgical procedure.**
   a) **Use surgeon preference card; if updates are needed ensure communication to charge, manager, or lead tech**

2. Scrubbed persons shall wear sterile gowns and gloves:

   a. The scrubbed person shall scrub hands and forearms according to surgical hand scrub procedure.

   b. The gown worn by the scrubbed person shall be considered sterile in front from chest to level of sterile field.

   c. Sleeves shall be considered sterile from above the elbow to the stockinette cuff.

   d. The stockinette cuff shall be considered unsterile and shall be covered by sterile gloves at all times.

   e. The neckline, shoulders, areas under the arms and back of the gown shall be considered unsterile.

   f. Materials for gowns shall be aseptic barrier materials.

   g. Self-gowning and gloving of the scrubbed person shall be performed from a separate sterile surface.

2. Sterile drapes shall be used to establish a sterile field:

a. Sterile drapes shall be placed on the patient, furniture and equipment to be included in the sterile field.

b. Drapes shall be handled as little as possible.

c. In the draping process, the material shall be held above the waist level, in a compact position, draping from the operative site to the periphery.

d. In placing drapes, the gloved hands shall be protected by cuffing the draping material over the hands.

e. Once placed in position, sterile drapes shall not be moved or shifted.

f. Surgical drapes shall be aseptic barrier materials.

3. All items used within a sterile field shall be sterile:

a. Packing materials shall meet the AORN recommended practice for in hospital packaging materials.

b. Method of sterilization, storage and handling of sterile items shall be according to sterilization and disinfection policy and procedure.

c. Before dispensing a sterile item to the sterile field, the unscrubbed person shall check the package integrity, chemical process indicator and, if present, expiration dates.

4. All items introduced into a sterile field shall be dispensed by methods that maintain sterility of the item and integrity of the sterile field:

a. A sterile package shall be opened from the far side first and near side last.

b. All wrapper tails shall be secured when supplies are presented to the sterile field to avoid contamination.

c. Sterile items shall be presented to the scrubbed person or placed securely on the sterile field. Sharp and/or heavy objects shall be presented to the scrubbed person or opened on a separate surface.

d. When dispensing irrigation solutions to the sterile field:

- Empty entire contents of the bottle. If unable to empty, the remainder is discarded into a sink.

- Solution receptacle shall be placed near the edge of the table or held by the scrubbed person.
- Solutions shall be poured to avoid splashing of fluids onto the sterile field.
- All solutions will be labeled on the sterile field.
- All blue wrapped items will be visually inspected by staff for compromised packaging.

5. A sterile field shall be constantly monitored and maintained:

a. Monitor for contamination of the sterile field and potential breaks in sterile technique and correct them immediately.

b. Sterile fields shall be prepared as close as possible to scheduled time of use and not covered and follow recommended AORN standards.

c. Position heater-cooler devices away from the sterile field, and direct the airflow exhaust of the equipment away from the sterile field.

d. Every team member shall observe for events, which may compromise the sterile field and initiate corrective action.

e. Conversation shall be minimal in the operating room.

f. All cables, tubing, etc. for equipment shall be secured on the sterile field with a nonperforating device.

g. Nonsterile equipment brought into the sterile field shall be draped with a sterile material.

h. Items of doubtful sterility shall be considered unsterile and discarded.

i. Sterile dressing material shall be applied before surgical drapes are removed, to avoid contamination of the incision.

j. Cover the sterile field if it will not be used immediately (e.g., procedural delay, sterile field for closure, multiple tables) or during periods of increased activity (e.g., pre-incision, repositioning). If the sterile field is in use, the portion of the sterile field that will not be immediately used (e.g., implants, instruments not in use) may be covered.

k. When using intraoperative debridement devices with irrigation (i.e., hydrosurgery, pulse lavage, low-frequency ultrasonic debridement) on open, infected wounds, implement

interventions to minimize personnel exposure to potentially infectious materials and reduce contamination of the sterile field

6. Traffic in and out of the operating room and around sterile field:
a. Only staff assigned to surgical procedure should be entering and/or exiting the operating room.

a. All personnel moving within or around a sterile field shall do so in a manner to maintain the integrity of the sterile field.

b. Scrubbed persons shall keep arms and hands within the parameters of the sterile field at all times.

c. Scrubbed surgical team members shall move from sterile to sterile areas. If they must change position, they shall turn back to back or face to face while maintaining a safe distance between each other and avoiding traffic pathway.

d. Scrubbed persons shall avoid changing levels and shall be seated only when the entire surgical procedure will be performed at this level.

e. Scrubbed persons shall stay close to the sterile field and shall not leave the room.

f. Unscrubbed surgical team members shall move from unsterile to unsterile areas, maintaining awareness of the need for distance from the sterile field.

g. Unscrubbed persons shall always approach sterile areas facing them and shall not walk between two sterile fields.

The OR furniture and equipment should be grouped and positioned prior to opening the sterile items

A. Any unnecessary furniture and equipment should be removed from the OR.

B. Equipment, such as electrosurgical unit, patient monitors, suction system, and specialty equipment, such as the tourniquet machine and microscope, should be tested for functionality prior to the start of the procedure.

C. New suction liners should be placed in the suction canister and confirm that the suction tubing is connected to the wall vacuum outlet.

D. Confirm that a separate suction system is prepared for use by the anesthesia provider.

Furniture should be grouped and positioned.

A. Furniture that will eventually be sterilely draped, including the back table, Mayo stand, and basin ring stand should be grouped and organized together. It is recommended these items be positioned so that the sterile field will be established in an area furthest from the OR door. When the OR doors open and close, this causes air movement and particles are stirred up; therefore, the furniture should be positioned as far as possible from the OR doors and human traffic that occurs in and out of the room.4,7,8

B. The furniture that will be set up and included in the sterile field should be positioned a minimum of 12 inches away from the wall and other non-sterile furniture and equipment.5

All other furniture that will not be included in the sterile field, such as linen and trash hampers, sponge/kick buckets, and sitting stools, should be positioned away from traffic patterns and the furniture to be used in the sterile field.

A. A biohazard bag should be positioned in the linen and trash hampers.

B. Sponge buckets should be lined with an impervious biohazard bag.

The OR table should be positioned according to the surgeon's preference under the OR lights.

The anesthesia machine should be positioned according to the anesthesia provider's preference and according to the position of the OR table.

A. A clean lift sheet and arm board covers should be placed on the OR table. 3

B. The safety strap should be placed according to the patient surgical position that will be used for the procedure.

REFERENCES:

- AORN Standards & Recommended Practices & Guidelines. Sterile Technique. April 18, 2024.
- Association of Surgical Technologist. AST Guidelines for Aseptic technique. Accessed June 25, 2024..

CROSS REFERENCE:

- Surgical Hand Scrub Policy

SUBJECT: **ASSESSMENT OF PATIENTS FOR SURGICAL/INVASIVE PROCEDURES**	SECTION: **Page 1 of 2**

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

PURPOSE:

To identify the need for care, the type of care to be provided, and the need for further assessment.

POLICY:

All patients admitted to the Surgical Services Department for operative and/or other invasive procedures shall be assessed by a qualified Registered Nurse (RN) for the physical, psychological, spiritual, and social needs of the patient.

AFFECTED AREAS/ PERSONNEL: *MAIN OPERATING ROOM (OR), FLEXCARE, AMBULATORY SURGERY DEPARTMENT (ASD) REGISTERED NURSES (RNs)*

PROCEDURE:

1. Upon admission to the pre-op area, an initial assessment is performed by a qualified Registered Nurse. The data obtained is to include, but is not limited to:

    a. Proper identification of the patient, including blood bank number, if applicable;

    b. Patient's known allergies;

    c. Patient's NPO (nothing by mouth) status;

    d. The patient's procedure to be performed per the physician's written order, appropriate consent obtained and verified with operating room scheduled, and the patient's understanding of the procedure to be performed;

    e. Prosthesis and metal location in body;

    f. Preoperative antibiotics status;

    g. Baseline vital signs and cardiac rhythm strip (admission vital signs are recorded in the EMR and the rhythm strip is placed in the chart);

    h. The patient's functional status and mobility;

    i. The patient's psychological and emotional status;

    j. Any diagnostic test results ordered by the surgeon or anesthesiologist or that are relevant to the surgery or procedure being performed.

    k. A blood glucose test for diabetic patients as well as any patient with an abnormal blood glucose value on their pre-op labs.

l. An updated list of current medications including vitamins and herbal supplements.

m. The patient's history and physical examination on the medical record, performed within 30 days, and updated on day of surgery;

2. The Procedural Patient Assessment and Checklist will provide the documentation for the initial assessment and readiness for the procedure.

3. The patient's response and tolerance to the procedure are continually reassessed. Modifications and changes in the plan of care are based on reassessment data.

4. The patient's post-operative status is reassessed upon admission and discharge from the Post Anesthesia Care Unit (PACU). This information is documented in the EMR and communicated to the Nursing Services Staff, who will continue the care of the patient. The data is available on the patient's medical record to provide collaborative interdisciplinary care for the patient's optimal and expedient recovery.

EVIDENCE-BASED REFERENCES:

- American Society of PeriAnesthesia Nurses. (2023). *Perianesthesia Nursing Standards Practice Recommendations and Interpretive Statements.* Cherry Hill, NJ: American Society of PeriAnesthesia Nurses.

SUBJECT: **CHEMOTHERAPY COMPETENCY POLICY**	SECTION: **Page 1 of 2**

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

PURPOSE:

Antineoplastic drugs are known to have teratogenic (relating to, or causing developmental malformations), mutagenic (inducing or capable of inducing genetic mutation), and/or carcinogenic (producing or tending to produce cancer) effects when administered to humans. Only adequately prepared registered nurses, which are skilled in administering chemotherapy, will assume responsibility for its administration in order to ensure quality of patient care and maintain the highest standards of patient and personnel safety.

POLICY:

1. Current intravenous therapy skills and cardiopulmonary resuscitation (CPR) certification will be acquired by all licensed personnel interested in chemotherapy administration.

2. An educational course in chemotherapy, to include didactic and clinical practicum, shall be successfully completed prior to administering chemotherapy.

   a. The didactic portion of the course must include a minimum 8 hours lecture format covering:

      - History of cancer chemotherapy
      - Drug development
      - Principles of cancer chemotherapy
      - Chemotherapy preparation, storage, and transport
      - Nursing assessment
      - Chemotherapy administration
      - Safety precautions during administration
      - Disposal, accidental exposure and spills
      - Institutional considerations
      - Demonstrated knowledge of lecture material via successful completion of a written evaluation with a passing score.

   b. The clinical practicum should include:

      - Observation of chemotherapy administration (if applicable)

- Successful completion of fundamentals of chemotherapy and immunology administration (Oncology Nursing Society, ONS)

3. An OCN certification by the ONS, if current, will waive the didactic requirement.

4. Participation in unit-based continuing education offerings on chemotherapy and oncology related topics are recommended on an ongoing basis in order to maintain a current knowledge base. It is the employee's responsibility to furnish evidence of review courses/lectures during the yearly performance evaluation.

5. Failure to demonstrate chemotherapy competency will result in an administrative decision to place the nurse on an alternate assignment.

AFFECTED AREAS/ PERSONNEL: *CHEMOTHERAPY STAFF*

REFERENCE:

- Oncology Nursing Society Cancer Chemotherapy Guidelines and Recommendations for Practice (2021). Oncology Nursing Society. Retrieved from https://www.ons.org/Chemotherapy-and-Immunotherapy-Guidelines-and-Recommendations-for-Practice.

SUBJECT: **CITATIONS/INTERVIEWS OF PATIENTS BY LAW ENFORCEMENT**	SECTION: *Leadership (LD)* **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 appropriate handling of patient citations or interviews with law enforcement personnel.
- To reduce the risk regarding the patient's condition.
- To ensure appropriate orientation of forensic law enforcement personnel to the hospital.

POLICY:

Physician will patient status review and provide clearance for interview if there is a concern for patient health and stability to participate in citation/ interview prior to law enforcement officers being their process. The hospital does not routinely care for in-custody patients. If this occurs, law enforcement personnel will be oriented to the hospital's protocols and procedures.

AFFECTED PERSONNEL/AREAS:

GOVERNING BOARD, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, STUDENTS, INSTRUCTORS, VENDORS

PROCEDURE:

1. Law enforcement officers requesting permission to interview or serve papers to a patient in the hospital will be referred to Risk Management during regular business hours and Nursing House Supervisor after hours.
2. Law enforcement officers must provide proper identification.
3. Law enforcement officers will request permission to interview any patient.
    a. Applicable to all patients regardless of the patient's relationship with the police (i.e., arrested, under investigation, victim, witness).
    b. Not applicable to patients who are receiving treatment for psychiatric disorders, alcohol or drug abuse, since such patients are afforded special statutory protection.
4. If the patient is listed in the Hospital Directory, law enforcement will be provided with the patient's room number and will be permitted to visit the patient.
5. Any patient who has "Opted Out" of the Hospital Directory will have that choice honored. Hospital personnel will use the standard script of "I have no patient listed in the Hospital Directory with that name. Federal Medical Privacy Laws permit us to disclose only the information in the Hospital Directory."

6. Law enforcement officers will be oriented to policy regarding citations or interviews with patients by a member of the hospital's Risk Management staff or after hours with Nursing House Supervisor.

7. If patient stability needs to be reviewed by physician before citation/interview it is the unit staff that will be responsible for contacting the physician. The physician will need to document that the patient is stable for citation/interview in the patient medical record.

8. Law enforcement officers presenting with a Warrant or Subpoena shall be referred to Risk Management, Administration and/or the Nursing House Supervisor.

Patient's Consents to Law Officer Interview:

- If a competent patient consents to cooperate with law enforcement officers, the patient's desire should be respected.
- Patient will be informed of any possible adverse medical consequences at the direction of the physician
- The physician or nursing staff will document the patient's understanding of medical consequences in the patient's medical record.
- If it is medically inappropriate to conduct an interview, but patient wants to cooperate with law enforcement officers, hospital personnel will coordinate the transmission of information from patient to the officers.

Patient Objects to Interview:

- The hospital may object to non-consensual interrogations, but may not obstruct justice, which may include interview / interrogation.
- Hospital personnel should never attempt to physically prevent law enforcement officers from interrogating a patient.
- When a law enforcement officer insists on interrogating a patient, despite a warning that it may adversely affect the patient's medical condition, the hospital will contact the law enforcement agency for assistance.
- If interview / interrogation is conducted, hospital personnel may monitor as appropriate to protect therapeutic interest of the patient. Law enforcement shall honor patient's request to have hospital personnel present.
- If law enforcement officers do not permit the presence of hospital personnel, despite the patient's desire to have them present, an objection should be clearly stated and recorded in the patient's

medical record and the Commanding Officer of the law enforcement shall be notified by nursing personnel, Risk Management, Administration and/or House Supervisor.

- If the patient wants to exclude hospital personnel from interview / interrogation, it should be respected.

Release of Medical Information:

The California Medical Information Act (CMIA) establishes more stringent limits on disclosures to law enforcement than does HIPAA. CMIA prohibits the hospital from disclosing medical information without patient authorization unless the disclosure is compelled by:

- A subpoena or summons for release of medical information must be accompanied by, or be issued as a result of a court order.
- A search warrant lawfully issued to a governmental law enforcement agency.

REFERENCES:

- *Policy – Prisoners / Wards of Legal System Care of*
- *Brochure – Security Services Forensic Handout / Emergency Terms*
- 45 C.F.R. § 160.203
- 45 C.F.R. § 164.510(a)
- Civil Code § 56.16
- Penal Code §§ 69, 148
- Penal Code, Part Two, Title 12 Chapter 3.5, Section 1453
- *Consent manual*. California Hospital Association. (2024, June 25). https://calhospital.org/publications/consent-manual/

SUBJECT: **COLOR – CODED WRISTBAND USE**	SECTION: ***Provision of Care, Treatment and Services (PC)*** **Page 1 of 4**

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

PURPOSE:

To have a standardized process that identifies and communicates patient-specific risk factors or special needs by using color-coded wristbands based upon the assessment of the patient, the patient's wishes and medical status.

POLICY:

A. To reduce confusion associated with the use of color-coded wristbands, Sierra View Medical Center will use colors that are standardized through California to communicate patient-safety risks to all health care providers.

B. The patient, family members and significant others will be included in the communication process and safe care promotion.

C. SVMC will adopt the following risk-reduction strategies when utilizing color-coded wristbands:

1. A preprinted written descriptive text is used on the bands, clarifying the intent (i.e; "Allergy", "Fall Risk", "Limb Alert", or "DNR").

2. Color-coded wristbands may only be applied or removed by a nurse conducting an assessment.

3. Social (community) cause wristbands should not be worn by patients in the hospital. (Social cause wristbands include, for example "LIVESTRONG"). Staff should have family members take the social cause wristbands home, or remove them from the patient and store them with their other personal items. This is to avoid confusion with the color-coded wristbands and to enhance patient-safety practices.

4. When a color-coded wristband is applied, the patient and family are educated regarding the wristband message.

D. The following represents the only color-coded wristbands used:

1. WHITE wristbands will be used for patient identification. The patient identification and admission identification bands may be applied by non-clinical staff in accordance with hospital policy.

2. PURPLE wristbands will be used to identify patients with a "Do Not Resuscitate" order written in the medical record in accordance with hospital policy. The letters "DNR" will be printed on the wristband.

3. RED wristbands will be used to identify patients with allergies. The list of allergies will be written in the medical record in accordance with hospital policy. Allergies

will include allergies to medication/s, food, environmental allergens or other substances that may cause an allergic reaction in the patient. The letters "ALLERGY" will be printed on the wristband.

4. YELLOW wristbands will be used to identify patients with a risk of falling. Patients are assessed for fall risk on admission, every shift and PRN. The letters "FALL RISK" will be printed on the wristband.

5. PINK wristbands will be used to identify patient with a limb alert . The Pink wristband will be placed on the limb that should not be used for procedure such as blood draws, or IV sticks. The letters "LIMB ALERT" will be printed on the wristband.

AFFECTED PERSONNEL/AREAS: *ALL PATIENT CARE AREAS*

PROCEDURE:

A. During the initial patient assessment, data is collected to evaluate the needs of the patient and a plan of care unique to the individual is initiated.

B. Throughout the course of care, reassessment is ongoing, which may uncover additional pertinent medical information, trigger key decision points, or reveal additional risk factors about the patient. During the initial and reassessment procedures, allergies, DNR status and risk factors associated with falls may be identified.

C. The nurse performing the patient assessment is designated to apply or remove color-coded wristbands. Color-coded wristbands will be used for all patients with these conditions, including all inpatient, outpatient and emergency department patients.

D. The nurse will examine the patient for "social (community) cause" wristbands, during the initial assessment. If "social cause" wristbands are present, the nurse will explain the risks associated with the wristbands and ask the patient to remove them. If the patient agrees, the band/s will be removed and given to a family member to take home, or stored with the patient's personal belongings.

E. The nurse performing the assessment is authorized to determine fall risk and patient allergies as determined by the assessment and place the appropriate color-coded wristband on the patient.

F. In the Emergency Department, the specific allergies will be written on the RED ALLERGY band. Once the patient is admitted, this band will be removed and replaced with the red allergy band with the printed letters "ALLERGY" and staff will refer to the medical record for specific allergies.

G. The determination of a "Do Not Resuscitate" status requires a physician's order or an Advance Directive prior to the nurse placing the DNR wristband on the patient. The wristband serves as an alert and does not take the place of an order.

H. All color-coded wristbands will be placed on the same wrist as the patient identification wristband.

I. Staff should assist and encourage the patient and family member/s to be active partners in the care provided and safety measures being used. When applying a color-coded wristband/s to a patient, the nurse will educate the patient and family member/s about the meaning of the wristband/s applied and the patient/family role in color-coded wristbands. The nurse will instruct the patient and family member/s, if present, that the wristband is not to be removed. The nurse will teach all patients and family members to notify the nurse whenever a wristband has been removed and is not reapplied; when a new band is applied and they have not been given an explanation as to the reason; or if color-coded wristband condition/s have changed.

J. If the patient is mentally competent and refuses to wear the color-coded wristband, an explanation of the benefits of wearing the color-coded wristband will be provided to the patient. The nurse will reinforce that this is an opportunity to participate in efforts to prevent errors, and it is his/her responsibility as part of the team. The nurse will document in the medical record patient refusals, and the explanation provided by the patient. The patient will be requested to sign a Patient Refusal to Participate in the Wristband Process form.

K. In the event that any color-coded wristband/s must be removed for a treatment or procedure, a nurse will remove the wristband/s. Upon completion of the treatment or procedure, risks will be reconfirmed and a new wristband/s immediately reapplied by the nurse.

L. The application of color-coded wristbands will be documented in the nurses' notes at the time of assessment/reassessment. DO NOT document the wristband color, only that the wristband corresponding to the condition assessed was applied, e.g. "Fall Risk wristband applied".

M. The nurse will reconfirm that the color-coded wristband/s are consistent with the documentation in the medical record with each shift assessment and with any transfer. Errors will be corrected immediately.

N. Color-coded wristbands are not removed at discharge. For home discharges, the patient is advised to remove the band at home. For discharges to another facility, the wristbands are left intact as a safety alert during transfer. The discharging nurse is responsible for communicating the condition that corresponds with the wristband; i.e. "FALL RISK", to the receiving nurse.

STAFF EDUCATION:

A. Staff education regarding color-coded wristbands will occur during the new orientation process and reinforced as indicated.

B. Color-coded wristbands will be included in annual competencies for all nursing staff to reinforce continued safety care.

REFERENCES:

- The Joint Commission (2024). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Roth, D. (2023, November 30). Ask CHPSO: Do hospitals use color-coded wristband identification and, if so, what colors do they use? *HQI*. https://hqinstitute.org/ask-chpso-do-hospitals-use-color-coded-wristband-identification-and-if-so-what-colors-do-they-use/#:~:text=Red%20for%20allergies,for%20do%20not%20resuscitate%20(DNR)

SUBJECT:	SECTION:
CONDUCT METHICILLIN RESISTANT STAPHYLOCOCUS AUREUS (MRSA) SCREENING	**Page 1 of 3**

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

POLICY:

PURPOSE: To reduce overall Hospital Acquired Infections (HAIs) and improve in-patient outcome by identifying patients at risk for known HAIs, and in this instance, specifically for methicillin resistant *Staphylococcus aureus* (MRSA) infections through active surveillance testing (AST).

BACKGROUND: Although many innovations and improvements have been made in treating patients for various types of conditions and diseases, it is crucial to monitor and prevent HAIs as they may be a major threat to patient safety. Of the various known HAIs, (CLABSIs, CAUTIs, VAPs and others) MRSA infections are easily monitored. Approximately 2 - 5% of all patients in U.S. hospitals carry MRSA bacteria in their nose or on their skin but most do not develop serious infections. MRSA is spread by contact with infected people or fomites carrying the bacteria. In facilities that care for vulnerable individuals such as GACH or SNF, MRSA infections may cause severe problems such as bloodstream infections, pneumonia, sepsis and even death. For this reason, the State of California passed legislation (CA SB 1058, Nile's Law, and SB 158) which aligns with guidelines from the CDC, and requires specific conditions be met for disease surveillance of patients, including the screening for MRSA infections.

DEFINITIONS:

AST: active surveillance testing;

CDC: The Centers for Disease Control and Prevention;

EMR: electronic medical record;

HAI/HAC: hospital acquired infections/conditions;

CAUTI: catheter associated urinary tract infection;

CLABSI: central line associated bloodstream infection;

GACH: general acute care hospital;

MRSA: methicillin resistant *Staphylococcus aureus*;

SNF: skilled nursing facility; VAP, ventilator associated pneumonia;

A. SCREENING CRITERIA: Eligible healthcare professionals (See D. RESPONSIBILITIES) will use the following parameters to identify in-patients in need of MRSA AST and then test these inpatients. According to CA SB 1058, inpatients must be screened upon admission to determine the need for an MRSA swab test (see

- MRSA Screening
  - Criteria

Discharged within Last 30 Days	Yes
Admitted to ICU	No
Patient on Dialysis	No
New Dialysis Patient	No
Admitted From SNF	Yes
Admitted for Hip or Knee Surgery	No

  - Indicated

MRSA Nasal Screen Indicated	Yes

  - Education

Prevention and Screening	Yes

Figure 1). The test should be conducted within 24 hours of the patient's admittance. The MRSA bundle criteria section in the EMR is to assess if:

1. This is a pre-operative patient who is having hip or knee replacements. The patient is to be retested when discharge is ordered. Any patient that tests positive will be notified and educated about MRSA
2. The patient is being admitted to the ICU
3. The patient is discharged from an acute care facility within the past 30 days
4. The patient is or will be receiving inpatient dialysis
5. This is a dialysis patient entering the facility that shows evidence of increased risk of invasive MRSA. If so, the patient shall be tested for MRSA immediately prior to discharge from the facility (this does not apply to a patient who has tested positive for MRSA infection or colonization upon entering the facility)
6. The patient is admitted from a SNF

Figure 1: MRSA AST and nasal screen should be administered within the patient's first 24 hours of admission.

B. CONTRAINDICATIONS FOR SCREENING: A physician's order is required to withhold MRSA screening, swab testing and culture

C. RESPONSIBILITIES: Any of the following health care professionals with current California licenses may perform MRSA swab tests – Licensed Vocational Nurse (LVN), Registered Nurse (RN), Family Nurse Practitioner (FNP), Physician's Assistant (PA), Laboratory Technician, MD or DO.

D. PROCEDURE:

1. Conduct MRSA AST questionnaire entitled Criteria within the EMR
2. Inform the inpatient of the purpose for performing a swab for laboratory culture
3. A single 'yes' response within the Criteria section of the MRSA Screening questionnaire is sufficient to require an MRSA swab test
    a. Use a single regular culture swab,
    b. Peel open and carefully remove the swab
    c. Insert the swab into the nostril at least 1 cm and swab the inside of the nose by rotating the swab against the anterior nasal mucosa for 3 seconds
    d. Repeat this procedure using the same swab in the second nostril
    e. Carefully place the swab into a labeled transport tube that has the inpatient's information for transport to the laboratory for culture
    f. Record the date that the screening culture collection was completed into the EMR
4. If an inpatient tests positive for MRSA:
    a. The physician should inform the patient or the patient's representative immediately or as soon as is feasibly possible
    b. The inpatient and/or caregiver shall receive verbal and written instructions regarding aftercare and precautions to prevent the spread of MRSA to others (Refer to ***Krames On Demand*** in SVMC Intranet, Infectious Disease, Diseases

& Conditions, Methicillin-Resistant Staphylococcus aureus (MRSA) Infection, to print out an information sheet that may be personalized with patient name and special instructions)

REFERENCES:

- California Senate Bill 158 (2008), California State Legislature. SB 158
- California Senate Bill 1058 (2008), California State Legislature. SB 1058
- CDC Interim Guidance for a Public Health Response to Contain Novel or Targeted Multidrug-resistant Organisms (MDROs) 2019. Page last reviewed July 10, 2019 and information retrieved July 3, 2024. https://www.cdc.gov/hai/containment/guidelines.html
- *Staphylococcus aureus* Basics. April 15, 2024. Content Source: Centers for Disease Control and Prevention. Information retrieved July 3, 2024. https://www.cdc.gov/staphylococcus-aureus/about/index.html
- Methicillin-resistant *Staphylococcus aureus* (MRSA) Basics. April 11, 2024. Content Source: Centers for Disease Control and Prevention. Information retrieved July 3, 2024. From: https://www.cdc.gov/mrsa/about/index.html
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- MRSA Factsheets & Posters. April 12, 2024. Content Source: Centers for Disease Control and Prevention. Information retrieved July 3, 2024. From: https://www.cdc.gov/mrsa/communication-resources/index.html
- Noorani HZ, Adams E, Glick S, et al. Screening for Methicillin-Resistant Staphylococcus aureus (MRSA): Future Research Needs: Identification of Future Research Needs From Comparative Effectiveness Review No. 102 [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2013 Jun. (Future Research Needs Papers, No. 40.) Retrieved July 29, 2022. Introduction. Available from: https://www.ncbi.nlm.nih.gov/books/NBK154512/

CROSS REFERENCE

Isolation & Standard Precautions Policy & Procedure

SUBJECT: **GUIDELINES FOR PRODUCT DATING**	SECTION:

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

GENERAL:

All medications at Sierra View Medical Center (SVMC) will be stored in accordance with the most recent guidelines as established by the United States Pharmacopoeia (USP) and the National Formulary (NF) as well as manufacturer recommendations, and recommendations from the Centers for Disease Control and Prevention (CDC).

PURPOSE:

To define the appropriate use/duration for an agent in order to maintain compliance with the pharmaceutical industry standards.

POLICY:

All medications will be stored in accordance with the manufacturer, USP, or NF guidelines. It is the responsibility of the pharmacist to determine the expiration date to be placed on the package, taking into account the nature of the drug repackaged, the characteristics of the package, and the storage conditions to which the drug may be subjected. This date must not be beyond that of the original package.

AFFECTED AREAS/ PERSONNEL: *PHARMACY, NURSING*

PROCEDURE:

1) Multi-dose vials

   a) All multi-dose medication containers shall display the concentration of the preparation made, dated (with the expiration date, not the date first opened), and initialed when opened.

   b) All multi-dose injectable medication containers will be refrigerated after opening, unless specifically labeled "DO NOT REFRIGERATE"

   c) Inspect prior to each use for suspected or visible contamination. Discard if contamination is suspected.

   d) If a multi-dose vial enters an immediate patient care area, it should be dedicated for single-patient use only.

   e) All multi-dose vials should be discarded after being used for a single patient whenever possible.

2) Warming of solutions

a) Once the containers have been removed from the warmer, they should be identified as having been warmed and should not be returned to the warmer. If unopened, the plastic bottles may continue to be used until the manufacturer's expiration date, provided that they have not been warmed more than once.

i) Large volume intravenous (IV) solutions (VIAFLEX plastic containers):

(1) IV solutions greater than 150ml to 1000ml may be warmed in their over pouches to temperatures and periods not exceeding:

40°C (104°F) for 14 days if greater than or equal to 3 months expiry remain on the product. If less than 3 months expiry remaining, the product should not be warmed.

ii) Irrigation Solutions packaged in Arthromatic and Uromatic Containers:
(1) Solution Fill Volumes 1000mL to 5000mL
- o Glycine for Irrigation, USP, UROMATIC Plastic Container
- o Lactated Ringer's for Irrigation, ARTHROMATIC Plastic Container
- o Sodium Chloride for Irrigation, USP, ARTHROMATIC Plastic Containers
- o Sodium Chloride for Irrigation, USP, UROMATIC Plastic Containers
- o Sorbitol Urologic Irrigation Solution, UROMATIC Plastic Container
- o Sterile Water for Irrigation, USP, UROMATIC Plastic Container

Table 1. Warming parameters for Irrigation Solutions in ARTHROMATIC or UROMATIC Plastic Containers in the plastic overwrap[2]

Irrigation Solution Fill Volumes	Warming Parameters
1000 mL to 5000 mL	Up to 40°C (104°F) and for a period of no longer than 14 days if greater than or equal to 3 months expiry remain on the product
	50°C (122°F) and for a period no longer than 72 hours

Products should not be warmed if there is less than 3 months expiry remaining. If not used within the maximum warming period they should be discarded.

(2) Irrigation solutions in Plastic Pour Bottles:
- Acetic Acid Irrigation, USP, Plastic Pour Bottle
- Lactated Ringer's Irrigation, Plastic Pour Bottle
- Sodium Chloride Irrigation, USP, Plastic Pour Bottle
- Sterile Water Irrigation, USP, Plastic Pour Bottle
- TIS-U-SOL Solution (Pentalyte Irrigation), Plastic Pour Bottle

i) May be warmed to temperatures and periods not exceeding:

Table 1. Warming parameters for Irrigation Solutions in Plastic Pour Bottle

Irrigation Solution Fill Volumes	Warming Parameters per Product Labeling
250 mL to 1000 mL	Warm in oven to not more than 50°C (122°F) for a maximum of 60 days. Discard after 60 days of warming.

If product not used within maximum warming period, the product should be discarded. The product should not be returned to room temperature or to the warmer.

2) Refrigerated Solutions

a) Large volume intravenous (IV) solutions (VIAFLEX plastic containers) that have not been spiked or admixed prior to refrigeration:

o 5% Dextrose Injection, USP, in VIAFLEX plastic container
o 0.9% Sodium Chloride Injection, USP, in VIAFLEX plastic container
o Lactated Ringer's Injection, USP, in VIAFLEX plastic container
o PLASMA-LYTE A Injection pH 7.4 (Multiple Electrolytes Injection, Type 1, USP)

Table 1. Refrigerated (2°C to 8°C) Storage Duration of Injection Solutions in VIAFLEX Containers

Container Volume	Refrigerated Storage Duration	
	Product removed from overwrap	Product remains in the overwrap
50 mL	15 days	Up to the expiry date printed on the individual container
100 mL – 1000 mL	30 days	

Once solutions removed from overwrap have been stored under refrigeration, they should be used within the "product removed from the overwrap" storage times listed above. Once refrigerated solutions should not be returned to room temperature for storage for later use or returned to the refrigerator.

PRODUCT EXPIRATION DATING

Description	Requires Date & Initials (yes/no)	Expiration Date
Injectables		
Ampules	No	Discard immediately after use. Use filter needles as per policy.
Single Dose Vials (without preservatives)	No	4 hours after initial entry into closed container; 12 hours in ISO Class 5 or cleaner
Multi-Dose Vials (with preservative)	Yes	28 days after opening
Insulin	Yes	28 days after opening
IV Solutions Mixed		
Mixed on unit/Patient care area	Yes	Administration should begin as soon as possible and not to exceed 4 hours or according to medication stability data whichever is shorter.
Mixed in pharmacy	Yes	As indicated by the date on the IV label which is determined by the pharmacist
IV Solutions Unmixed (Overwrap removed, otherwise until date on container)		
IV solutions 100 ml or over	Yes	28 days
IV solutions less than 100 ml	Yes	15 days
Mini-Bag Plus VIAFLEX Containers (Overwrap removed, otherwise until date on container)		
5% Dextrose Injection, 50 & 100mL MINI-BAG Plus Container Single Pack	No	Use Immediately (Up to 24hrs)-if prepared in pharmacy date & initials required on label
0.9% Sodium Chloride, 50 & 100mL MINI-BAG Plus Container Single Pack	No	Use Immediately (Up to 24hrs)- if prepared in pharmacy date & initials required on label
Irrigation solutions		
Pour bottles once opened.	Yes	Discard according to package insert, otherwise discard any unused portion that was not used during irrigation.
Otic, ophthalmic, and nasal medications	Yes	Discard according to package insert, otherwise 1 year after opening or manufacturer's expiration date-whichever comes first. Medication is patient specific and is to be discarded upon patient discharge if opened.
Oral Medications		
Liquids - elixirs, solutions, suspensions, syrups	Yes	Discard according to package insert, otherwise 1 year after opening or manufacturer's expiration date-whichever comes first.
Solids- capsules, tablets		Discard according to package insert, otherwise 1 year after opening or manufacturer's expiration date-whichever comes first
Nitroglycerin tablets	Yes	Discard according to package insert, otherwise 6 months after opening or manufacturer's expiration date-whichever comes first.

Topicals		
Solutions, ointments, creams, etc.	Yes	Discard according to package insert, otherwise 1 year after opening or manufacturer's expiration date-whichever comes first. Medication is patient specific and is to be discarded upon patient discharge if opened.
Antiseptics – Alcohol, Betadine, Hibiclens, Phisohex	Yes	Discard 1 year after opening or manufacturer's expiration date- whichever comes first

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- "Revised USP Standards for Product Dating, Packaging, and Temperature Monitoring," Am J Health-System Pharmacy Volume 57, Aug 1, 2000: 1441-1445.
- USP <7> Labeling. Retrieved May 20,2024 from https://doi.org/10.31003/USPNF_M4908_11_01.
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- Medical Information Letter from Baxter Healthcare Corporation. Retrieved May 30, 2024.

SUBJECT: **INTRAVENOUS THERAPY: POTASSIUM SALTS**	SECTION: **Page 1 of 2**

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

PURPOSE:

To provide safe and consistent therapy utilizing potassium agents.

POLICY:

It is the policy of Sierra View Medical Center to provide intravenous potassium replacement therapy utilizing safe and effective methods to ensure patient safety and comfort and reduce the risk of serious adverse events. This policy applies to all injectable salt forms of potassium including chloride, phosphate and acetate.

AFFECTED AREAS/PERSONNEL: *NURSING, PHARMACY*

PROCEDURE:

1. Intravenous potassium must always be diluted in IV solutions and is NEVER administered by IV push, IM, or Subcutaneously.

2. Electronic infusion devices (smart pumps) must be used for all potassium infusions.

3. Orders that contain "IV push" or "bolus" will not be carried out and these orders will be clarified immediately by the nurse or the pharmacist.

4. Orders must contain the following:

   a. Salt form (e.g. chloride, acetate, phosphate, etc.)
   b. The rate of the infusion must be clearly present before the solution is administered.

5. All potassium infusions for **adults greater than age 17**, must be administered according to the following parameters:

Maximum Concentration	**CENTRAL LINE**	**PERIPHERAL LINE**
Large volumes (e.g.maint. IV)	80 mEq/liter (8 mEq/100ml)	40 mEq/liter (4 mEq/100ml)
Small volumes (e.g. buretrols or volumes less than or equal to 100 ml)	20Eq/100ml minibag	10 mEq/100 ml minibag
Maximum Rate	**CENTRAL LINE**	**PERIPHERAL LINE**
Without EKG monitor	0.5 mEq/kg/hour (maximum. 10 mEq/hour)	0.5 mEq/kg/hour (maximum. 10 mEq/hour)
With EKG monitor	1 mEq/kg/hour (Maximum 20 mEq/hour)	1 mEq/kg/hour (Maximum 20 mEq/hour)

6. All potassium infusions for **pediatric patients** must be administered according to the following parameters:

Maximum concentration	**CENTRAL LINE**	**PERIPHERAL LINE**
Large volumes (e.g.maint. IV)	80 mEq/liter (8 mEq/100ml)	40mEq/liter (4 mEq/100ml)
Small volumes (e.g.buretrols or volumes less than or equal to 100 ml)	20 mEq/100ml	10 mEq/100 ml minibag
Maximum Rate/Dose	**CENTRAL LINE**	**PERIPHERAL LINE**
Without EKG monitor	0.5 mEq/kg/hour (maximum. 10 mEq/hour)	0.5mEq/kg/hour (maximum. 10 mEq/hour)
With EKG monitor	1 mEq/kg/hour (Maximum 20 mEq/hour or 40 mEq/m2/day)	1 mEq/kg/hour (Maximum 20 mEq/hour)

7. Stocking

   a. Concentrated potassium will not be stocked anywhere in the hospital except in the inpatient pharmacy.
   b. Pharmacy will not dispense concentrated potassium.

8. Potassium is a HIGH ALERT medication and safety measures outlined in HIGH-ALERT MEDICATIONS AND LOOK ALIKE SOUND ALIKE MEDICATIONS will be followed.

REFERENCES

- B. Kruse, J,A. Carlson, RW,(1990) "Rapid Correction of Hypokalemia Using Concentrated Intravenous Potassium Chloride Infusion", *Arch Intern Med*,1990, 150: 613-17.
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SUBJECT: **LARYNGOSCOPE BLADES PROCESSING & STORAGE**	SECTION: **Page 1 of 2**

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

PURPOSE:

To standardize the use and processing of non-disposable laryngoscope equipment.

POLICY:

Laryngoscope blades, which are 'semi-critical" items, are considered contaminated after use and must be steam sterilized or high-level disinfected before use on the next patient.

The Central Processing Department (CPD) will be responsible for cleaning, packaging and sterilizing all used laryngoscope blades

AFFECTED AREAS/ PERSONNEL:

SURGICAL SERVICES / MATERNAL CHILD HEALTH / RESPIRATORY THERAPY / EMERGENCY DEPARTMENT/ ANESTHESIA SERVICES / CENTRAL PROCESSING DEPT

PROCEDURE:

MAIN OR and ASD:

1. Used laryngoscope blades are placed in a container on the anesthesia carts to be taken to the "soiled utility room" by the surgical orderlies.

2.

3. The blades are steam sterilized according to IFU.

4. After cooling and drying, the sterilized blades are placed into peel packs which are sealed. (Note: The decontaminated blades may be placed into the peel-packs post-sterilization to prevent contamination during storage.)

5. The packaged blades are then returned to the anesthesia carts.

6. The handles of the laryngoscopes are wiped with disinfectant wipes by the orderlies when cleaning the rooms.

CENTRAL PROCESSING:

1. Used laryngoscope blades from the adult and neonatal crash carts, adult, pediatric and neonatal intubation trays are sent to the Central Processing Department for processing.

2. The blades are washed with medical enzymatic detergent and water, rinsed and dried. The handles are wiped off with disinfectant.

3. Before being placed into the peel packs, the blades are attached to the handles and checked to ensure working order.

4. The blades are then placed into peel packs and steam sterilized according to manufacturers' recommendations, then returned to the crash carts or intubation trays along with the handles.

5. The peel-packed blades and handles are returned to the OB-OR with the C-Section supplies.

REFERENCE:

- Onesource. RLDatix. Special Instruments and Equipment. Laryngoscopes. 2018. Retrieved from https://search.onesourcedocs.com/document/view/revision/2139536/model/94238?source=search

SUBJECT:	SECTION:
MANAGEMENT OF RADIOGRAPHIC CONTRAST MEDIA	***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 address the safe use of radiographic contrast media throughout Sierra View Medical Center (SVMC).

POLICY:

A. Selection of Contrast Media

Pharmacy & the Pharmacy and Therapeutics Committee must approve contrast media selected for use in the organization. Such media will be made part of the medication formulary (inventory).

B. Procurement of Contrast Media

Contrast media will be procured by Pharmacy, or by a department of the organization utilizing procurement procedures that have been approved by Pharmacy.

C. Delivery of Contrast Media

Contrast media is first delivered to the pharmacy and then it may be delivered directly to the utilizing department so long as the media is delivered to a secure area and to an individual(s) authorized by scope of practice and organization policy to access medication.

D. Storage of Contrast Media

Contrast media will be stored in accordance with manufacturer specifications for light, temperature, and shelf life. Pharmacy must approve all storage areas outside of the main pharmacy. Pharmacy will assure that storage areas are inspected at least monthly.

E. Ordering of Contrast Media

Contrast media may be ordered only by those individuals authorized by license, scope of practice, and organization policy to order medications. Individuals ordering contrast media must be knowledgeable in the recognition and treatment of adverse events involving contrast media.

- For the Radiology Department Only

Prior review of non-emergent intravenous contrast media orders by a pharmacist is not required if the patient is under direct supervision of the physician & the physician controls the ordering, preparation, and administration of the medication or when a delay would harm the patient in an urgent situation. For the purposes of this policy, direct attendance by the physician means that a physician is immediately available to respond to an adverse event involving the use of contrast media.

New orders for oral and rectal contrast media do not require prior review by Pharmacy provided the following conditions are met:

- The oral media is ordered only by those individuals authorized by license, scope of practice, and organization policy to order medications, or in accordance with protocols approved by Pharmacy.
- The oral media is administered only by those individuals authorized by license, scope of practice, and organization policy to do so.
- The oral media is administered in accordance with manufacturer instructions and/or in accordance with protocol(s) approved by Pharmacy.
- Pharmacy conducts a periodic random sampling (quarterly) retrospective audit of oral media use to assure that such use is safe and appropriate

F. Administration of Contrast Media

Contrast media will be administered only by those individuals authorized by license, scope of practice, and organization policy to do so. The media will be administered in accordance with manufacturer instructions and/or in accordance with protocol(s) approved by Pharmacy. Individuals administering contrast media must be aware of the signs and symptoms of adverse effects involving contrast media.

Before administering a radioactive pharmaceutical for diagnostic purposes, staff verify that the dose to be administered is within 20% of the prescribed dose, or, if the dose is prescribed as a range, staff verify that the dose to be administered is within the prescribed range.

G. Monitoring of Patients Receiving Contrast Media

Patients will be monitored while receiving contrast media by staff sufficiently trained to recognize and respond to a significant reaction or adverse event. The nature and degree of monitoring is not prescribed, but rather is based on the individual clinical needs of each patient, the type of contrast media being used, and the procedure being performed.

H. Reporting of Errors and/or Adverse Reactions

Contrast media is considered a medication. As such, any incidence of an error or adverse reaction will be reported through the Event Reporting software located on the Intranet.

AFFECTED PERSONNEL/AREAS: *PHARMACY DEPARTMENT & RADIOLOGY DEPARTMENT*

REFERENCES:

- The Joint Commission (2024). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
  - MM.06.01.01 EP13
- ACR Manual on Contrast Media (2023). Retrieved on 7-17-23 from https://www.acr.org/-/media/acr/files/clinical-resources/contrast_media.pdf

SUBJECT: **MEDICAL SCRIBE POLICY**	SECTION: ***Record of Care, Treatment and Services*** **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 ensure proper documentation of clinical services when the billing provider has elected to utilize the services of a medical scribe. For the purpose of this policy, a scribe is defined as an individual who is present during the provider's performance of a clinical service and documents (on behalf of the provider) everything said during the course of the service. Any individual serving as a scribe must not be attending to the patient in any clinical capacity and must not interject their own observations or impressions.

DEFINITION:

A scribe is an unlicensed person hired to enter information into the electronic medical record (EMR) or chart at the direction of a physician or practitioner (Licensed Independent Practitioner, Advanced Practice Registered Nurse or Physician Assistant).

POLICY:

Individuals serving as scribes must sign a scribe agreement prior to scribing. Scribed documentation must clearly support the name of the scribe, the role of the individual documenting the service (i.e., scribe), and the provider of the service. The provider is ultimately responsible for all documentation and must verify that the scribe's note accurately reflects the service provided.

Authorized area for medical scribes:

- Emergency Department
- Urology clinic
- Cancer Treatment Center

AFFECTED PERSONNEL/AREAS: *HEALTH INFORMATION MANAGEMENT, EMERGENCY DEPARTMENT, MEDICAL STAFF*

PROCEDURE:

Scribes assists the provider with chart documentation by entering data into the bedside computer information system that is collected during the history & physical examination.

1. Scribes can document, at the direction of the provider, any dictations of medical decision making, treatment plan and/or activities (i.e. family meetings, patient counseling, re-evaluations, etc.)
2. Notifies physician or provider of completed lab, x-ray, EKG results and nursing orders.
3. Print out discharge orders as directed by the physician or provider but do not write prescriptions.
4. Scribes performs no clinical duties and do not provide direct patient care.

5. Scribes may assist the provider as he or she rounds on their patients and may update patients and family members of the status of their test results at the direction of the provider.

6. Scribes do not transcribe or enter orders.

7. Verbal orders can never be given nor entered by scribes.

8. The ED physician or provider is responsible for the accuracy of the documentation by the Scribe performing this job duty in the ED.

9. Any individual that desires to serve as a scribe must review the policy on the use of scribes and sign a policy agreement.

10. A scribed note must accurately reflect the service provided on a specific date of service.

11. A scribe's entry can be hand-written, dictated, or created/typed in an electronic health record (EHR). Documentation of a scribed service must include the following elements:

    - The name of the scribe and a legible signature
    - The name of the provider rendering the service
    - The date and time the service was provided
    - The name of the patient for whom the service was provided

12. The provider is ultimately responsible for the contents of the documentation.

    - A signature stamp is not permitted for use and the provider must sign or authenticate through the clinical information system.
    - The authentication must take place before the provider leaves the patient care area since other providers may be using the documentation to inform their decisions regarding care, treatment and services.
    - Authentication cannot be delegated to another provider.
    - The provider note should indicate:
        - Affirmation that the provider was present during the time the encounter was recorded
        - Verification that the information was reviewed
        - Verification of the accuracy of the information
        - Any additional information needed
        - Authentication including date and time

5. Individuals can only create a scribe note in an EHR if they have their own password/access to the EHR for the scribe role. Documents scribed in the EHR must clearly identify the scribe's identity and authorship of the document in both the document and the audit trail.

6. Scribes are required to notify the provider of any alerts. Alerts must be addressed by the provider.

7. Providers and scribes are required to document in compliance with all federal, state, and local laws, as well as with internal policy.

8. Failure to comply with this policy may result in corrective and/or disciplinary action.

REFERENCES:

- American College of Clinical Information Managers. "CIMCAT." ACCIM website: May 2012. http://www.theaccim.org/the-clinical-information-manager-certification-and-aptitude-test-the-cimcat-purchase-page.

- The Joint Commission. "Standards FAQs." May 2011. http://www.jointcommission.org/mobile/standards_information/jcfaqdetails.aspx?StandardsFAQId=345&StandardsFAQChapterId=66.

- Karen Zupko and Associates, Inc. "EMR Scribes: Real-Time Tech Support Boosts Physician Productivity & Reduces 'Paper Care' Hassles." February 2011. http://www.physiciansangels.com/download.aspx.

- Nunn, Sandra. "Managing Audit Trails." *Journal of AHIMA* 80, no. 9 (September 2009): 44-45.

SUBJECT: **PATIENT ADMISSION PROCESS**	SECTION: **Page 1 of 4**

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

PURPOSE:

To define the process by which patients are admitted to the facility.

POLICY:

Patients shall be admitted to Sierra View Medical Center (SVMC) upon the order of a member of the medical staff.

Those patients that will not be accepted for admission and/or treatment are:

- Cases of contagious nature in which isolation cannot be maintained or adequate care given.
- Patients requiring acute psychiatric treatment (psychiatric patients may be admitted only for treatment of a medical diagnosis).

EXCEPTION: *Patients with expressed or reliably reported suicidal ideation or behavior can be admitted to the Medical Unit based on their medical needs. (See: "Suicidal Patient Assessment & Management" policy.) Suicide screening tool must be complete.*

AFFECTED AREAS/PERSONNEL: *CLINICAL NURSING UNITS, ADMITTING, HOUSE SUPERVISOR, UTILIZATION REVIEW/ CASE MANAGEMENT*

PROCEDURE:

1. All patient admissions will be upon the order of a member of the medical staff.

2. During the hours 0700- 1930 direct admissions from the physician's office are to be called to the the transfer nurse

3. After hours, and when no transfer nurse is available all admits are called to the house supervisor.

4. The admitting physician or designee is to:

    - Designate the service to which the patient is to be assigned.
    - Give appropriate information (e.g. name, age, sex, diagnosis, payer source) regarding the patient.

5. Transfer Nurse/house supervisor receiving the referral from the physician will:

    - Complete the Direct Admit Worksheet
    - Fax to the appropriate registration department

TYPES OF ADMISSIONS:

1. PRE-SCHEDULED ADMISSIONS FOR THE SAME DAY

   A. Registration personnel will obtain the following patient information and insurance benefits prior to admission.

   - Patient's legal name
   - Date of birth
   - Diagnosis
   - Physician request/order
   - Admitting physician
   - Type of admission (inpatient or outpatient/observation)
   - Insurance

2. PRE-SCHEDULED ADMISSIONS FOR A FUTURE DATE

   A. Registration personnel will begin the pre-registration and pre-authorization process by:

   - Verifying insurance benefits
   - Calculating co-payments and necessary deposits
   - Referring collection of co-payments and deposits to Financial Counselors

   B. Registration personnel will complete a face sheet for each patient. These are filed until the patient comes in.

   C. Registration personnel will enter the following patient's information into the Health Information System:

   - Patient's legal name
   - Date of birth
   - Diagnosis
   - Date of procedure/surgery
   - CPT code
   - Diagnosis Code
   - Physician/surgeon's name
   - Date of planned procedure/surgery
   - Type of admission (inpatient or outpatient)
   - Insurance
   - Scan all necessary documents into patient's records

3. DIRECT ADMISSION

A. When the transfer nurse/house supervisor receives the physician request for the direct admit and pertinent patient information, they will notify:

- The bed coordinator and clinical charge nurse of the requested nursing unit and obtain room assignment.
- The Registration Department by calling them and alerting them of the incoming fax (direct admit worksheet).
- The admitting physician's office to give them the room number.
- The Emergency Department if the patient will be arriving by ambulance.

B. In the event that a patient's condition changes/worsens and the attending physician is not present, licensed staff members directly attending to the patient should have the authority to determine if the patient should be seen in the Emergency Department (ED) before going to his/her room.

C. Depending on the determination from the physician, the patient will either be registered in Registration or at the bedside. If bedside registration has been determined, the patient will be placed in a wheelchair and taken directly to their assigned room.

D. The Registration personnel will complete all necessary paperwork once the patient is in their room.

4. EMERGENCY DEPARTMENT ADMISSIONS

- The ED physician will declare acceptance of the patient by the appropriate admitting physician and clarify the patient's status e.g. In-patient or Outpatient/Observation.
- The Bed Coordinator or House Supervisor will contact the Charge Nurse of the requested Nursing Unit and obtain room assignments.
- All admitting paperwork is to be completed by the Registration personnel at the patient's bedside in the Emergency Room and signatures obtained if condition warrants.

EXCEPTION: In a defined emergency, when the House Supervisor is unable to facilitate the process, the Emergency Department may call the receiving unit directly.

5. UNSCHEDULED ADMISSIONS

- These admissions are those patients already in the hospital and whose condition changes enough to require a higher level of care.
- Once it is determined that the patient needs to be admitted, the department (i.e.; PACU) will notify the Bed Coordinator/ House Supervisor and obtain the bed assignment.

- Registration personnel will be notified of the admission and room number.

REFERENCE:

- California Code of Regulations (2021). Title 22. §70053.2. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

CROSS REFERENCE:

- *Suicidal Patient Assessment & Management* – SVMC Policies and Procedures

SUBJECT: **PHARMACY FLOOR CHECKS**	SECTION: **Page 1 of 2**

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

PURPOSE:

Nursing area floor inspections will be conducted by Pharmacy to ensure that all pharmaceuticals used at Sierra View Medical Center (SVMC) have guaranteed stability and are readily available for use for our patients.

POLICY STATEMENT:
A pharmacist or technician will inspect the floor stock by checking automated dispensing devices and emergency drug supply of each nursing, or other user areas where drugs are stored, dispensed or administered.

PROCEDURE:

A. Inspections of all medications (controlled and non-controlled) will be conducted at least once each month by a pharmacist or a technician.

B. A record will be kept of such inspections that will verify that:

1. The area is clean, neat, well-organized, and sufficiently illuminated.
2. The medication crash cart is locked or kept in a secure place.
3. Only authorized drugs and supplies are present, and are locked or kept in a secured place.
4. Drugs brought into the hospital by patients are sent home, or stored according to PATIENT'S OWN MEDICATIONS policy.
5. Reconstituted drugs are appropriately labeled with the concentration.
6. Opened multiple-dose vials are free of particulate and are normal in appearance and color.
7. Drugs requiring special storage conditions are properly stored (e.g. protected from light or refrigerated).
8. There are no expired, recalled, deteriorated, broken, or contaminated drugs.
9. Test agents, germicides, disinfectants and cleaning agents are stored separately from drugs.
10. External use drugs in liquid, tablets, capsule, or powder form are segregated from internals.
11. Controlled substances are securely stored.

12. Emergency drug supplies (crash carts and kits) are readily available, as appropriate for the area, sealed, and in date.

13. The refrigerator is clean, free from excessive frost, and has maintained a temperature between 36 and 46 degrees Fahrenheit (2-8 degrees Celsius) for the last month. Temperature record (if applicable) is up to date.

14. Sample drugs are not maintained. (If found, return to the pharmacy for disposal).

15. All drugs and chemicals are labelled according to statutory requirements.

16. Poison hotline telephone number is displayed.

C. Completed floor inspection form will be signed and dated by the pharmacist/technician conducting the floor check.

D. Any irregularities or deficiencies in the floor stock or the emergency supplies must be reported to the Director of Pharmacy and to the Chief Nursing Officer within 24 hours.

E. A record of such inspections will be maintained by the Pharmacy Service for a period of 3 years.

DOCUMENTATION: Pharmacy Floor Inspection Form

EDUCATION:

- Patient, Family, Significant Other: N/A
- SVMC Staff: All staff will receive education regarding how monthly nursing floor inspections by pharmacy will be conducted.

REFERENCES:

- California Code of Regulations Title 22; Division 5. Chapter 1. Article 3. 70263(f)(3),(q) (10). (June 10th, 2024) Retrieved from https://govt.westlaw.com/calregs/Document/IB0E3FEDC5B6111EC9451000D3A7C4BC3?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)
- Business and Professions Code 4115(i)(3). (June 2024) Retrieved from https://codes.findlaw.com/ca/business-and-professions-code/bpc-sect-4115/
- The Joint Commission (2024). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

KEY WORDS: floor inspections, outdated, medications

SUBJECT: **POST OPERATIVE CARE FOR SURGICAL/INVASIVE PROCEDURE PATIENTS**	SECTION: **Page 1 of 5**

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

PURPOSE:

- To provide guidelines for the post-procedure assessment, nursing management and monitoring of the patient who has had general, regional, monitored anesthesia care or local anesthesia with or without sedation.

POLICY:

1. All post-procedure patients receiving inhalation, intravenous, spinal, epidural or local anesthesia will be transferred to the Post Anesthesia Care Unit (PACU) or Intensive Care Unit (ICU) until they have become recovered from the anesthesia and have been stabilized.

2. Patients recovering from local anesthesia with sedation will fall under the protocol in this policy. Patients receiving straight LOCAL anesthesia may be discharged directly back to the nursing unit per the discretion of the anesthesia provider.

AFFECTED AREAS/ PERSONNEL: *PACU-FLEXCARE-ICU-MATERNAL CHILD HEALTH (MCH)/REGISTERED NURSES (RN)*

PROCEDURE:

GENERAL INFORMATION

1. Equipment to have available for each Phase I patient includes:

   a. Cardiac monitor with printout

   b. Stethoscope

   c. Blood pressure apparatus

   d. O_2 and administration equipment - nasal cannula, aerosol mask, non-rebreather mask, T-piece for connection to endotracheal tube

   e. Pulse oximetry

   f. Suction equipment

   g. Thermometer

2. Nurses in the PACU/ICU will take respiratory rate, temperature, pulse, blood pressure and SpO_2 readings **immediately** on arrival to the PACU/ICU and report findings to the anesthesia provider.

Report from the anesthesia provider and circulating nurse will include but not be limited to the following:

a. Identity of the patient; allergies

b. The surgical procedure performed

c. Review of the general health and any problems such as chronic disease or addiction

d. Anesthetic agents used/medications given intra-operatively and the patient's tolerance

e. Surgical or anesthetic complications

f. Presence of drains/dressings

g. Estimated fluid/blood loss

h. Replacement of fluids (type and amount) and urine output

i. Emotional status on arrival to the operating or procedure room.

3. Vital signs will be monitored every 5 minutes for the first 15 minutes in PACU and then every 15 minutes until time of discharge from PACU.

4. For patients needing extended recovery, or patients waiting for a bed assignment, vital signs will be monitored every 30 minutes for the first 2 hours, and then every 4 hours unless otherwise directed by physician.

ASSESSMENT & INTERVENTION

Respiratory System:

1. Assessment of airway patency, respiratory rate, breath sounds, and SpO_2 will be done upon admission to PACU. Continuous airway assessment will take place during PACU care. Respiratory rate and SpO2 will be documented every 5 minutes for 15 minutes, then every 15 minutes if patient stable. If upper airway obstruction is present:

a. Reposition the head and apply jaw thrust and/or chin lift prn

b. Insert oral or nasal airway prn

c. Suction oral nasal or endotracheal tube

~~2.~~ Position patient on side if airway is obstructed. Elevate head of bed 30 degrees for general anesthesia patients if not contraindicated.

3. Have patient cough and deep breathe every 15 minutes. Auscultate bilateral breath sounds, and note depth and respirations, color of mucous membranes and skin. Report to anesthesia provider respiratory rate below 10/min and/orSpO_2 below 92%, or any other complications.

4. Apply, monitor, and titrate delivery of supplemental oxygen as requested by the anesthesia provider to maintain SpO_2 above 92% or patient "baseline"

5. Documentation of airway interventions will be placed in electronic medical record.

Cardiovascular System:

1. All patients will be placed on the cardiac monitor and monitored in Lead II unless otherwise requested by the anesthesia provider. Documentation of the rhythm will be done on admission to PACU/ICU and if any changes occur during the post-operative phase. Strips of the initial rhythm and any changes will be placed into the patient record. Cardiac rhythm, pulse, and blood pressure will be monitored every 5 minutes X 3, then every 15 minutes if stable.

2. If central venous pressure (CVP) or pulmonary artery pressure (PA) are being monitored, document reading every 15 minutes. Arterial line readings are documented at B/P intervals.

3. Note patency of the IV on admission to the PACU/ICU and observe every 15 minutes. Document solution and additives of the parenteral infusions on arrival. Maintain IV fluids at rate ordered by the anesthesiologist. If not specified, maintain at the rate ordered by the surgeon in the post-operative orders. Use a pump or controller if indicated by prescribed rate or by drug being administered.

4. The IV solution from surgery will be followed with the IV solution specified in the postoperative order. If there are no postoperative orders for IV fluids, the present IV fluids may be discontinued prior to transfer unless contraindicated by the patient's condition. If this situation occurs, the surgeon or anesthesia provider must be contacted for orders.

5. Check peripheral pulses when indicated (e.g. extremity surgery, vascular surgery) and document on arrival to PACU/ICU, every 30 minutes, if any change occurs, and on discharge.

6. Report to anesthesia provider adverse findings such as cyanosis, excessive perspiration, hemorrhage, or decreased urine output (less than 30 cc/hr.). If patient is hypotensive and symptomatic, position patient flat, infuse isotonic IV fluids rapidly (unless contraindicated), administer oxygen, monitor vital signs every 5 minutes, and have emergency drugs available.

7. If patient becomes bradycardic (heart rate ↓ 50) and is symptomatic, notify the anesthesia provider, administer O2, have Atropine available, and continue to monitor vital signs every 5 minutes.

8. If Foley catheter is in place, document color of urine on admission to PACU/ICU. Urine output will be measured on arrival to PACU, at discharge, and PRN. If Foley is not present, observe for bladder distention and discomfort.

9. Make sure all drains and tubes are patent. Document amount and characteristics of drainage on admission to and discharge from the PACU/ICU.

10. Document amount and character of any emesis. Notify the anesthesia provider of excessive nausea or emesis, medicate as directed, and document medication administration in the EMR. Document patient response to medication administered.

11. Assess temperature on admission to PACU/ICU. Repeat in 15 minutes if temperature is less than 96.8 degrees or more than 100 degrees. Temperatures will be taken with the temporal thermometer unless otherwise specified. Provide warming assistance as needed; i.e., warmed blanket, warm fluids, warming device.

Neurological System:

1. Assess patient response to stimulus and orientation to person, time and place.

2. Report to anesthesia provider if patient experiences convulsions or hyperpyrexia.

Motor Activity:

1. Assess mobility on admission to PACU/ICU and every 30 minutes thereafter, position body in alignment and for safety. For regional anesthesia, assess and document descending level of anesthesia every 15 minutes until full recovery is achieved. Patient may be transferred to inpatient area prior to total resumption of sensation and movement in lower extremities, but will continue to be monitored. Lower extremity activity and strength will be documented.

2. Have side rails up at all times. Use bumper pads for protection of patients who are pediatrics, restless or under seizure precautions. Notify physician if restraints are necessary.

3. Lock all four wheel brakes on the stretcher before helping the patient to get up. Allow the patient to sit on the side of the gurney prior to getting up. Have a step stool available for the patient to use if needed.

Comfort Management/Pain Control:

1. Reduce anxiety by giving emotional support with positive verbal and non-verbal communication. Explain all procedures to the patient before performing them using a calm, confident manner. Provide for the patient's right to privacy, including the use of curtains.

2. Turn and re-position the patient as indicated, and provide hygiene as needed.

3. Assess the patient's level of pain, using a 0-10 scale or a pain assessment scale. Administer analgesics as ordered by the anesthesia provider and/or physician. Administration of the analgesia will be documented in the EMR including reason for administration and effect of the medication.

4. Observe suture line if dressings are absent. Observe dressings for amount of bleeding or drainage every 30 minutes if dry, or every 15 minutes if drainage is present. Mark boundaries of drainage for reference. Reinforce dressing or change as needed per physician preference. Carefully estimate and document amount of bleeding. Ensure dressings are not restrictive.

DISCHARGE: (See Discharge from PACU policy.)

DOCUMENTATION: *(See Documentation in the PACU policy)*

REFERENCES:

- American Society of Perianesthesia Nurses. *Perianesthesia Nursing Standards Practice Recommendations and Interpretive Statements* (2023/2024).

CROSS REFERENCES:

- Discharge From PACU – SVMC Policy
- Documentation in the PACU – SVMC Policy
- Restraint use-Medical/Surgical and behavioral restraint- SVMC Policy

SUBJECT:	SECTION:
QUALIFIED PERSONNEL: ARTERIAL PUNCTURE	**Page 1 of 1**

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

PURPOSE:

To define the personnel qualified to collect arterial blood samples.

POLICY:

The Respiratory Care Department at Sierra View Medical Center (SVMC) is available to collect arterial blood samples 24 hours per day, 7 days per week. Outpatients at the Medical Office Building (MOB) will be directed to the main hospital for procedure.

AFFECTED AREAS/PERSONNEL:

RESPIRATORY CARE PRACTITIONER (RCP), REGISTERED NURSE (RN).

PERSONNEL QUALIFICATIONS:

1. To perform an arterial puncture, the individual must have competency assessed by the Respiratory Care Services Medical Director or Department Leader. This competency will be reviewed on an annual basis.

2. To analyze a blood sample through the blood gas analyzers and/or co-oximeter, all personnel must be at least one of the following:

    a. A Respiratory Care Practitioner

    b. Registered Nurse in the Critical Care (ICU and ED) Department or in the Cardiac Cath Lab

    c. Clinical Lab Scientist

    d. Phlebotomist/Lab Aide

CERTIFICATION:

Persons authorized to perform arterial punctures will have one of the following: Respiratory Care Practitioner license (CRT or RRT) or Registered Nurse license (RN).

REFERENCES:

- Respiratory Care Board of California, Scope of Practice, https://www.rcb.ca.gov/licensees/forms/scope_of_practice.pdf, 2020.

SUBJECT: **R.I.S.E. (RESPONSE IN A STRESSFUL ENIVIRONMENT)**	SECTION: **Page 1 of 4**

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

PURPOSE:

R.I.S.E. (Response in a Stressful Environment) is a care for the caregiver program to support employees affected by emotional trauma and aid in the prevention of adverse events related to second victim phenomenon. R.I.S.E. provides guidelines and structure for offering emotional first aid and support of staff and physicians after a harm, adverse event, traumatic event, or exposure to emotionally charged situation in which one is having difficulty coping.

DEFINITIONS:

Adverse/Harm Event: An unanticipated event that may have or did result in harm.

Care for Caregiver: Emotional first aid provided to a person who is involved in an unexpected healthcare or other emotionally traumatic event.

Peer Supporter: A trained member of the R.I.S.E. Peer Support Team who is available to respond to physicians or staff to offer and provide emotional first aid following harm, adverse or emotionally traumatic event.

Intake Coordinator: The program's lead or appointed staff that is responsible to triage the peer support needs of the event. The house supervisor will have an on call schedule of program lead and/or appointed staff.

Debriefing: Process of holding a post-event discussion about what happened during the event. The discussion may include input from participants regarding what occurred, what worked well, what could be improved upon, or personal feelings associated with the event. The scope and purpose of the debriefing should be established in the opening comments. A debriefing is not an investigation and is separate and apart from a peer support interaction.

Harm: Any amount of physical, psychological, or financial injury.

Traumatic event: An experience in the workplace that causes emotional upheaval, or has the potential to impact the well-being of staff/employee(s) in the work environment. Examples of a traumatic event include, but are not limited to, the following:

- Workplace violence event
- Severe injury or death to a patient, employee, or visitor
- Medical error
- Unanticipated patient harm or death (especially when the age or other characteristics remind the individual of a family member or loved one)
- Sudden loss of a co-worker
- Collective, significant personal loss
- Multiple deaths in a clinical area
- Seriously troubled employee creating havoc with multiple staff members
- Actual suicidal or homicidal attempts by a patient, employee, or visitor

Triggering event: *An adverse, unanticipated, traumatic event, or emotionally charged event.*

POLICY:

Sierra View Medical Center (SVMC) recognizes the potential emotional and psychological impact adverse, harm and emotionally traumatic events can have on employees and physicians. To that end, this organization is committed to providing support and care for our caregivers, staff, and physicians impacted by emotionally traumatic events.

The Care for the Caregiver process is part of the Patient Safety and Risk Management Program. As such, all program-related referrals and encounters are maintained in a confidential manner. The effectiveness and evaluation of the R.I.S.E. program is reported up through Performance Improvement and Patient Safety (PIPS) Committee.

AFFECTED PERSONNEL/AREAS: *ALL SVMC STAFF AND PROVIDERS*

PROCEDURE:

1. R.I.S.E. program can be activated by anyone in response to a harm or emotionally traumatic event that triggers the need for emotional support of employees and/or physicians.

2. Activation of the program will be accomplished through communication to the house supervisor or online referral.

    a. The R.I.S.E. program Intake Coordinator will be reached via telephone for stat intervention; otherwise an internet referral will prompt an email and will be handled the next business day.

    b. Upon activation, R.I.S.E. program Intake Coordinator may need to contact the involved individual or their supervisor/manager to determine the level of post event support and resources needed. Resources and referrals may include, but are not limited to R.I.S.E. Support Team member, Chaplain/Pastoral Services, or the Employee Assistance Program.

3. Tier One Activation: Department /Unit level support will be provided by unit manager, fellow team member/colleague, supervisor, or department chair. Support includes:

    a. Connect with affected individual(s).

    b. Provide one-on-one reassurance and/or professional support.

    c. Reaffirm confidence in individual.

    d. Assist with contacting the R.I.S.E. Intake Coordinator, to determine if additional resources are needed.

    e. Assist individual to temporarily leave unit and go to the designated 'Safe Space' to process the event.

f. Consider relieving involved individuals of duties for balance of shift and longer if necessary through collaboration with Human Resources or staffing office, call in flex staff if available, requesting oncoming employees to come in early, etc.).

g. Check in on staff member regularly after initial interaction.

h. Notify individual of next steps, if any.

4. Tier Two Activation: Upon receipt of notification, the Intake Coordinator will gather initial information, triage the call, and provide a handoff report to a trained peer supporter or resource as needed.

a. Intake information includes: Date and time of request, name of involved staff member, unit, type of event, effectiveness of tier one support, any special concerns, etc.

b. Trained peer supporter may receive request for peer support from anyone; however, the peer supporter should notify the intake coordinator if the request is made outside of the formal activation process.

c. The on-call peer supporter will respond by phone or in person if able to provide support to involved employee/physician.

5. Peer supporter will (in addition to support provided in Tier One):

a. Provide one-on-one crisis intervention.

b. Demonstrate active listening techniques.

c. Offer support.

d. Redirect conversation as needed to focus on individual rather than event.

e. "Be there" for the staff member.

f. Evaluate and determine the need for referral to Tier 3 support for additional assistance as needed.

g. Document on the Peer Support Encounter form.

h. Participate in ongoing team meetings and education.

6. Tier Three Support may be triggered by the peer supporter, supervisor, a colleague or the individual when needed. Additional resources include, but are not limited to:

    a. Employee Assistance Program

    b. Social Work

    c. Chaplain

    d. Staff Relations Coordinator

7. Individuals manifesting signs consistent with impairment will be managed according to the organization's process for evaluating potentially impaired physicians/employees. The peer supporter shall notify manager/director when it is believed the individual may be affected to the point of impairment regardless of when the concern presents.

Program Evaluation:

a. Peer supporters will complete a confidential Peer Support Encounter form and submit to the R.I.S.E. Intake Coordinator within 72 hours of interaction.

b. Employees and physicians participating in the R.I.S.E. program interactions will be asked to complete a confidential program evaluation.

c. Evaluation of the R.I.S.E. program will be achieved through volume statistics (number and frequency of encounters) as well as qualitative analysis through post-event surveys.

    i. Program statistics will be reported up through Patient Safety and Performance Improvement Committee.

    ii. Data detailing the effectiveness of the R.I.S.E. program will be shared via a dashboard.

REFERENCES:

- Care for the Caregiver Tools and Resources. (n.d.). Beta Heart. Retrieved from https://www.hqinstitute.org/sites/main/files/file-attachments/care_for_caregiver_beta_heart_tools_and_resources.pdf.

- Communication and Optimal Resolution (CANDOR) Toolkit. Content last reviewed April 2018. Agency for Healthcare Research and Quality, Rockville, MD. Retrieved from https://www.ahrq.gov/patient-safety/capacity/candor/index.html.

SUBJECT: **SCABIES**	SECTION: **Page 1 of 2**

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

PURPOSE:

To determine if an employee has had an exposure to or has become infested with scabies. To provide guidelines for the appropriate treatment for an exposure that results in a confirmed infestation of scabies.

POLICY:

Employees will receive appropriate evaluation and treatment for suspected and/or confirmed scabies infestation.

AFFECTED AREAS/PERSONNEL: *ALL EMPLOYEES*

GENERAL INFORMATION:

Scabies is a disease of the skin caused by the mite *Sarcoptes scabiei var. hominis*. Transmission occurs primarily through prolonged skin-to-skin contact with an infested person. Transmission through casual or brief contact with objects such as bedding or clothing has been reported to be infrequent. However, healthcare workers will require treatment if they have an exposure that is followed by signs of infestation.

The initial lesion is a burrow ½ to 2 cm in length. A burrow is a minute, slightly raised tunnel in the epidermis that may end in a vesicle. Skin lesions often include small papules, pustules and/or excoriation.

The most common symptoms after infestation are intense itching and rash. The itching is often worse at night. Lesions commonly occur on the hands, webs of fingers, wrists, the extensor surfaces of elbows and knees, the outer surfaces of feet, armpits, buttocks and waist.

INCUBATION PERIOD:

Symptoms begin to show about 3-6 weeks after the initial infestation period. If previously infested, symptoms may begin to show up as soon as 1-4 days after re-exposure due to sensitization.

PERIOD OF TRANSMISSIBILITY:

Even without symptoms, scabies is considered to be transmissible until mites and eggs are completely destroyed by treatment. A single treatment is usually effective in eradicating the mite infestation. However, a second treatment one week later may be indicated for some individuals.

PROCEDURE:

1. Infection Prevention should be notified when a patient is diagnosed with scabies either by a physician or by confirmation via a skin scraping. Departments that have had contact with the patient will be notified of the event by Infection Control. The Director (or the Director's designee) will identify individual employees that must be notified of the exposure and give instructions for follow up.

2. Employees who have had prolonged skin-to-skin contact with the patient or who develop symptoms of scabies will report to Employee Health Services (EHS) for assessment and sent for physician evaluation.

3. The EHS Nurse will review and document history and allergies.

4. EHS Nurse will assess skin appearance, location of rash and type of exposure. If an employee develops a rash with a differential diagnosis of scabies, the employee will be sent for physician evaluation and treatment if necessary.

5. Employees with a positive diagnosis of scabies are not to work for a minimum of 24 hours after the completed treatment.

    a. Instructions to the employee should include the following:

        - Wash all clothing, towels, bedding and other linen using the hot cycles of the washer and the dryer. Clean upholstered furniture.
        - All household members and intimate contacts should be treated by their personal physician.
        - Pruritus may persist for as long as 2 weeks after treatment.
        - Notify EHS for continued symptoms.

REFERENCES:

- Centers for Disease Control and Prevention (Feb. 23, 2024). For Everyone: About Scabies. Signs and Symptoms; How it Spreads; Preventing: Treatment. Retrieved July 3, 2024. From: https://www.cdc.gov/scabies/about/index.html
- Centers for Disease Control and Prevention (Dec. 18, 2023). Health Care Providers. Clinical Care of Scabies; Clinical Overview of Crusted Scabies. Retrieved July 3, 2024. From: https://www.cdc.gov/scabies/hcp/clinical-care/index.html
- Centers for Disease Control and Prevention (Dec. 18, 2023). Scabies Outbreaks in Institutional Settings; Public Health Strategies for Crusted Scabies Outbreaks in Institutional Settings. Retrieved July 3, 2024. From: https://www.cdc.gov/scabies/php/public-health-strategy/index.html.

SUBJECT: **SCOPE OF SERVICES FOR THE INTENSIVE CARE UNIT**	SECTION: **Page 1 of 2**

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

POLICY:

The Intensive Care Unit (ICU) is a 10 -bed multi-disciplinary care unit that provides for the care of the critically ill patient.

The Intensive Care Unit (ICU) provides service in a nursing unit in which there are specially trained nursing and supportive personnel and diagnostic, monitoring and therapeutic equipment necessary to provide specialized medical and nursing care to critically ill patients.

PATIENT POPULATION:

The Intensive Care Unit provides care for a population of patients including adolescents, adults and geriatric patients.

COMPLEXITY OF CARE:

Admission to the ICU is based upon the need for intensive services in the presence of real or potential life-threatening healthcare problems and by the requirements for continuous observation and intervention to prevent complications and promote a return to health.

Those intensive needs that require ICU include invasive and noninvasive hemodynamic, cardiac, pulmonary, and neurologic monitoring.

Cardiac invasive procedures do not include angiography/angioplasty.

All patients are evaluated by a physician to determine the type and extent of care to be provided to the patient. In the event that the patient requires care that the ICU is unable to provide, the patient shall be transferred to a facility able to provide the required care. The physician shall make the necessary arrangements for transfer. Transfer to outside facilities is addressed in the "Transfer Policy."

The ICU does not provide for psychiatric care; those patients admitted to the ICU with a medical emergency related to an underlying psychiatric diagnosis shall be treated in the ICU until they are medically stable and evaluated by a psychiatric professional, at which time they may be transferred to a psychiatric facility.

PHYSICIAN RESPONSE

Physicians shall respond by phone within 5 minutes and arrive to the hospital within a timely manner when a patient has been identified by the ER physician to require an intensivist's evaluation. If this time exceeds 2 hours without reasonable grounds, the incident will be reported to the chair of clinical department for further investigations and can be subjected to disciplinary action.

STAFFING:

ICU maintains a fixed amount of RN licensed staff nurses to provide for patient care. The patient-to-nurse ratio shall not exceed 2:1 and in the event that there is a deficiency in the amount of staff required

to care for the patients, all attempts shall be made to replace the deficiency with a qualified staff member. The unit manager maintains ultimate responsibility for providing adequate staffing and shall provide patient care in the event that a qualified nurse is unavailable.

QUALIFICATIONS OF STAFF:

The critical care nurse at Sierra View Medical Center is a professional nurse committed to ensuring that the critically ill patient receives optimal care. He/she maintains a current state license as a Registered Nurse, as well as Advanced Cardiovascular Life Support (ACLS), Basic Life Support (BLS), and NIH Stroke Scale (NIHSS) certification. He/she has successfully completed basic ICU training. He/she participates in ongoing educational activities to allow for the continued delivery of updated care. The plan of care reflects the nurse's recognition of the physical, psychological and social needs as part of the uniqueness and wholeness of every patient.

STANDARDS OF PRACTICE:

The American Association of Critical Care Nurses (AACN) Core Curriculum is used as reference for the development of standards and policies in the ICU, as well as information submitted by the ICU personnel to allow for formulation of policies appropriate to the resources and needs of the facility.

REFERENCES:

- California Code of Regulations (2024). Title 22. §70491. Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1

- Johnson, K. L. (2024). *AACN Procedure Manual for progressive and critical care*. Elsevier.

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

- The Leapfrog Hospital Survey Scoring Algorithms. LeapfrogGroup.org. https://www.leapfroggroup.org/sites/default/files/Files/2024_HospitalSurveyScoringAlgorithm_20240401_v9.1%28version%201%29.pdf. Published July 10, 2024. Accessed July 15, 2024.

CROSS REFERENCE:

- TRANSFER OF PATIENT TO HIGHER LEVEL OF CARE

SUBJECT:	SECTION:
SEEING/HEARING/COMPANION DOG (SERVICE ANIMALS)	***Ethics, Rights & Responsibilities (RI)*** 2 **Page 1 of 5**

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, 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.

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: **STERILE HAZARDOUS DRUG HANDLING**	SECTION: **Page 1 of 20**

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

PURPOSE:

To provide practice and quality standards for handling hazardous drugs (HDs) to promote patient safety, worker safety, and environmental protection. In addition, to provide for the safe receipt, storage, compounding, dispensing, administration, and disposal of sterile hazardous products and preparations at Sierra View Medical Center (SVMC).

DEFINITIONS:

A. Hazardous Drugs- Medications that in small quantities can produce severe adverse physiological effects. This category can be further subdivided into antineoplastic (Group 1), non-antineoplastic (Group 2), reproductive risk only (Group 3).

B. USP 797- Refers to a chapter from the United States Pharmacopeia publication. The USP is a nationally recognized authority that established quality standards for the preparation of sterile intravenous products.

C. USP 800- Refers to a chapter from the United States Pharmacopeia (USP) publication. The USP is a nationally recognized authority that established quality standards for the preparation of sterile hazardous products.

D. Class II Type A2 Biological Safety Cabinet (BSC)- A ventilated cabinet often used for preparation of hazardous drugs. A partial barrier system that rely on the movement of air to provide personnel, environmental, and product protection.

E. ISO Class 5- A reference to a space of air that contains no more than 3,520 particles per cubic that are 0.5 microns or larger.

F. PPE- Personnel Protective Equipment includes chemotherapy rated gloves, gowns, eye, face, head, shoe, sleeve coverings that are intended to prevent exposure to hazardous drugs.

G. Category 1 Compounded Sterile Preparation (CSP)- Category 1 is a risk-based approach defined in USP 797 that establishes a specific BUD for products, personnel qualifications, environmental monitoring. It assigns a BUD of 12 hours at room temperature and 24 hours refrigerated.

H. Category 2 Compounded Sterile Preparation (CSP)- Category 2 is a risk-based approach defined in USP 797 that establishes a typically longer BUD. It assigns a BUD of 4 days at room temperature and 10 days under refrigeration.

I. BUD- Beyond Use Date is either the date or hour after which a CSP must not be used or administration must not begin. The BUD is determined from the date and time that preparation of the CSP is initiated.

J. CSTD- Stands for Closed System Transfer Device "a drug transfer device that mechanically prohibits the transfer of environmental contaminants into the system and the escape of the hazardous drug or vapor concentrations outside the system."

POLICY:

It is the policy of SVMC that all injectable hazardous medications as defined by NIOSH (Group 1, 2 & 3), may be prepared at the Cancer Treatment Center in a negative pressure CACI/BSC by properly trained personnel who will practice safe established preparation techniques and proper handling procedures as outlined in USP 797, USP 800, and California State Board of Pharmacy regulations. No hazardous injectable on NIOSH Group 1, will be compounded at the main pharmacy, however products on Niosh Group 2 & 3 may be compounded at main pharmacy so long as an assessment of risk has been performed and any additional requirements there in are followed during the compounding process.

Medications compounded in the satellite compounding pharmacy shall only be administered to registered patients who are on the premises of the same physical plant as the hospital satellite compounding pharmacy location.

Group's 2 & 3 hazardous drugs compounded at the main pharmacy will follow normal USP 797 procedures and hospital sterile compounding procedures with additional direction on PPE/processes outlined in the Assessments of Risk Dictionary.

The following procedure defines the processes for hazardous compounding at the satellite compounding pharmacy.

AFFECTED PERSONNEL/AREAS: *PHARMACY, CANCER TREATMENT CENTER, NURSING*

A. PERSONNEL PREPARATION:

1. All activities not requiring a sterile environment (e.g., checking labels, doing calculations) should be completed before accessing the CACI/BSC.

2. Hand washing is a critical component to ensuring IV admixtures are aseptically prepared as well as reducing chemotherapy trace contamination of both product and personnel.

   a. Wash hands before and after cleaning hood or preparing chemotherapy products.

   b. Wash hands for 30 seconds using chlorhexidine (digital timer provided). Wash up to elbows when possible.

   c. Utilize bactericidal soap.

   d. Pay particular attention to under fingernails and between fingers. Use nail picks to remove debris from underneath fingernails.

   e. No jewelry (rings, watches, etc.) may be worn during compounding.

   f. No nail polish, artificial nails, or cosmetics may be worn during compounding.

   g. After washing, use a lint-free (non-shedding) cloth or paper towel to dry hands.

   h. Prior to donning first pair of sterile HD-certified gloves, after washing hands as above, apply Sterillium© and allow contact time of at least 3 minutes.

Utilize gowns that are specifically designed for this purpose. This will help protect both you as well as others from trace chemo contamination. Gowning will help protect you from any gross chemotherapy spills that could occur. Wearing protective garments (gown and gloves) is required when preparing, compounding, handling, cleaning, and disposing chemotherapy.

a. After washing hands and applying Sterillium, don first (interior) set of sterile HD gloves.

b. Sanitize outside the gloves with 70% isopropyl alcohol. Allow alcohol to dry.

c. Don protective chemotherapy-approved gown.

d. First set of gloves should be tucked under/inside the cuff of the gown.

e. Don second set of chemotherapy-approved sterile gloves (double gloves are recommended for hazardous drugs as permeability varies with material, thickness, and exposure duration).

f. Extend outer glove over the cuff of gown.

g. Sanitize outer HD glove with 70% isopropyl alcohol, and allow alcohol to dry.

h. Change gloves if they become contaminated, torn, or punctured.

i. Change outer gloves whenever you must exit and re-enter the BSC by opening the face of the BSC for cleaning or decontamination.

j. Gowns are not to be worn outside of the buffer area.

k. TWO sets of booties must be worn while compounding.

B. CHEMOTHERAPY PREPARATION TECHNIQUE:

1. Nothing should interrupt the flow of air between the HEPA filter and the sterile starting components. To maintain sterility, nothing should be placed above the work surface. Starting components should be placed at least six inches from the sides and front edge of the hood without blocking air vents. Hands should also be positioned to assure that airflow in the critical area of the HEPA filter and the sterile starting components is not blocked.

2. BSCs must run continuously 24 hours a day and must be inspected and certified by qualified personnel every six months.

3. Nothing should be stored on top of the BSC.

4. Clean the drug preparation area, left to right and top to bottom, with an approved sterile water, 70% isopropyl alcohol, and sporicidal agent approved by designated person (with a dwell time of at least 3 minutes). This will be done at the beginning and the end of the shift, when there is a spill or as needed.

5. Keep the area free of solutions, additives, and equipment that are not required to prepare the product.

6. All products necessary for preparing the admixture or batch should be gathered and sanitized with sterile 70% alcohol and readied for placement in the CACI or BSC. Obtain the basic parenteral solutions, additive drugs, syringes, needles, swabs, labels, Chemo-transport bag, etc.

7. When using a BSC, place the medication label nearby for reference. You may also affix the label onto the final container to prevent errors. Then, place the sanitized starting components and supplies on top of the clean disposable mat inside the PEC.

8. If an infusion container (IV bag) will be utilized, attach the IV tubing and completely prime the tubing in the hood, making sure it is free of all air bubbles.

9. Prime tubing with fluid from container PRIOR to adding chemotherapy agent whenever possible.

10. Clean diaphragms and injection ports with sterile 70% alcohol swab prior to needle puncture.

11. The safe handling of hazardous drug solutions in vials or ampoules requires the use of a syringe that is no more than three-fourths full when filled with the solution. This minimizes the risk of the plunger separating from the syringe barrel.

12. Ensure that the syringe is the appropriate volume and needle is the appropriate gauge and length.

13. Use CSTD (ONGUARD system or other approved CSTD depending on market availability and as approved by PIC (Designated person) for all compounding in the CACI/BSC.

14. When reconstituting, the syringe should remain in the CSTD, and the contents should be swirled carefully until dissolved.

15. With the vial inverted, the proper amount of drug solution should be withdrawn in small aliquots (e.g., 1/4th to 1/5th of total volume in each aliquot) while equal volumes of air are exchanged for solution. The exact volume needed must be measured while the syringe is in the CTSD and any excess drug should remain in the vial.

    - If the preparation is to be administered in a syringe then it may be capped and labeled at this point in the procedure. If the final dosage form is an IV bag, then continue with the following procedure.

16. When transferring drug to the IV bag, attach the CSTD to the IV bag containing the base solution. Avoid puncturing the sides of the port or bag.

17. Attach the syringe with the drug to the CSTD on the IV bag and slowly inject.

After the drug solution is inserted into the IV bag; the IV port, container set, and gloves. should be decontaminated with sterile alcohol 70%.

18. The injection port of the final product should then be covered with a protective shield and chemotherapy seal.

19. The final preparation should then be placed into the pass-through chamber, inner airlock door closed, and the clean inner gloves should be used for labeling and placement into the chemotherapy transport bag.

20. When using a negative pressure BSC, all items must be wiped down with 70% sterile alcohol prior to being placed inside. They must be at least 6 inches in the hood and placed such that that turbulent airflow does not exist.

C. INSPECTION OF FINAL PRODUCT:

After completion of preparation, the pharmacist will notify the Cancer Treatment Center (CTC) nursing staff. One of the licensed registered chemo-certified nurses and the pharmacist will verify that the final product is free from visible particulate matter, turbidity, or discoloration. At this point, the final preparation is ready for administration to the patient. It will be sealed in a chemotherapy transport bag and taken by the nurse.

D. LIST OF HAZARDOUS DRUGS

1. A list of hazardous drugs that are handled at Sierra View Medical Center will be maintained by the pharmacy (PIC) and reviewed against the NIOSH list for changes annually.

E. RESPONSIBILITIES OF PERSONNEL HANDLING HAZARDOUS DRUGS

1. The pharmacist-in-charge will be responsible for developing and implementing appropriate procedures and overseeing entity compliance with USP 800.

   a. Program integrity will be assured through the following:

      - Testing of product, environment, and personnel.
      - Correcting actionable results when necessary.
      - Hand-hygiene and use of PPE shall be employed at each phase of hazardous drug (HD) handling, e.g., receipt, transport, compounding, administration, spill, and disposal.

F. FACILITIES AND ENGINEERING CONTROLS

1. Designated areas for handling HDs

a. Segregated Compounding Area (Main Pharmacy) and Suite B

- A sign designating "hazard" must be displayed.
- Access to HD preparation area must be restricted to authorized personnel.
- Located away from breakrooms or areas for patients and visitors

b. Receipt and Unpacking of HDs located at Cancer Treatment Center

- A pharmacist will receive the HDs from the wholesaler.
- A properly-garbed pharmacist will unpack the HD shipments in the compounding area.

c. Storage at Cancer Treatment Center

- HDs will be stored in the HD room, behind a locked door.
- HDs will be stored as per manufacturer's recommendations and monitored as per SVMC policy MEDICATION PROCUREMENT, STORAGE, DISTRIBUTION AND CONTROL.

d. Hand washing shall occur after handling and PPE has been doffed.

e. Designated Administration Areas

- Cancer Treatment Center-Chemotherapy
- Operating Room- Bladder Instillation

G. RECEIPT

1. Antineoplastic HDs must not be unpacked (removal from shipping containers) from their external shipping containers in positive-pressure areas.

a. If the shipping container appears damaged:

- Seal the container without opening and contact the supplier.

- If the unopened package is to be returned to the supplier, enclose the package in an impervious container and label the outer container "Hazardous".
- If the supplier declines return, dispose of as hazardous waste.

b. If a damaged shipping container must be opened:

- Seal the container in a plastic or an impervious container.
- Transport it to a negative-pressure CACI/BSC and place on a plastic-backed preparation mat.
- Open the package and remove undamaged items.
- Wipe the outside of the undamaged items with a disposable wipe.
- Enclose the damaged item(s) in an impervious container and label the outer container "Hazardous."
- If the supplier declines return, dispose of as hazardous waste.
- Deactivate, decontaminate, and clean the CACI/BSC and discard the mat and cleaning disposables as hazardous waste.
- Hand washing shall occur after handling and PPE has been doffed.

H. STORAGE

1. HDs must not be stored on the floor.
2. HDs must be stored on secured shelves with raised front lips.
3. Antineoplastic HDs must be stored separately from non-HDs in a manner that prevents contamination and exposure.
4. Refrigerated antineoplastic HDs must be stored in a dedicated refrigerator.
5. After stocking, hand washing shall be completed.

I. COMPOUNDING

1. One licensed registered chemotherapy nurse will double check, and initial, the pharmacist's calculations prior to compounding.
2. Hand washing is a critical component to ensuring IV admixtures are aseptically prepared as well as reducing chemotherapy trace contamination of both product and personnel.

a. Wash hands before and after cleaning the PEC or preparing chemotherapy products.

b. Wash hands for 30 seconds with timer. Wash to elbows when possible.

c. Utilize bactericidal soap.

d. Pay particular attention to under the fingernails and between fingers. Use a nail pick for debris under fingernails.

e. No jewelry (rings, watches, etc.) may be worn during compounding.

f. No nail polish, artificial nails, or cosmetics may be worn during compounding.

g. After washing, use a lint free (non-shedding) cloth or paper towel to dry hands.

h. Apply sterillium to bare hands prior to donning first pair of HD gloves.

3. Gowning will help protect both you as well as others from trace chemo contamination. Gowning and gloving is required when preparing, compounding, handling, cleaning and disposing of HDs.

a. After washing hands, don first (interior) set of HD gloves.

b. Sanitize HD gloves with 70% isopropyl alcohol.

c. Don protective chemotherapy-approved gown.

d. First set of gloves should be tucked under/inside the cuff of the gown.

e. Don second set of chemotherapy approved gloves (double gloves are recommended for hazardous drugs as permeability varies with material, thickness, and exposure duration).

f. Extend outer glove over the cuff of gown.

g. Sanitize and or soak outer glove with 70% isopropyl alcohol and allow product to dry.

h. Change gloves if they become contaminated, torn, or punctured.

i. Change outer gloves whenever you must exit and re-enter the PEC.

j. Gowns are not to be worn outside of preparation/buffer area.

4. Head, Hair, and Shoe Covers

   a. A second pair of shoe covers must be worn when entering the compounding area and compounding HDs. It also must be removed before leaving that area.

   b. Head covers/bouffants will be worn while compounding HDs.

5. Doffing of PPE after HD compounding

   a. Remove outer pair of HD gloves and place in HD waste container in buffer area.
   b. Remove outer pair of booties and place in yellow HD waste container in buffer area.
   c. While in the HD buffer area, remove the HD gown and place in yellow HD waste container.
   d. Remove inner pair of HD gloves while in buffer area.
   e. Exit HD buffer room, enter the clean side of anteroom, and go to the sink.
   f. Remove bouffant/mask and place in yellow HD waste container found under the sink.
   g. Wash hands as stated above.
   h. Remove inner booties and step across LOD.
   i. Use Sterillium gel.

6. Eye and Face Protection

   a. Must be worn when there is a risk of splash or spills outside of CACI/BSC, i.e., cleaning a spill, or working above eye level.

   b. Goggles must be used, not eye glasses.

   c. Goggles plus face shield provide full protection.

7. Respiratory Protection

   a. Shall be worn when unpacking HDs that are NOT contained in plastic bags.

   b. A N95 surgical respirator provides barriers to splashes, droplets, and sprays but not to vapors or gases.

   c. A full face-piece, chemical cartridge-type respirator should be worn when risk of exposure to vapor or:

      - Attending HD spills larger than what can be contained with a spill kit.

      - Deactivating, decontaminating, and cleaning underneath work surfaces.

- Known or suspected airborne exposure to powders or vapors.

8. Engineering Controls

   a. Primary Engineering Control (PEC) – A CACI/BSC will be used for all phases of compounding that provides an ISO Class 5 or better air quality.

   b. Supplemental Control - A closed system transfer device will be used in compounding and administering HDs.

9. CACI/BSC

   a. Must operate continuously 24 hours a day and 7 days a week.

- Will be recertified every 6 months.
- If there is any loss of power or if repair or moving occurs:
  - All activities in CACI/BSC must be suspended.
- Upon return of power
  - Decontamination, cleaning, and disinfection must occur and the BSC must be given the manufacturer specified time to recover before compounding resumes.
- A sink must be available for hand washing.
- An eyewash station must be readily available.
- Water sources and drains must be located at least 1 meter away from CACI/BSC.
- CACI/HD hood must be externally vented.
- Must provide an ISO Class 5 or better environment.

10. STERILE COMPOUNDING

- All sterile NON-HD compounding must follow USP 797 standards.
- LABELING
  - HDs shall be labeled "Caution Chemotherapy-Dispose of properly" or "hazardous- dispose of properly" and "Compounded by Pharmacy".

- All product labels shall include:
  - Name of pharmacy
  - Name of medication, strength, and volume
  - IV admixed medications shall include the solution used.
  - Instructions for storage, handling, and administration or rate of infusion
  - Beyond use date
  - Date of compounding
  - Lot number or pharmacy reference number

All compounded HDs will undergo visual inspection for particulate matter, turbidity, and evidence of contamination. Products with suspected adulterants will be discarded into the yellow HD waste container after the patient information has been removed and destroyed.

11. SVMC Policy IV PREPARATION AND DISPENSING shall be applied. HD guidelines from USP 800 shall supersede non-HD procedures where conflict exists.

12. Hand washing and donning PPE shall occur before compounding. Hand washing shall occur after doffing PPE.

A. TRANSPORT OF HDs

1. LABELING

   a. HDs must be clearly labeled as per USP 797 at all times during transport and include labels of "Chemotherapy-dispose of properly" or "Hazardous drugs-dispose of properly".

2. PACKAGING

   a. A designated HD transport tote will be labeled "Hazardous Drugs" and will be used solely for HDs.

   b. The transport tote will be cleaned before and after transport of HDs by properly garbed pharmacy technicians.

   c. Hand washing shall occur after PPE has been doffed.

B. ADMINISTERING

1. Sterile intravenous HDs will be administered via needleless closed system transfer device.

2. PPE used when administering HDs will be disposed of in a chemotherapy waste receptacle.

3. Hand washing shall occur after proper PPE has been doffed.

C. DISPOSAL

1. All personnel who perform custodial waste removal and cleaning activities will be trained to prevent and protect themselves from accidental exposure and contamination of the environment.

2. Hand washing shall occur after proper PPE has been doffed.

D. DISPENSING OF FINAL DOSAGE FORMS

1. Any hazardous drug that does not require any further manipulation other than counting or repackaging of the final dosage form must not be placed into an automated counting machine unless otherwise specified by its Assessment of Risk.

E. DEACTIVATING, DECONTAMINATION, CLEANING, AND DISINFECTING

1. All personnel who perform deactivation, decontamination, cleaning, and disinfection in HD handling areas will be:

   a. Trained annually

   b. All personnel performing these activities will wear impervious personnel protective equipment, double gloves (chemo-grade), and eye protection if splashing is likely.

2. CACI/BSC MAINTENANCE

   a. Do not use a spray bottle. Lint free wipes shall be used.

   b. Disposal meets FDA regulations.

   c. All cleaning activities will be documented.

3. Deactivation

   a. Shall occur daily, after a spill, or as deemed warranted.

   b. A process whereby the HD compound is rendered inert. SVMC will use sporicidal agent approved by designated person with verified deactivation compounds per USP 800 that include deactivating compounds such as peroxide. Examples of (but not limited to) appropriate products include Periodox & Decon-Spore.

4. Decontamination

   a. Performed prior to any compounding, in between compounding different HDs, at the end of a shift, when a spill occurs, before and after certification, voluntary interruption, and if ventilation tool is moved.

      - Removal of HD residue
        - Sterile Alcohol 70%

5. Cleaning

   a. Shall occur prior to any compounding, in between compounding different HDs, at the beginning and end of a shift, when a spill occurs, before and after certification, voluntary interruption, at least every 30 minutes when compounding involving human staff is occurring, and if ventilation tool is moved.

      - Removal of organic and inorganic material

      SVMC will use sporicidal agent approved by designated person, such as Peridox© or Decon-Spore, with a contact time of 3 minutes when agent is visibly wet.

6. Disinfecting

   a. A process of inhibiting or destroying microorganisms. This shall be performed prior to any compounding, in between compounding different HDs, at the end of a shift, when a spill occurs, before and after certification, voluntary interruption, and if ventilation tool is moved. SVMC will use sporicidal agent approved by designated person, such as Peridox© or Decon-Spore, with a contact time of at least 3 minutes.

   b. Must occur after surfaces are cleaned using sterile 70% alcohol

   c. SVMC Policy: STERILE PRODUCTS: STERILE PRODUCT QUALITY ASSURANCE shall be applied and followed.

7. Spill Control

   a. Pharmacy personnel involved in handling HDs will receive annual training in the use of personnel protective equipment and respirator.

   b. Spills must be contained and cleaned immediately by qualified personnel with appropriate PPE.

   c. Signs must be used to restrict access to spill.

   d. Spill kits must be available at all times while HDs are being handled.

   e. All used spill kit items must be disposed of as hazardous waste.

   f. Spill kits are located in CTC HD Pharmacy and Main Pharmacy.

   g. Face pieces must be used if capacity of kit is exceeded or if vapors are known or suspected.

   h. Material Safety Data Sheets are accessible 24 hours a day via the SVMC intranet.

   i. When a spill occurs, protect the patients or employees who had cytotoxic drugs spilled on them.

   a. If skin is exposed, wash the affected areas with copious amounts of non-medicated soap and water for 20 minutes.

   b. If mucous membranes are exposed (i.e. eyes), rinse with copious amounts of clean water for at least 15 minutes.

8. Spills should be cleaned up immediately by the person responsible. An Environmental Services Supervisor is available during business hours. Call the Supervisor to assist if the spill is complicated (i.e., >50ml or >12 inches in diameter, or difficult to contain, for example liquid mercury spills) or the area is difficult to clean. The supervisor may also be called as an information resource on cleaning spills.

9. A written procedure for spill management is included in each spill kit. Components of a spill kit include, but may not be limited to, the following:

   a. 2 pairs of disposable HD gloves

   b. Low permeability gown and shoe covers

   c. Goggles or face shield

   d. Respirator mask (unless included in face shield)

   e. Plastic backed absorbent sheets or spill pads (sufficient to absorb a spill of up to 1000mL)

f. Disposable towels or swabs for absorbing and cleaning liquid spills

g. At least 2 sealable plastic waste bags "Cytotoxic Waste"

h. Disposable scoop for collecting glass fragments

i. Puncture-resistant container for glass fragments, clearly labeled as cytotoxic waste container

j. Cleaning solution for cleaning and decontamination of area

k. Instructions on the management of a cytotoxic chemotherapy spill

l. Warning signs to alert other staff to the hazard and isolate the area of the spill

F. General clean-up procedure:

1. Assess the size and scope of the spill.

2. Spills that cannot be contained by two spill kits may require outside assistance and supervisor should be alerted.

3. Post signs to limit access to spill area.

4. Obtain spill kit.

5. Don PPE, including inner and outer gloves and mask.

6. Once fully garbed, contain spill using spill kit.

7. Carefully remove any broken glass fragments and place them in a puncture-resistant container.

8. Absorb liquids with spill pads.

9. Absorb powder with damp disposable pads or soft toweling.

10. Spill cleanup should proceed progressively from areas of lesser to greater contamination.

11. Completely remove and place all contaminated material in the disposal bags.

12. Rinse the area with water and then clean with detergent, sodium hypochlorite solution/wipes and neutralizer.

13. Rinse the area several times and place all materials used for containment and cleanup in disposal bags. Seal bags and place them in the appropriate final container for disposal as

hazardous waste.

14. Carefully remove all PPE using the inner gloves. Place all disposable PPE into disposal bags. Seal bags and place them into the appropriate final container.

15. Remove inner gloves; contain in a small, sealable bag; and then place into the appropriate final container for disposal as hazardous waste.

16. Wash hands thoroughly with soap and water.

17. Once a spill has been initially cleaned, have the area re-cleaned by housekeeping, janitorial staff, or environmental services.

G. After the spill has been cleaned up and the people who came in contact with the cytotoxic drugs have washed the involved skin areas for 20 minutes, consider the following:

1. If the spill is on a patient, notify the physician.

2. If the spill is on an employee:

   a. Call Employee Health Services during business hours or the emergency room for further instructions. The Employee Health nurse or emergency room physician will assess for injury related to the exposure with particular attention to the skin, eyes, and mucous membranes. If a baseline CBC has not been drawn, a CBC with differential will be done.

   b. A CBC with differential and follow-up exam will be done by the Employee Health Service nurse at the time of the expected nadir (the lowest point of circulating blood counts (e.g., WBCs and RBCs) of the drug.

3. Complete an incident report if a spill occurs anywhere or if a spill occurs on a patient or employee.

H. DOCUMENTATION AND STANDARD OPERATING PROCEDURES

1. Must be reviewed by the pharmacist-in-charge every 12 months.

2. Any changes to policy or records must be communicated and documented to all personnel handling HDs.

I. MEDICAL SURVELLIANCE

1. Pharmacy personnel involved in routine handling of HDs will be enrolled into SVMC's medical surveillance program which is administered through employee health.

2. All employees with potential exposure to cytotoxic drugs will be informed by their

department of the potential risks and the need to follow the procedures related to handling of chemotherapy. Training in the policies will be provided as appropriate for the department involved.

3. Employees will be informed by their department of the potential reproductive hazards and if they so request, staff members who are pregnant or breast-feeding, will be transferred to comparable duties that do not involve handling cytotoxic drugs.

4. ACTIONS IN RESPONSE TO EXPOSURE-RELATED HEALTH CHANGES

   a. Post-exposure examination tailored to type of exposure.

   b. Compare performance of controls with recommended standards.

   c. Conduct environmental wiping samples.

   d. Verify that all engineering controls are operating properly.

   e. Verify and document that employee complied with existing policies.

   f. Develop and document a plan of action that will prevent future exposure.

   g. Ensure a confidential two-way communication between employee and employee health regarding notification of a change in health condition.

   h. Provide and document a follow-up medical survey to demonstrate actions that are effective.

   i. Ensure that any exposed employee receive notification of any adverse health effect.

   j. Provide ongoing medical surveillance of all employees that handle HDs to ensure plan implemented is effective.

J. TRAINING

1. Personnel will be trained annually

   a. According to OSHA standards 1910.120 Hazardous Waste Operations Emergency Response

   b. USP 797

   c. USP 800

   d. California State Law. CCR 1735, CCR 1751.

e. Sierra View Medical Center Policy and Procedures related to USP 797 and 800.

f. Chemo Check Workbook ™

g. Environmental Services, Nursing, and Pharmacy shall read and sign "Hazardous Drug Risk" form that acknowledges risk of HDs to employees.

K. QUALITY ASSURANCE PROGRAM

1. Quality Indicators found in SVMC policy COMPOUNDED STERILE PREPARATION:QUALITY ASSURANCE PROGRAM that shall be followed include:

a. Personnel Performance

b. Equipment and Facilities

c. Product and Environment

- At a minimum of every 6 months, or as needed to verify containment, the following shall be done upon the interior of PEC, pass-thru chambers, surfaces in staging or work areas near PEC, areas adjacent to PEC, areas immediately outside buffer area, patient administration areas:
  - Environmental Wipe Sampling for Trace Chemo:
- In the event of a positive result, the pharmacist-in-charge shall:
  - Identify, document, and contain the cause of contamination
  - Reevaluate the workplace practices
  - Re-train personnel
  - Perform deactivation, decontamination, cleaning, and improving engineering controls
  - Repeat wipe-sampling to validate decontamination complete
- End Product Sampling
  - Sterility
  - Potency

L. HAZARD COMMUNICATION PROGRAM

1. Standards of handling HDs shall be implemented and evaluated thru annual employee competencies.

2. All containers of HDs shall be labeled with the identity of the material and appropriate hazard warning.

3. Material Data Sheets are available for all employees 24 hours a day via the SVMC intranet.

4. Personnel shall receive training on exposure prior to handling HDs or when there are hazard changes.

5. Personnel of reproductive capability shall confirm in writing that they understand the risk of handling HDs.

M. CONTAINMENT REQUIREMENTS

1. For dosage forms (tablets or capsules, solid intact medications) that are administered to patients without modification shall be handled as per assessment of risk.

2. The selected containment strategy (handling precautions) will be communicated to staff via Electronic Medical Record and auxiliary stickers or pharmacy labels.

3. The facility risk assessment shall be reevaluated annually.

N. In the event of a drug recall, the procedure found in SVMC policy DRUG RECALL PROCEDURE shall be followed.

O. The pharmacy maintains written policies and procedures for compounding and understands any material failure to follow the pharmacy's policies and procedures shall constitute a basis for disciplinary action by the Board of Pharmacy.

P. All medications used for compounding sterile products, both hazardous and nonhazardous, will be procured from a registered wholesaler or from an FDA registered manufacturer.

Q. Documentation Retention

1. All records of compounding and materials used to compound sterile preparations shall be maintained in a readily retrievable form for three (3) years from the date the record was last in effect.

U. Whenever a change in a policy or procedure occurs, the pharmacist-in-charge will notify the staff via a meeting or email. Staff shall sign off on changes acknowledging changes and intent to comply. Any material failure to follow the pharmacy's written policies and procedures shall constitute a basis for disciplinary action by the Board of Pharmacy.

V. All policies related to sterile HD IV compounding will be reviewed annually by the pharmacist-in-charge, and recordation of the annual review shall be present on each policy and be readily retrievable upon request by the Board of Pharmacy.

1. The pharmacy will maintain records of the acquisition, storage, and destruction of any components used in compounding.

R. A pharmacy technician may, at the discretion of the pharmacist, remain in the pharmacy but may only perform nondiscretionary tasks. The pharmacist will be responsible for reviewing any tasks completed in the temporary absence, i.e., restroom break, etc.

REFERENCES:

- USP 800 Hazardous Drugs- Handling in Healthcare Settings (2017). Retrieved from http://www.usp.org/sites/default/files/usp/document/our-work/healthcare-quality-safety/general-chapter-800.pdf. Accessed 6/24/2020.
- "ASHP Guidelines on Handling Hazardous Drugs." *American Journal of Health-System Pharmacy* 63, no. 12 (June 15, 2006): 1172–1191. doi:10.2146/ajhp050529. Accessed: November 6, 2018.
- Occupational Safety and Health Administration (OSHA) Guidelines for Controlling Occupational Exposure to Hazardous Drugs Accessed 6/24/20.https://www.osha.gov/SLTC/hazardousdrugs/index.html.
- 2023 Lawbook for Pharmacy. Business and Professions Code 4000. https://www.pharmacy.ca.gov/laws_regs/lawbook.pdf Accessed 3/2/2022.

CROSS REFERENCES:

- MEDICATION PROCUREMENT, STORAGE, DISTRIBUTION AND CONTROL
- IV PREPARATION AND DISPENSING
- COMPOUNDED STERILE PREPARATION: QUALITY ASSURANCE PROGRAM
- DRUG RECALL PROCEDURE
- STERILE PRODUCTS: STERILE PRODUCT QUALITY ASSURANCE

SUBJECT:	SECTION:
STERILE PRODUCTS: STERILE PRODUCT QUALITY ASSURANCE	**Page 1 of 14**

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

PURPOSE:

To provide procedures to ensure that compounded sterile preparations (CSPs) prepared at Sierra View Medical Center (SVMC) are of high quality and sterility.

DEFINITIONS:

Biological Safety Cabinet (BSC), Class II – A ventilated cabinet with an open front and inward and downward unidirectional HEPA-filtered airflow and HEPA-filtered exhaust. A BSC used to prepare a CSP must be capable of providing an ISO Class 5 or better environment for preparation of the CSPs.

Beyond-use date (BUD) – The date, or hour and the date, after which a CSP must not be used, stored, or transported. The date is determined from the date and time the preparation is compounded.

Category 1 CSP – A CSP that is assigned a BUD of 12 hours or less at controlled room temperature or 24 hours or less refrigerated

Category 2 CSP – A CSP that may be assigned a BUD of greater than 12 hours at controlled room temperature or greater than 24 hours refrigerated

Compounded sterile preparation (CSP) – A preparation intended to be sterile that is created by combining, admixing, diluting, pooling, reconstituting, repackaging, or otherwise altering a drug product or bulk drug substance.

Compounding aseptic isolator (CAI) – A type of RABS that uses HEPA filtration to provide an ISO Class 5 unidirectional air environment designed for compounding of sterile non-HDs.

Compounding aseptic containment isolator (CACI) – a type of RABS that uses HEPA filtration to provide an ISO Class 5 unidirectional air environment designed for the compounding of sterile HDs.

ISO Class 5 - An airborne-particulate standard that states there are no more than 3,520 particles of at least 0.5-microns in size per cubic meter.

Media-fill test: A simulation used to qualify processes and personnel engaged in sterile compounding to ensure that the processes and personnel are able to prepare CSPs without contamination.

Primary engineering control (PEC) - A device or zone that provides an ISO Class 5 or better environment through the use on non-turbulent air, unidirectional HEPA-filtered first air for compounding sterile preparations.

Restricted-access barrier system (RABS) – An enclosure that provides HEPA-filtered ISO Class 5 unidirectional air that allows for the ingress and/ or egress of materials through defined openings that have been designed and validated to preclude the transfer of contamination, and that generally are not to be opened during operations. Examples include CAIs and CACIs.

Secondary Engineering Control (SEC) – The area where the PEC is placed (e.g., a cleanroom suite or an SCA).

Segregated Compounding Area (SCA) - Space designated for sterile-to-sterile compounding where a PEC is located within a demarcated area (of at least 3 foot perimeter). This area will be void of activities and materials extraneous to sterile compounding. This area shall not be in a location that has unsealed windows or doors that connect to outdoors, location with high traffic flow, or adjacent to food preparation areas or construction. The SCA must contain a PEC and is suitable for preparation of Category 1 CSPs only.

USP 797 - United States Pharmacopeia (USP) is a national quality agency that creates the sterile product quality standards. The "797" designation is the chapter that relates specifically to the sterile product environment.

POLICY STATEMENT:

It is the policy of SVMC that all compounded sterile preparations (CSPs) will adhere to USP 797 standards of practice. No CSP shall be compounded if it is known, or reasonably known, that the environment fails to meet criteria specified in the pharmacy's written policies and procedures for the safe compounding of CSPs.

PROCEDURE:

I. SVMC will administer aseptic manipulation competency evaluations to ensure a quality product.

A. The evaluation consists of the following:
   a. Visual observation
   b. Media-fill testing
   c. Gloved fingertip and thumb (GFT) sampling on both hands
   d. Surface sampling of the direct compounding area

B. Process validation is assured by using simulated production of the aseptic processes in use at SVMC, substituting growth media for medications to check sterility.

C. All staff responsible for CSPs must be trained in aseptic technique and demonstrate competency by direct observation and successful passing of a media-fill test.

D. Aseptic technique will be monitored and critiqued. Retraining will be considered if major technique violations are seen. Major violations may include:

1. Violations of gowning, gloving and hand-washing policy

2. Touching of critical sites

3. Failure to wipe stoppers

4. Failure to work within proper hood area

5. Blockage of "first air" to critical sites

6. Failure to clean hood properly and keep clean during compounding

E. Gloved fingertip sampling

Initial Competencies	Subsequent Competencies
Visual observation of hand hygiene and garbing (3 times)	Visual observation of hand hygiene and garbing (1 time)
GFS after visual observation of hand hygiene and garbing (3 times)	GFS after visual observation of hand hygiene and garbing (1 time)
Media-fill test	Media-fill test
GFS after the media-fill test	GFS after the media-fill test
Surface sample in the DCA after the media-fill test	Surface sample in the DCA after the media-fill test

Note: GFT sampling shall occur after production of CSPs but before sterilization with alcohol.

F. An actionable level is a CFU count (from both hands) greater than zero after garbing and greater than 3 CFUs after media-fill testing.

1. Employee will be retrained in hand-hygiene, garbing, glove and surface disinfection and conduct in compounding area. Sampling will be repeated and didactic testing repeated.

2. Actionable levels will result in removal from compounding duties and require retraining.

3. Repeated actionable levels will require complete retraining and removal from compounding until sampling meets minimum standards. Root cause for repeat positive sampling will be sought out by the pharmacist-in-charge.

II. The sterile-compounding areas will be cleaned as per USP 797 established standards. All cleaning materials must be non-shedding and dedicated to use in compounding areas and shall not be removed except for disposal.

A. Cleaning of the compounding areas must be documented on a cleaning log.

B. Minimum cleaning frequency

Site	Cleaning	Disinfecting	Sporicidal
PEC(s) and equipment inside the PEC(s)	Daily and when surface contamination is known or suspected	Daily and when surface contamination is known or suspected	Monthly for entities compounding Category 1 or 2 CSPs
Removable work tray of the PEC	Daily on days when compounding occurs Monthly on all surfaces and the area underneath the work tray	Daily on days when compounding occurs Monthly on all surfaces and the area underneath the work tray	Monthly on all surfaces and the area underneath the work tray
Pass-through chambers	Daily on days when compounding occurs	Daily on days when compounding occurs	Monthly for entities compounding Category 1 or 2 CSPs
Work surface(s) outside the PEC	Daily on days when compounding occurs	Daily on days when compounding occurs	
Floor(s)	Daily on days when compounding occurs	Daily on days when compounding occurs	
Wall(s), plastic curtain(s), door(s), and door frame(s)	Monthly	Monthly	Monthly
Ceiling(s)			
Storage shelving and bin(s)			
Equipment outside the PEC(s)			

C. Disinfection of a PEC will be executed with sterile water, sterile 70% isopropyl alcohol (cleaning and disinfecting), and sporicidal agent approved by designated person, such as Peridox© or Decon-Spore (agent must be applied and be visibly wet for 3 minutes)

D. Sterile 70% isopropyl alcohol must also be applied in the follow scenarios:
   a. At the beginning of each shift and at the end of each shift
   b. After a spill
   c. At least every 30 minutes if the compounding process takes 30 minutes or less
   d. Immediately after when compounding activities exceed 30 minutes, or
   e. When surface contamination is known or suspected

E. Daily mopping of the floor using a clean/low-shedding mop. Mop must be kept in the SCA or buffer area and only be used for cleaning the buffer area floor. Mopping will be done by trained personnel using approved cleaning agents and will mop in a direction from clean area to dirty area. To ensure proper contact time, the mopped floor must remain visibly wet for 10 minutes.

F. Competency records of housekeeping staff will be kept in pharmacy for a minimum of three years after employment.

G. Weekly cleaning

   1. Hoods must be disinfected using an approved disinfecting agent, sporicidal agent approved by designated person, such as Peridox© or Decon-Spore, will be used (agent must be applied and be visibly wet for 3 minutes). Use of this agent will occur after the use of sterile water and sterile 70% alcohol.

H. Monthly cleaning

   A. In addition to above cleaning, all surfaces in ISO classified areas or segregated compounding area will be wiped with sterile water and then sterile 70% alcohol including the inside of storage bins, carts, wheels, outside of hood, and wire racks, shelves, walls and ceilings, stools, and all other items in segregated compounding area

   B. A sporicidal will be used on the entire room and outside AND inside the RABS or BSC. SVMC will use sporicidal agent approved by designated person, such as Peridox© or Decon-Spore (agent must be applied and be visibly wet for 3 minutes).

I. Fixed glove assembly will be changed at least every 6 months or:

   1. When there is a visible tear;

   2. When a positive culture is obtained from sampling;

3. When there is suspected contamination of product

IV. Certification or recertification

A. **Classified areas and PEC(s) will be recertified every six months by an outside agency**. During certification, the agency will evaluate the following:

1. Airflow testing
2. HEPA filter integrity testing
3. Total particle count testing
    a. Failure to meet ISO standards will be immediately addressed PRIOR to the vendor testing the PEC or before leaving SVMC.
    2. Corrective actions may include the following:
        - Replacing HEPA filters
        - Re-measuring the airborne particle count
        - Searching for mechanical causes
4. Dynamic airflow smoke pattern test

B. In addition, classified areas will be recertified in the following circumstances:

1. Classified area was redesigned
2. Classified area was constructed
3. Any PEC was replaced or relocated
4. Configuration of the room was altered that could affect airflow or air quality

C. A corrective action plan will be implemented in response to any out-of-range results.

D. Decontamination and terminal cleaning of PEC and SEC will occur immediately AFTER recertification.

V. Viable Sampling

A. The Department of Pharmacy or an outside agency will conduct viable surface and air sampling at least every one and six months, respectively.

1. In addition, sampling must be performed in the following circumstances:

a. In conjunction with the certification of new facilities and equipment

b. After any servicing of facilities or equipment

c. In response to identified problems (e.g. positive growth in sterility tests of CSPs)

d. In response to identified trends (e.g. repeated positive GFT sampling results, failed media fill testing, or repeated observations of air or surface contamination

2. Surfaces include one surface in each PEC, surfaces of all classified areas, and pass-through chambers connecting to classified areas.

B. An actionable level of colony-forming units (CFUs) upon viable surface sampling is:

1. Action Levels for Surface Sampling

ISO Class	Surface Sampling Action Levels (CFU/Plate)
5	>3
7	>5
8	>50

C. An actionable level of CFUs upon viable air sampling shall be:

1. Action Levels for Air Sampling

ISO Class	Air Sampling Action Levels (CFU/m^3)
5	>1
7	>10
8	>100

D. Any actionable level in the PEC will result in the following action(s):

1. Immediate cessation of activity in the PEC.
2. Immediate cleaning and disinfecting of PEC and SEC.
3. Resampling of affected area after cleaning and disinfecting is completed.
4. Evaluation of engineering controls.
5. Communication with Infection Control and expert infectious disease consultation.
6. Communication with Risk Department and investigation for any product potentially-contaminated.
7. Review of cleaning and compounding operations and facility management.
    a. If levels measured exceed above action levels, an investigation and corrective action must be taken to prevent future deviations.
    b. Corrective action plans may include a change in procedure, facility, or equipment.

E. Any actionable level outside the PEC will result in the following action(s):

1. Investigate the cause.
2. Implement corrective action.
3. Evaluate the trend if data is available.
4. Resample the failed area to confirm corrective action was successful.
5. Attempt to identify microorganisms recovered to the genus level.

F. When evaluating the results, the designated person will examine the counts in relation to previous data to identify adverse results or trends.

G. If needed, Pharmacy will adopt current SOPs when collecting viable surface samples to monitor environmental sterility.

H. If needed, Pharmacy will adopt current SOPs when collecting viable air samples to monitor environmental sterility.

VI. Quality Assurance/ Quality Control Testing

A. Sterility testing of a Category 1 CSP will occur at least quarterly.

a. In the event of a positive culture

i. Technician who compounded IV will be retrained in hand hygiene, garbing, gloving, and surface disinfection. Fingertip and sterility testing

will be repeated under observation for technique. Technician will stop compounding until a negative test is obtained.

ii. If repeat testing results in a positive response, the technician will be removed from compounding duties and completely retrained.

iii. In addition to the above, if the product is a batched product where more than one dose of a preparation has been made:

- The lot number of the product will be identified
- Potential patients exposed to contaminated product will be identified using dispensing and administration records
- The physicians involved in that patient's care and infection control officer will be notified of possible exposure as well as organism(s) involved in order to evaluate the patient.

iv. Risk, Infection Control, and Chief Nursing Officer will be immediately informed.

B. Quantification testing shall be performed at a minimum of twice a year to ensure product integrity and to validate labeled strength.

A. A random CSP will be sent out to a qualified laboratory to test for potency, endotoxin, and particulate matter. Pharmacy will follow the process outlined by the contracted laboratory.

B. If the drug sample is identified as not within the standards for potency, endotoxin, or particulate matter:

a. The technician and pharmacist making/checking the product will be removed from sterile product processing and retrained.

b. A complete analysis of the compounding process will occur.

c. An additional product will be sent out for validation.

C. All of the above steps will be performed and BUD dating will be confirmed by using standard reference materials and research.

VII. Compounding Room Temperature and Lighting

A. The sterile compounding area shall have a well-lit working environment.

B. A room temperature of 68 degrees Fahrenheit and humidity below 60% is ideal for sterile compounding. The temperature and humidity will be recorded daily.
   i. In the event of a temperature excursion:
      1. Engineering will be contacted for temperature or humidity correction.
   ii. Pharmacist-in-Charge will be notified.
   iii. If temperature > 40 degrees Celsius for at least 4 hours, any CSP exposed to these conditions will be discarded.

VIII. Pressure Differential

A. A minimum of 0.02-inch water column is required for positive pressure to separate each ISO classified area, except in segregated compounding areas.
B. Negative pressure will be negative 0.01 to negative 0.03 inches of water.
C. A pressure gauge or velocity meter will be used to monitor airflow between the following paired areas:
   1. Ante-area and buffer areas
   2. Ante area and outside the cleanroom suite
   3. RABS and the SCA.
D. The pressures will be documented and reviewed daily or by a continuous monitor.

IX. In the event of a product recall, SVMC will follow the established policy of DRUG RECALL PROCEDURE

X. All records will be retained for a minimum of three years.

XI. Whenever a change in a policy or procedure occurs, the pharmacist in charge will notify the staff via a meeting or email. Staff shall sign off on changes, acknowledging changes and intent to comply. Any material failure to follow the pharmacy's written policies and procedures shall constitute a basis for disciplinary action by the Board of Pharmacy.

EDUCATION:

SVMC Pharmacy Staff: All pharmacists and pharmacy technicians will receive education regarding the preparation of pharmacy-prepared IV admixtures.

REFERENCES:

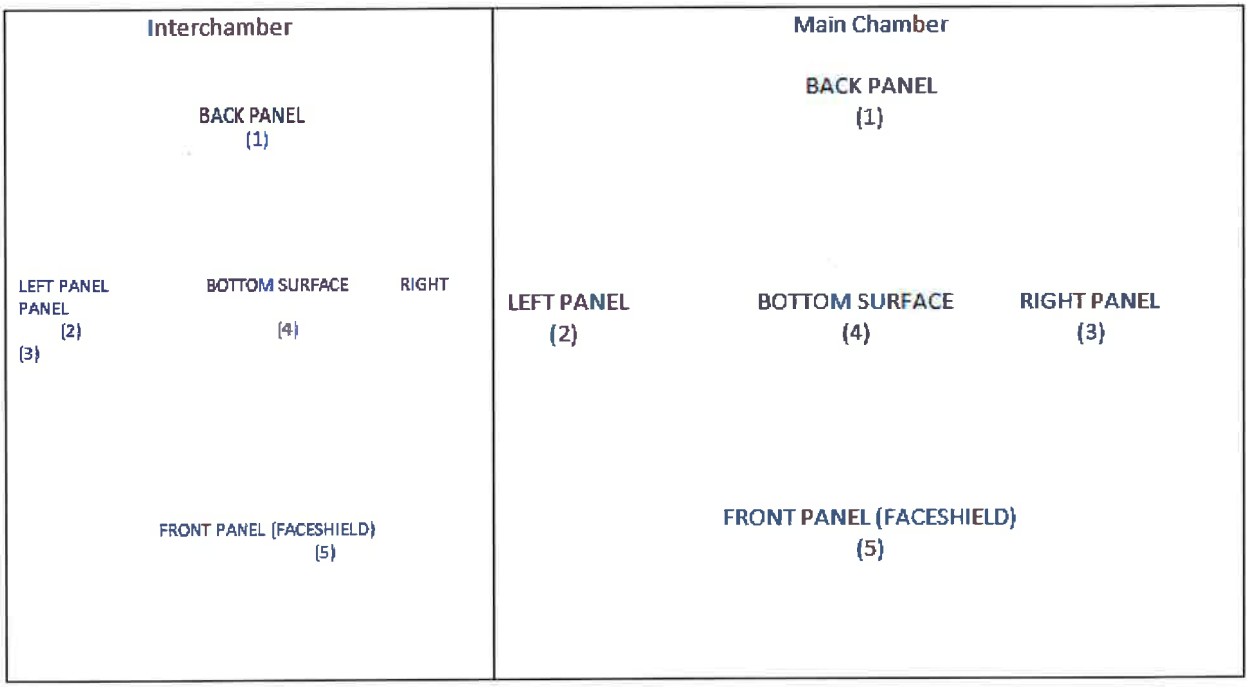
- The Joint Commission (2024). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Pharmacy Law: California Edition. (2024) San Clemente, California: Law Tech Publishing Group.
- USP 797.(n.d.). from http://www.usp.org/compounding/general-chapter-797.

- CCR 1751.4 Facility and Equipment Standards for Sterile Compounding. Retrieved November 24, 2021, from https://www.law.cornell.edu/regulations/california/16-CCR-Sec-1751-4.

CROSS REFERENCES:

- DRUG RECALL PROCEDURE

Map of NuAire COMPOUNDING ASEPTIC ISOLATOR – Main Pharmacy



SUITE "B" POSITIVE & NEGATIVE PRESSURE HOODS ENVIRONMENTAL SAMPLING MAP

NUAIRE HOOD

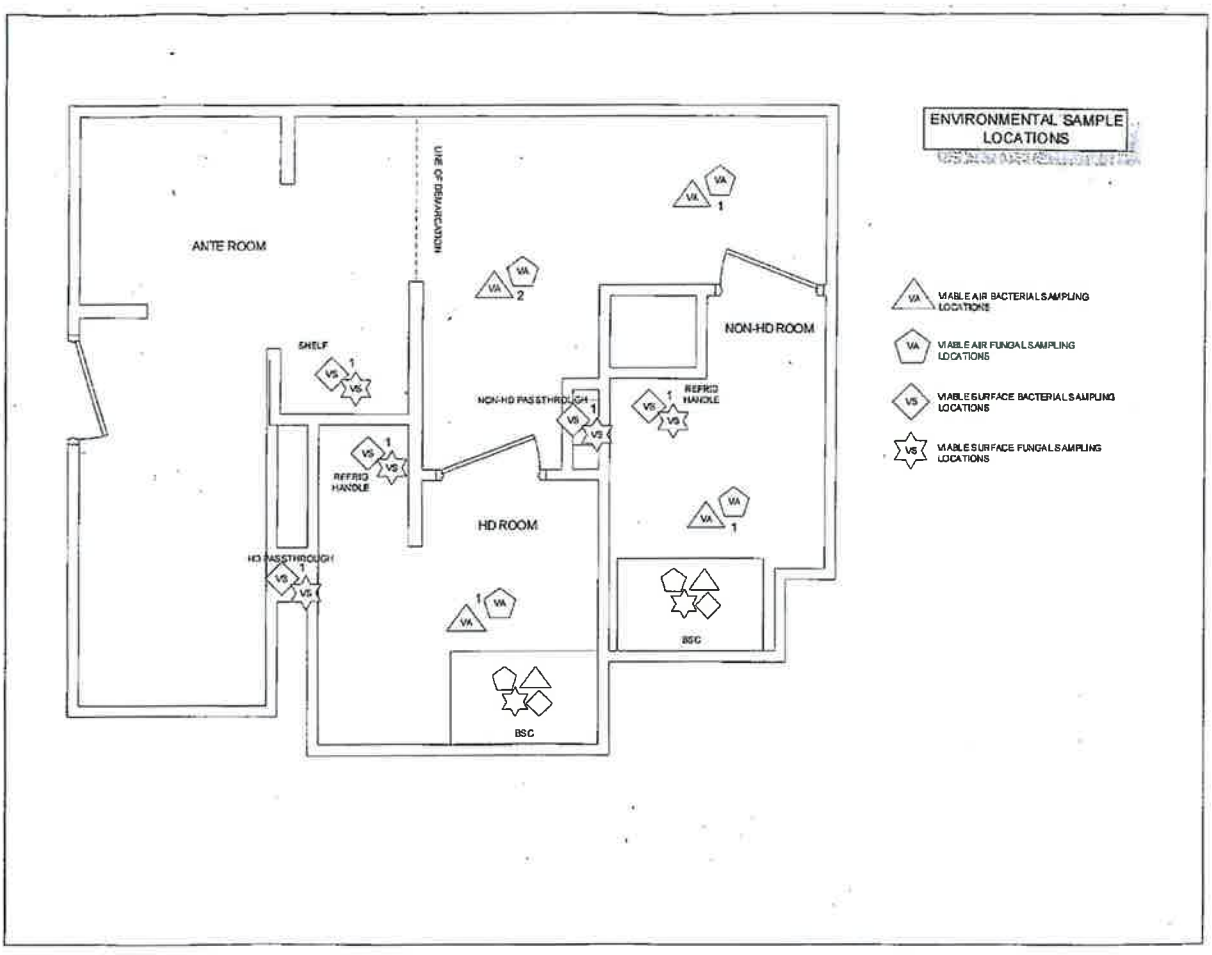
BACK PANEL
2

LEFT PANEL
1

BOTTOM PANEL
3

RIGHT PANEL
4

FRONT PANEL
5


ENVIRONMENTAL SAMPLE LOCATIONS
ANTE ROOM
LINE OF DEMARCATION
NON-HD ROOM
SHELF
NON-HD PASSTHROUGH
REFRIG HANDLE
REFRIG HANDLE
HD ROOM
HD PASSTHROUGH
BSC
BSC
VIABLE AIR BACTERIAL SAMPLING LOCATIONS
VIABLE AIR FUNGAL SAMPLING LOCATIONS
VIABLE SURFACE BACTERIAL SAMPLING LOCATIONS
VIABLE SURFACE FUNGAL SAMPLING LOCATIONS

SUBJECT: **SURGICAL HAND SCRUB**	SECTION: **Page 1 of 3**

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

PURPOSE:

To define the procedures to be followed in order to mechanically and chemically reduce microbial flora on the skin of hands and forearms of the surgical scrub team, in the event of glove failure, by:

1. Removing soil and transient microorganisms from hands and forearms;
2. Reducing the resident microbial count to as low a level as possible;
3. Inhibiting the rapid rebound growth of microorganisms.

POLICY:

A surgical hand scrub will be performed by members of the sterile surgical team before donning gloves for surgical or invasive procedures. Use of either an antimicrobial surgical scrub agent intended for surgical hand antisepsis or an FDA-approved alcohol-based antiseptic surgical hand rub is acceptable.

AFFECTED AREAS/ PERSONNEL: *MAIN OPERATING ROOM (OR), MATERNAL CHILD HEALTH (MCH) OR, AMBULATORY SURGERY DEPARTMENT (ASD) OR / ALL SCRUB PERSONNEL, CARDIAC CATH LAB PERSONNEL, INTERVENTIONAL RADIOLOGY*

PROCEDURE:

INITIAL PREPARATION:

1. Do not wear jewelry (e.g., rings, watches, bracelets) on the hands or wrists.
2. All perioperative team members should maintain healthy fingernail and hand skin condition.
3. Fingernails should be kept short, free of nail lacquer or gel, and well maintained.
4. At no time are acrylic nails allowed to be worn by personnel providing direct patient care.
5. Hands and forearms must be free of open lesions and breaks in skin integrity.
6. Take measures to prevent hand dermatitis.
7. Restrict the activities of health care personnel with dermatitis, infections, exudative lesions, and non-intact skin when these activities pose a risk for transmission of infection to patients and other health care providers.[15] Follow state, federal, and professional guidelines and strategies to determine the need for work restrictions for health care personnel with bloodborne infections.
8. Must wear complete operating room attire.

SCRUB PROCEDURE:

1. Utilize hospital-approved antimicrobial soap or detergent that is:
   a. Rapid acting;
   b. Has a broad spectrum of activity in reduction of transient microflora;
   c. Has minimal harsh effects on skin;
   d. Inhibits rapid rebound growth of microbes.
2. Adjust water temperature for comfort; lukewarm temperature is most acceptable, neither too hot nor too cold, as this may be responsible for skin breakdown.
3. Keep arms level and well away from body and hands up above elbows for duration of scrub as this keeps areas that have already been cleansed from being re-colonized with bacteria from areas of the arms that have not yet been cleansed.
4. Remove brushes from wrapper and nail cleaner.
5. Wet hands and forearms
6. Apply sufficient water to sponge part of brush and work up lather.
7. Clean nails and subungual areas with disposable nail cleaner, under running water.
8. Discard nail cleaner in receptacle.
9. Rinse hands and arms thoroughly without touching any part of the scrub sink or faucet.
10. Scrub hands and forearms, with disposable brush, to two (2) inches above elbow using anatomical timed method.
11. Apply an antimicrobial soap with friction to wet hands and forearms. Using a sterile disposable brush/sponge, (a Betadine impregnated brush/sponge is available) the hands and arms are scrubbed to two inches above the elbow. This lasts for at least 2-3 minutes. Start at the fingertips using a circular motion and complete all sides of the fingers and webbed spaces. Proceed to the arms, scrubbing all 4 sides, including the antecubital space to 2 inches above the elbow. The hands and forearms are held higher than the elbows and out away from the surgical attire to prevent contamination and for water to run from the cleanest area down the arm.
12. Discard brush into sink or waste receptacle.

13. Turn off water, using knee control.

14. Hands will be dried with sterile towel, avoiding contact with surgical attire.

ALCOHOL-BASED SURGICAL HAND RUB

An alcohol-based surgical hand rub can be used in lieu of the surgical timed hand scrub. An FDA approved surgical hand rub is the only product to be used for this technique. The initial surgical hand scrub of the day must be the timed method described above. Subsequent surgical hand scrubs may be performed using the following procedure:

1. Hands and arms must be clean and dry.

2. Dispense one pump (2 ml) into the palm of one hand. Dip fingertips of the opposite hand into the hand prep and work under the fingernails. Spread the remaining hand prep over the fingers, hand, and forearm up to just above the elbow.

3. Dispense one pump (2 ml) into the palm of opposite hand and repeat procedure.

4. Dispense a final pump (2 ml) of hand prep into either hand and reapply to all aspects of both hands up to the wrists.

5. Allow to air dry. Do not use towels to dry.

6. Gown and glove per routine for procedure.

7. General hand hygiene is to be performed immediately after surgical gloves are removed.

REFERENCE:

- AORN Standards and Recommended Practices Hand Hygiene. June 15, 2022.

SUBJECT: **THERAPEUTIC DRUG SUBSTITUTION PROTOCOL**	SECTION: ***Clinical Pharmacy Drug Protocols*** **Page 1 of 11**

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

PURPOSE:

To promote cost effective, rational drug therapy by controlling the number of similar medications within a given therapeutic class that will be available on formulary.

POLICY:

A therapeutically equivalent drug may be dispensed following the development of objective interchange guidelines by the medical and pharmacy staff through the Pharmacy and Therapeutic Committee.

AFFECTED AREAS/PERSONNEL: *MEDICAL STAFF, PHARMACY, NURSING*

PROCEDURE:

The Pharmacy and Therapeutics Committee will identify potential therapeutic classes of medications, which may provide an opportunity for therapeutic interchange. Upon identification, experts in the area of therapeutic classification will be changed with selecting an appropriate therapeutic class representative drug. In making this selection, the following factors should be considered: mechanism of action, adverse effect profile, dosing schedule, monitoring parameters, potential drug interactions, and cost. Following the agent selection, objective interchange guidelines will be established and will be reviewed with other members of the medical staff.

The P&T Committee will review these guidelines. Following approval by P&T, the Medical Executive Committee of the institution will review and approve. Once approved the medications within "Non-Form" section will become non-formulary.

Medications with a DAW or dispense as written designation will be reviewed through the non-formulary process.

If patient has documented allergy to therapeutic substitute, the substitute will not take place.

DEFINITIONS:

1. Therapeutic Substitutions- Is the replacement of the originally prescribed drug with an alternative molecule with assumed equivalent therapeutic effect. The alternative drug may be within the same class or from another class with assumed therapeutic equivalence.

2. Biosimilar- FDA approved medication that is highly similar to the reference product. For approval, the structure and function of an approved biosimilar were compared to reference product and shown to have no clinically meaningful differences in safety, purity, or potency (safety and effectiveness) compared to the reference product.

Appendix A: Proton Pump Inhibitor:

Pantoprazole (Protonix®) will be the preferred (medication substituted to) proton pump inhibitor at Sierra View Medical Center. Lansoprazole (Prevacid®) 30mg Solutabs may be used if PPI needed to be delivered via G-tube. Orders written for oral dexlansoprazole (Dexilant®), esomeprazole (Nexium®), lansoprazole (Prevacid®), omeprazole (Prilosec®) or rabeprazole (Aciphex®) are autosubstituetd by Pharmacy per the table below.

Preferred Agent					
Pantoprazole (Protonix®)	**Omeprazole (Prilosec®)**	**Esomeprazole (Nexium®)**	**Rabeprazole (Aciphex®)**	**Lansoprazole (Prevacid®)**	**Dexlansoprazole (Dexilant®)**
20mg daily	10mg daily	20mg daily	20mg daily	15mg daily	30mg daily
40mg daily	20mg daily	20mg daily	20mg daily	30mg daily	60mg daily
40mg BID	20mg bid or 40mg daily	40mg daily	20mg BID	30mg BID	30mg BID
80mg BID	40mg bid	80mg daily	40mg BID	60mg BID	60mg BID

Note: In the event of a drug shortage for Pantoprazole; Esomeprazole will be the substitute agent.

Appendix B: Nasal Corticosteroid Products

Substitutive Agent-Therapeutic Interchange	Non-Form
Fluticasone Nasal 1 spray each nostril daily	Beclomethasone Nasal, 1-2 spray each nostril BID
Fluticasone Nasal 1 spray each nostril daily	Budesonide Nasal, 1-2 spray each nostril BID
Fluticasone Nasal 1 spray each nostril daily	Flunisolide Nasal, 2 sprays each nostril BID
Fluticasone Nasal 1 spray each nostril daily	Mometasone Nasal, 2 sprays each nostril daily
Fluticasone Nasal 2 spray each nostril daily	Triamcinolone Nasal, 2 sprays each nostril daily

Note: In the event of a drug shortage for Fluticasone nasal, Triamcinolone Nasal is the substitute agent.

Appendix C: Inhaled Combination Medication Therapeutic Interchange

Substitutive Agent- Therapeutic Interchange	Non-Form
Fluticasone/Salmetrol (Advair) 100/50 mcg 1 puff BID 250/50 mcg 1 puff BID	Budesonide/Formoterol (Symbicort) 80/4.5 mcg 2 puffs BID 160/4.5 mcg 2 puffs BID
Fluticasone/Salmetrol (Advair) 100/50 mcg 1 puff BID 250/50 mcg 1 puff BID 500/50 mcg 1 puff BID	Fluticasone/Salmeterol(Advair HFA) 45/21 mcg 2 puffs BID 115/21 mcg 2 puffs BID 230/21 mcg 2 puffs BID
Fluticasone/Salmetrol (Advair) 100/50 mcg 1 puff BID 250/50 mcg 1 puff BID	Fluticasone/Vilanterol (Breo) 100/25 mcg daily 200/25 mcg daily
Albuterol MDI same dose and frequency plus Tiotropium (Spiriva Respimat) 2 INH daily	Ipratropium/Albuterol (Combivent)
Fluticasone/Salmeterol (Advair) 250/50 mcg 1 puff BID 250/50 mcg 1 puff BID	Mometasone/Formoterol (Dulera) 100/5 mcg 2 puffs BID 200/5 mcg 2 puffs BID
Tiotropium (Spiriva Respimat) 2 inhalations (2.5mcg) daily	Tiotropoium (Spiriva Handihaler) Inhale contents of one capsule daily

Appendix D: Insulin Therapeutic Interchange

Substitutive Agent- Therapeutic Interchange	Non-Form
Insulin Lispro (Humalog) 1:1 conversion	Insulin Aspart (Novolog)
Insulin glargine 1:1 conversion	Insulin degludec (Tresiba)
Insulin glargine 1:1 conversion	Insulin detemir (Levemir)

Note biosimilar's for substitutive therapeutic interchange may be used.

Appendix E: Antihistamine agents

Substitutive Agent- Therapeutic Interchange	Non-Form
Loratadine (Claritin) 10mg daily	Cetirizine (Zyrtec) Oral 5mg or 10mg daily
Loratadine (Claritin) 10mg daily plus Equivalent Pseudoephedrine up to 60mg po QID	Cetirizine/Pseudoephedrine (Zyrtec-D) All doses
Loratadine (Claritin) 10mg daily	Desloratidine (Clarinex) Oral 5mg daily
Loratadine (Claritin) 10mg daily	Fexofenadine (Allegra) Oral all doses
Loratadine (Claritin) 10mg daily Equivalent Pseudoephedrine up to 60mg po QID	Fexofenadine/Pseudoephedrine (Allegra-D) All doses
Loratadine (Claritin) 10mg daily	Levocetirizine (Xyxal) Oral 2.5 to 5mg daily
Loratadine (Claritin) 10mg daily Equivalent Pseudoephedrine up to 60mg po QID	Loratidine/Pseduoephedrine (Claritin D)

Appendix F: HMG CoA Reductase Inhibitors

Substitutive Agent- Therapeutic Interchange	Non-Form
Atorvastatin (Lipitor) 5mg daily 10mg daily	Fluvastatin (Lescol) 40mg daily 80mg daily
Atorvastatin (Lipitor) 5mg daily 10mg daily 20mg daily	Lovastatin (Mevacor) 20mg daily 40mg daily 80mg daily
Atorvastatin (Lipitor) 20mg daily 40mg daily 80mg daily 80mg daily	Rosuvastatin (Crestor) 5mg daily 10mg daily 20mg daily 40mg daily
Atorvastatin (Lipitor) 5mg daily 10mg daily 20mg daily	Simvastatin (Zocor) 10mg daily 20mg daily 40mg daily
Atorvastatin (Lipitor) 5mg daily 10mg daily 20mg daily	Pitavastatin 1mg daily 2mg daily 4 mg daily

Note: In the event of a drug shortage for Atorvastatin, Rosuvastatin will be the substitute agent.

Hepatic impairment prior to treatment initiation:

Child-Turcotte-Pugh Class A: No dosage adjustment necessary

Child-Turcotte-Pugh class B: Initial 20mg once daily; maximum recommended dose 20mg/day

Child-Turcotte-Pugh class C: Convert patient to rosuvastatin per table.

Appendix G: Angiotensin II Receptor Blocker

Substitutive Agent- Therapeutic Interchange	Non-Form
Losartan 25mg 50mg 100mg 150mg	Telmisartan (Micardis) 20mg 40mg 80mg >80mg
Losartan 25mg 50mg 100mg 150mg	Olmesartan (Benicar) 5-10mg ----- 20mg 40mg
Losartan 25mg 50mg 100mg 150mg	Irbesartan (Avapro) 75mg 150mg 300mg ---
Losartan 25mg 50mg 100mg 150mg	Candesartan (Atacand) 4-8mg --- 16mg 32mg
Losartan 25mg 50mg 100mg 150mg	Azilsartan (Edarbi) 40mg 80mg --- ---
Losartan 25mg 50mg 100mg 150mg	Eprosartan (tevetan) 400mg 600mg 800mg ---

Appendix H: Angiotensin Converting Enzyme (ACE)

Substitutive Agent- Therapeutic Interchange Equivalent Daily Dosage	Non-Form
Lisinopril 10mg (Max 40mg)	Benazepril 10mg
Lisinopril 10mg (Max 40mg)	Enalapril 5mg
Lisinopril 10mg (Max 40mg)	Fosinopril 10mg
Lisinopril 10mg (Max 40mg)	Moexipril 7.5mg
Lisinopril 10mg (Max 40mg)	Perindopril 4mg
Lisinopril 10mg (Max 40mg)	Quinapril 10mg
Lisinopril 10mg (Max 40mg)	Ramipril 2.5mg
Lisinopril 10mg (Max 40mg)	Trandolapril 2mg

Appendix I: Biosimilar Medications

Note- Preferred agents should be utilized for inpatient and outpatient use. If a patient's payer requires use of a non-preferred agent, the non-preferred biosimilar may be used.

Therapeutic Interchange (Preferred agent)	Reference Product	Comments
Alymsys (Bevacizumab- maly)	Avastin (Bevacizumab)	As required by payor
Ogivri (trastuzumab-dkst) Kanjinti (Trastuzumab-anns)	Herceptin (Trastuzumab)	As required by payor
Stimufend (pegfilgrastim-fpgk)	Pegfilgrastim (Neulasta)	As insurance allows Pegfilgrastim biosimilar and products is NON-FORMULARY for inpatients. Filgrastim should be used for inpatients
Releuko (Filgrastim-ayow)- preferred Zarxio (Filgrastim-sndz)	Neupogen (Filgrastim)	As required by payor
Renflexis (infliximab-abda)- preferred Inflectra (infliximab-dyyb)	Remicade (Infliximab)	As required by payor
Retacrit- epoetin alpa-epbx	Procrit/Epogen- epoetin alpha	
Truxima (rituximab-abbs)- preferred Riabni (rituximan-arrx)	Rituxan-rituximab	As required by payor

Cancer Treatment Center Procedure:

If it is discovered that a patient's insurance rejects said biosimilar as part of the patient's treatment, the patient's care plan will be adjusted by the CTC pharmacist to reflect the approved agent. Example: Mvasi is rejected but insurance will cover Avastin→Pharmacist will be allowed by physician to make the adjustment in the patient's care plan.

1. Upon receipt of new care plan, CTC pharmacist will confirm with said list and if necessary, adjust the medication within the care plan to reflect the current approved medication from Addendum A if necessary to conform to insurance authorized and physician requested care plan.

2. After pharmacist adjustment in care plan, they will forward to insurance authorizer for approval. Once approved, Pharmacy will order as needed.

Dose Rounding for Continuous Infusion of Oncology Medications

1. Upon receipt of new orders for chemotherapy or biotherapy, the pharmacist will verify all calculations for dosage of agents ordered by the MD.
2. The pharmacist will evaluate the availability of the medications ordered. If the medication is available as a single use vial, the pharmacist shall calculate the difference in the dose ordered and the dose rounded to vial size.
3. For all single use vials of chemotherapy the pharmacist shall round the dose to a vial size within a 10% range of the dose ordered.
4. For all single use vials of monoclonal agents, the pharmacist shall round the dose to vial size within a 10% range of the dose ordered.
5. The provider will not be notified for dose changes of up to 5% for either chemotherapy or monoclonal agents.
6. The provider will be notified for dose changes greater than 5% and up to 10% for either chemotherapy or monoclonal agents.
7. Patients enrolled in clinical trials are excluded from the policy (unless dose rounding is specifically allowed in the investigational protocol)
8. If the physician does not wish to have the rounding policy applied, they will document on the order "no dose rounding" within the treatment plan within the administration instructions section.

Duplicate Orders

- Pharmacists may delete duplicate orders of the same medication, dose, and route with varying schedules. It will be assumed the new order with updated schedule is intended to replace the previous order (update frequency, dose, etc). E.g. Acetaminophen 650mg PO Q4HRS prn pain and Acetaminophen 650mg po Q6hrs prn pain. Pharmacist can authorize to delete the old order, and verify the new order while adding additional comments not to exceed 4gm/day as they see necessary.

Interchange between liquid and solid dosage forms

Pharmacists may automatically interchange between liquid and solid forms and route. EG patient is receiving medication and/or feedings via NG,OG,PEG; Pharmacist after discussion with patient's nurse will switch from oral to liquid form if available. Exception-Phenytoin with consult to patient practioner.

Therapeutic Duplications

Duplicate orders for the same indication are only appropriate if clear instructions around the circumstances each order applies to are indicated by the ordering practitioner. Any duplicative order without clear distinction will be assessed and addressed by the reviewing pharmacist.

Any parenteral (IV, IM, SQ) or rectal (PR) medication ordered as needed (PRN), will have direction added by pharmacist to "use when unable to tolerate oral" if another order for an oral alternative is ordered for the same as needed indication.

> Example: Order written for Ondansetron 4mg IV q8h prn Nausea/vomiting with an existing Ondansetron 4mg PO q8h prn Nausea/vomiting. Pharmacist to clarify in the comment field of the IV order: Ondansetron 4mg IV q8h prn Nausea/vomiting, use when unable to tolerate oral

> Example: Order written for Oxycodone 5mg PO q4h prn pain scale 4-7 with an existing Hydromorphone 0.4mg IV q4h prn pain scale 4-7. Pharmacist to clarify in the comment field: Hydromorphone 0.4mg IV q4h prn pain scale 4-7, use when unable to tolerate oral

Any order for a parenteral (IV, IM, SQ) as needed (i.e., PRN) opioid will be discontinued when a subsequent order for a parenteral PRN opioid is placed unless there is clear criteria included on the order for when to administer one opioid over the other (e.g. breakthrough pain).

> Example: Order written for HYDROmorphone (Dilaudid®) 0.5 mg IV q4h PRN pain 8-10 ordered on a patient with an existing order for Morphine 2 mg IV q4h PRN pain 8-10. Pharmacist will discontinue the existing Morphine order and validated the new HYDROmorphone (Dilaudid®) order.

Any order for a short-acting PRN oral opioid will be discontinued when a subsequent order for a short-acting oral PRN opioid is placed unless there is clear criteria included on the order for when to administer one opioid over the other (e.g. Breakthrough pain).

> Example: Order written for Oxycodone Immediate Release (IR) 5 mg PO q4h prn pain 8-10 ordered on a patient with an existing order for Tramadol (Ultram) 50 mg PO q4h prn pain 8-10. Pharmacist will discontinue the existing Tramadol order and validate the new Oxycodone order.

Any orders for parenteral or oral as needed (i.e. PRN) opioids will discontinued when a subsequent order for a PCA or epidural is placed unless a clear indication that both can be administered concurrently via an order clarified with the provider.

Any orders for parenteral or oral as needed (i.e. PRN) opioids will be left unvalidated if ordered at the same time as a PCA or epidural unless a clear indication that both can be administered concurrently via an order clarified with the provider. Upon PCA or epidural discontinuation, parenteral or oral as needed opioids will be validated.

Any orders with overlapping pain scales ordered at the same time will be clarified that the higher dose of medication is clarified to the higher pain scale as long as no medication is indicated for that pain scale.

> Example: Orders written for Oxycodone Immediate Release 2.5mg PO q4h prn pain 4-7 and Oxycodone Immediate Release 5mg PO q4h prn pain 4-7. Pharmacist will adjust the Oxycodone Immediate Release 5mg PO q4hr prn pain 4-7 to a pain scale of 8-10 upon validation.

Any orders with pain scales of 1-3 or 4-7 and no order or information that include the higher pain scales will be clarified to include the higher pain scale as long as no medication is indicated for that pain scale.

> Example: Order written for Tramadol 50mg PO q4hr prn pain 4-7. Pharmacist will adjust the Tramadol 50mg PO q4hr prn pain 4-7 to a pain scale of 4-10 upon validation.

Appendix: IV to PO Subsection

PURPOSE: To provide a process for changing parenteral medications to the oral/enteral route when medically appropriate. The advantages of this program are to provide an oral/enteral dosage form with comparable bioavailability to the intravenous form, which has been shown to decrease length of hospitalization.

To reduce the added risks associated with continued intravenous therapy.
To lower overall medication and associated costs to the patient and the hospital.

Additional benefits include greater patient comfort, decreased nursing needs, & easier ambulation. Orders for approved intravenous (IV) medications are automatically changed to PO (by mouth) administration form when medical staff approved conditions and guidelines are met, and the switch is appropriate.

PROCEDURE: Patients must meet the following criteria in order to be considered for automatic IV to PO conversion of the selected medications. If the patient does not meet all criteria listed below, they will not be considered for automatic IV to PO conversion.

Inclusion Criteria

- The patient must be on IV therapy for at least 24 hours before IV to PO conversion consideration.
- The patient is tolerating scheduled medications and diet (orally, or via NG or G tube).

- The patient is not on a pre-operative or -procedure or post-operative or -procedure fast.
- The patient has not experienced any recurrent nausea, vomiting or diarrhea for at least 24 hours.
- The patient does not have documented esophophageal sphincter incompetence.
- The patient does not have an active gastrointestinal bleed.
- The patient does not have documented problems with oral absorption (i.e., ileus, short bowel syndrome, celiac sprue, and inflammatory bowel disease or malabsorption syndrome).
- The patient is not at risk for aspiration (e.g., decreased consciousness, seizures, etc.).

Additional criteria for antibiotic/antifungal agents

- The patient is afebrile for at least 24 hours (temp < 100.4° F).
- The patient is clinically improving (white blood cell count decreasing, bands decreasing, improved signs and symptoms as documented in prescriber progress notes).
- The infection is at a site where an oral agent will achieve an adequate level (not endocarditis, meningitis, brain abscess, orbital cellulitis, other CNS infections, osteomyelitis, and endophthalmitis).
- The patient is not septic, and is hemodynamically stable (heart rate ≤ 100 beats/minute, respiratory rate ≤ 24 breaths/minute, and systolic blood pressure > 90 mm Hg without vasopressor support).
- For documented fungemia, fluconazole will continue IV for 7 days before PO switch.

The pharmacist may automatically switch the following medications to the oral dosage form, if the conditions under section 1 of this policy are met:

Antimicrobials

Medication	Intravenous Dose	Oral Equivalent
Azithromycin	250 mg IV daily 500 mg IV daily	250 mg PO daily 500 mg PO daily
Ciprofloxacin	200 mg IV every 12 hours 400 mg IV every 12 hours 400 mg IV every 8 hours	250 mg PO every 12 hours 500 mg PO every 12 hour 750 mg PO every 12 hours
Clindamycin	600mg-900mg IV every 8 hours	300mg-450 mg PO every 8 hours
Doxycycline	100 mg IV every 12 hours	100 mg PO every 12 hours
Levofloxacin	250 mg IV daily 500 mg IV daily 750 mg IV daily	250 mg PO daily 500 mg PO daily 750 mg PO daily
Fluconazole	100 mg IV daily 200 mg IV daily 400 mg IV daily	100 mg PO daily 200 mg PO daily 400 mg PO daily
Linezolid	600 mg IV every 12 hour	600 mg PO every 12 hours
Metronidazole	500 mg IV every 8 hours	500 mg PO every 8 hours
Rifampin	600 mg IV daily	600 mg PO daily
Trimethoprim / Sulfamethoxazole (TMP/SMX)	5-20 mg TMP/kg/day in 3-4 divided doses IV	As close to 1:1 conversion of TMP as possible: 1 double strength = 160 mg TMP 1 single strength = 80 mg TMP
Voriconazole	3-4 mg/kg IV every 12 hours (maintenance dose)	<40 kg: 100 mg PO every 12 hours ≥40 kg: 200 mg PO every 12 hours

Others

Medication	Intravenous Dose	Oral Equivalent
Acetaminophen IV	IV to PO is equivalent	Same dose regimen and frequency. May need to adjust in multiples of

(Ofirmev) (restricted only for those with strict NPO)		325mg. IV acetaminophen doses limited to 2 doses for PRN orders and 4 doses for scheduled orders.
Famotidine	20 mg IV every 12 hrs.	20 mg PO every 12 hours
Ranitidine	50 mg IV every 6 or 8 hrs.	150 mg PO every 12 hours
Pantoprazole	40 mg IV daily	40 mg PO daily (lansoprazole 30mg NG daily)
Folic Acid	1mg IV daily	1mg PO daily
Levetiracetam	500 mg IV every 12 hours	500 mg PO every 12 hours
Metoclopramide	10 mg IV every 6 hours PRN	10 mg PO Q6H every 6 hours PRN
Thiamine	100 mg IV daily	100 mg PO daily
Multivitamin	10 ml IV daily	1 tablet PO daily

The pharmacist will review the criteria and effect the change when appropriate. He/She will enter an order in the patient's chart under "Physician Orders" as "Change I.V. (*insert drug name*) to P.O. per protocol". The notation "Per SVMC Policy" will be entered or written adjacent to the pharmacist's signature.

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SUBJECT: **UTILIZATION REVIEW PLAN**	SECTION:

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

PURPOSE:

The Utilization Review Plan provides an organized, collaborative, system-wide approach to resource management while maintaining quality of services and adhering to professionally recognized standards. The major principles outlined in the plan are to ensure that the hospital provides medically necessary,services at the appropriate level of care while optimizing quality outcomes and financial performance. The plan describes methods for conducting reviews of the appropriateness and medical necessity of admissions, continued stays and supportive services while providing for a continuum of care services and discharge planning. Open communication and on-going education on appropriate utilization practices are key components of the plan.

POLICY:

Authority and Responsibility

The Board of Directors has the ultimate authority and responsibility to require and support the utilization review program at Sierra View Medical Center (SVMC). The Board of Directors has delegated the responsibility of implementing an organization-wide utilization review program to Administration, the Medical Staff, and the Utilization Review Committee.

Administration:

Administration of this plan is the responsibility of the Director of Health Information Management in collaboration with SVMC's Utilization Review Committee. The Utilization Review Committee is a standing committee established by the Medical Staff in accordance with the Bylaws, Rules, and Regulations of the Medical Staff of Sierra View Medical Center.

Meeting & Reporting:

The Utilization Review Committee shall meet as often as necessary at the call of its chair, but at least on a quarterly basis. It shall maintain a record of its findings, proceedings, and actions, and shall report its activities and recommendations to the Medical Executive Committee.

Additionally, pertinent information sharing and reporting is facilitated through Sierra View Medical Center's Medical Staff for communication and/or actions as appropriate beyond the scope of this plan and/or committee.

Membership:

- The Utilization Review Committee shall consist of sufficient members to afford fair representation and be in compliance with Centers for Medicare & Medicaid Services Conditions of Participation, Subpart C, §482.30, and appropriate clinical and administrative support staff as deemed beneficial by the committee.

- The Utilization Review Committee will also act as the oversight committee for the duties and responsibilities of medical records review functions.

- No member of the committee may be involved in the review of a case in which he/she has a direct financial interest or was professionally involved in the care of the patient.

Sierra View Medical Center has entered into an agreement with secondary physician vendors who will act as Physician Advisors or designees. They are members of the Utilization Review Committee without voting abilities.

AFFECTED AREAS/PERSONEL: *UTILIZATION MANAGEMENT, CARE INTEGRATION, HEALTH INFORMATION MANAGEMENT, ADMINISTRATION AND MEDICAL STAFF*

PROCEDURE:

Duties:

The duties of the Utilization Review Committee or designee shall include:

- Conducting utilization review studies designed to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices, use of medical and hospital services and related factors which may contribute to the effective utilization of services. The committee shall communicate the results of its studies and other pertinent data to the Medical Executive Committee and shall make recommendations for the utilization of resources and facilities commensurate with quality patient care and safety.

- Establish a utilization review plan which shall be approved by the Medical Executive Committee.

- Obtaining, reviewing, and evaluating information and raw statistical data obtained or generated by the hospital's utilization management department.

- Evaluating the medical necessity of admissions. Determining if continued hospital services and professional services furnished for patients were appropriate. Ensuring that; (i) the attending physician is consulted and afforded an opportunity to present his/her views(ii) The availability of hospital facilities and services is considered prior to any decision that an admission or further inpatient stay is not medically necessary; (iii) a determination that admission or continued stay is not medically necessary is made by at least two physician members if the responsible practitioner does not concur with the determination or fails to present his/her view; and (iv) written notice of any decision that further inpatient care is not medically necessary is given within two (2) days following that determination. Reviews may not be conducted by a practitioner who has a direct financial interest in the hospital, and no practitioner shall have review responsibility for any case in which he or she was professionally involved.

Health Information Management (Medical Records) duties to include:

- Review of medical records to ensure that they are accurate, clinically pertinent, complete and readily available for continuing patient care and medico-legal requirements.

- Ensure the medical staff completes all the medical records of patients under their care in a timeframe consistent with state and federal regulations. The delinquency rate will be reviewed and reported to the committee quarterly.

-

Review:

Wherever possible, the utilization review criteria and guidelines used will have evidence-based development including input from recognized medical experts and which are applied to a broad number of members.

The guidelines used may include, but are not limited to:

- InterQual Level of Care - Adult Care
- InterQual Level of Care - Pediatric Care
- MCG-Milliman Care Guidelines- Adult and/or Pediatric
- CMS/Medicare coverage guidelines

Utilization review criteria are utilized as a screening guide and are not intended to be a substitute for physician judgment.

Utilization reviews will include appropriate:

- Admission to the organization
- Concurrent review
- Services furnished, including drugs and biologicals
- Discharge Planning

Utilization review decisions are made in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm as stated in the screening criteria.

When there is disagreement between published guidelines or clinical criteria and the physician of record, the Physician Advisors will be contacted for resolution. In turn, the Physician Advisors may use the organization's Utilization Review Committee as an additional resource.

Before making any determination that an admission or continued stay is not medically necessary, the Utilization Review (UR) Committee or designee will consult the practitioner(s) responsible for the care of the patient and afford the practitioner(s) the opportunity to present their views.

The Utilization Review Committee has deemed the organization's utilization review team responsible for day-to-day implementation, management, monitoring and reporting on the organization's Utilization Review Plan (reviews as outlined above):

1. The organization will follow the general model:
    a. The utilization review activities will be evidence-based
    b. Utilization Review will be conducted by the UR team, which include RN's and LVN's.
    c. Social Services will be responsible for discharge planning

The Utilization Review Committee will also review all cases reasonably assumed to be outlier cases secondary to extended stays, utilization or resources and/or other factors.

As part of the review process, each record reviewed will include all necessary information needed to facilitate the utilization review. This information will include, at minimum, all appropriate items identified under §456.111

Records & Reports:

The Utilization Review Committee will record actions and meeting business through regular minutes. Minutes will be reviewed and approved as part of the business function of the Utilization Review Committee.

Confidentiality:

All identifiers of individual recipients in all UR records and reports will be kept confidential.

Adverse Decisions:

The Utilization Review Committee will provide written notice of any adverse final decisions on the need for admission [as specified under §456.123 (e) through (g)]. An adverse decision shall be considered any decision where the UR Committee overrides the decision of the Admitting or Attending physician. In such cases, notice shall be sent to:

1. The hospital designated executive authority

2. The admitting or attending physician
3. The Medi-Cal agency (as appropriate)
4. The recipient of care
5. If possible – the next of kin or sponsor to the recipient of care

Any such notifications will be made timely and in accord with §456.126.

Focus Review:

As part of the Utilization Review Committee's regular activities, the committee will identify areas for focused, ongoing review. The focus areas will be incorporated into the Utilization Review Plan. Review of the below areas, but not limited to will occur as part of the regular Utilization Review Committee business.

- Length of Stay
- Avoidable Days
- Appeal Outcomes
- Observation (including # converted to IP, Average LOS (hours), number exceeding 48 hours
- Readmission review
-

Plan Review:

The UR Plan will be reviewed annually to determine whether the plan reflects the UR program needs and objectives. Revisions will be made as necessary.

REFERENCES:

- The Joint Commission (2020). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Centers for Medicare & Medicaid Services, Utilization Control, Subchapter C, §456.50-456.145.
- Centers for Medicare & Medicaid Services Conditions of Participation, Subpart C, §482.30.
- California Code of Regulations, Title 22, Article 7 §70703.

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MINUTES OF A REGULAR MEETING OF THE BOARD OF DIRECTORS OF SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The monthly meeting of the Board of Directors of Sierra View Local Health Care District was held **July 23, 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, PANDYA**

Others Present: Donna Hefner, President/Chief Executive Officer, Jeffery Hudson, VPPCS/CNO/DIO, Tracy Canales, VP of Human Resources, Craig McDonald, Chief Financial Officer, Melissa Mitchell, VP Quality and Regulatory Affairs, Ron Wheaton, VP of Professional Services/Physician Recruitment, Terry Villareal, Executive Assistant and Clerk to the Board, Malynda Parsons, Senior Marketing and Community Relations Specialist, 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 Vice Chairman LOMELI, seconded by, Director KASHYAP and carried to approve the agenda. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:03 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

C. Pursuant to Gov. Code Section 54957(b); Health and Safety Code Section 32106(b): Discussion Regarding Confidential Personnel Matter; Pursuant to Gov. Code Section 54957(b) and Gov. Code Section 54962; Health and Safety Code

Section 32106(b): Discussion Regarding Confidential Personnel Matter as it pertains to Trade Secrets and Services. Estimated Date of Disclosure, for non-confidential personnel records – August, 2027

Closed Session Items D, E and F were deferred to the conclusion of Open Session as there was not enough time for discussion prior to Open Session.

III. Open Session: Chairman REDDY adjourned Closed Session at 5:35 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 via Zoom Call. Information only; no action taken.

B. Pursuant to Evidence Code Section 1156 and 1157.7:

1. Evaluation – the Quality of Care/Peer Review

Following review and discussion, it was moved by Director PANDYA, seconded by Vice Chairman LOMELI, and carried to approve the Quality of Care/Peer Review as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Abstain

2. Quality Division Report – Quality Repot

Following review and discussion, it was moved by Director PANDYA, seconded by Vice Chairman LOMELI, and carried to approve the Quality Report as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

C. Discussion Regarding Trade Secrets and Confidential Personnel Matter
Recommended Action: Information Only: No Action Taken

IV. Public Comments

No Public Comments

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 Director MARTINEZ, seconded by, Vice Chairman LOMELI and carried to approve the Consent Agenda as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

VI. Approval of Minutes:

A. Following review and discussion, it was moved by Director MARTINEZ and seconded by Vice Chairman LOMELI to approve the June 25, 2024 Regular Board Meeting Minutes as presented. The motion carried and the vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

VII. Business Items

A. June 2024 Financials

Craig McDonald, CFO presented the Financials for June 2024. A copy of this presentation is attached to the file copy of these minutes.

Following review and discussion, it was moved by Director PANDYA, seconded by Vice Chairman LOMELI and carried to approve the June 2024 Financials as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
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 – August 27, 2024 at 5:00 p.m.
B. Special Board of Directors Meeting - August 10, 2024 at 7:00 a.m.
C. November 5th General Election Nomination Period is Open from

X. Closed Session: Board adjourned Open Session at 5:54 p.m., reconvening in Closed Session at 6:00 p.m. to discuss the following items.

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Professional Services (2 Items). Estimated Date of Disclosure for Item One October, 2024. Estimated date of Disclosure for Item 2, August 2026.

Chairman Reddy exited the Board Room at 6:19 p.m., prior to discussion of the second professional service item in Closed Session Item D, due to a conflict of interest.

Chairman Reddy returned to the Board Room at 6:34 p.m. to continue with Closed Session Item E.

E. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning Estimated Date of Disclosure August, 2027

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 (2 Items).

XI. Open Session: Chairman REDDY adjourned Closed Session at 7:04 p.m., reconvening in Open Session at 7:04 p.m.

Pursuant to Gov. Code Section 54957.1; Action(s) taken as a result of discussion(s) in Closed Session.

D. Discussion Regarding Trade Secrets Pertaining to Professional Service
Information Only: No Action Taken

E. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning
Information Only: No Action Taken

F. Discussion Regarding Confidential Personnel Matter
Information Only: No Action Taken

XII. Adjournment

The meeting was adjourned at 7:05 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: tv

MINUTES OF A SPECIAL MEETING OF THE
BOARD OF DIRECTORS OF
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The special meeting of the Board of Directors of Sierra View Local Health Care District was held **August 10, 2024 at 7:00 A.M.** in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California.

Directors Present: **REDDY, LOMELI, MARTINEZ, KASHYAP and PANDYA**

Others Present: Donna Hefner, President and CEO
Tracy Canales, VP of Human Resources and Marketing
Jeff Hudson, VP of Patient Care Services and CNE
Craig McDonald, VP and CFO
Melissa Mitchell, VP of Quality and Regulatory Affairs
Ron Wheaton, VP Physician Recruitment & Professional Services
Terry Villareal, Executive Assistant and Clerk to Board of Directors
Barbra Riegel, CEO, Strategic HealthCare Advisors

I. Call to Order: Chairman REDDY called the meeting to order at 7:25 a.m.

II. Approval of Agendas: Director Reddy asked for approval of the agenda. It was moved by Director PANDYA and seconded by Director MARTINEZ, and carried to approve the agenda as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Absent
MARTINEZ	Yes
KASHYAP	Yes
PANDYA	Yes

III. Public Comments
No Comments were made

IV. Closed Session: Board adjourned Open Session and went into Closed Session at 7:26 a.m. to discuss the following items:

A. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secret, Pertaining to Service and Strategic Planning (1 Item). Estimated Date of Disclosure - June 2029

Vice Chairman Lomeli arrived to the meeting at 7:57 a.m.

V. Open Session: Board adjourned Closed Session at 1:43 p.m. and went into Open Session at 1:43 p.m. to discuss the following items:

A. Discussion Regarding Trade Secret, Pertaining to Service and Strategic Planning
Information only; no action taken.

VI. Announcements:

A. Regular Board of Directors Meeting – August 27, 2024

VII. Adjournment: Director Reddy called for adjournment of the meeting. It was moved by Vice Chairman LOMELI and seconded by Director MARTINEZ, and carried to adjourn the meeting. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
KASHYAP	Yes
PANDYA	Yes

The meeting was adjourned at 1:45 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors
AM: tv

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FINANCIAL PACKAGE
July 2024

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

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Balance Sheet	3-4
Income Statement	5
Statement of Cash Flows	6
Monthly Cash Receipts	7

Sierra View Medical Center
Financial Statistics Summary Report
July 2024

	Jul-24				YTD					Increase/	
Statistic	Actual	Budget	Over/ (Under)	% Var.	Actual	Budget	Over/ (Under)	% Var.	Fiscal 24 YTD	(Decrease) Jul-23	% Change
Utilization											
SNF Patient Days											
Total	31	56	(25)	-44.9%	31	56	(25)	-44.9%	101	(70)	-69.3%
Medi-Cal	31	56	(25)	-44.6%	31	56	(25)	-44.6%	101	(70)	-69.3%
Sub-Acute Patient Days											
Total	1,047	970	77	8.0%	1,047	970	77	8.0%	950	97	10.2%
Medi-Cal	557	823	(266)	-32.3%	557	823	(266)	-32.3%	806	(249)	-30.9%
Acute Patient Days	1,559	1,648	(89)	-5.4%	1,559	1,648	(89)	-5.4%	1,678	(119)	-7.1%
Acute Discharges	429	427	2	0.5%	429	427	2	0.5%	439	(10)	-2.3%
Medicare	170	159	11	6.6%	170	159	11	6.6%	164	6	3.7%
Medi-Cal	191	210	(19)	-9.1%	191	210	(19)	-9.1%	216	(25)	-11.6%
Contract	62	56	6	9.9%	62	56	6	9.9%	58	4	6.9%
Other	6	1	5	517.1%	6	1	5	517.1%	1	5	500.0%
Average Length of Stay	3.63	3.86	(0.23)	-5.9%	3.63	3.86	(0.23)	-5.9%	3.82	(0.19)	-4.9%
Newborn Patient Days											
Medi-Cal	147	157	(10)	-6.2%	147	157	(10)	-6.2%	176	(29)	-16.5%
Other	34	36	(2)	-4.4%	34	36	(2)	-4.4%	38	(4)	-10.5%
Total	181	192	(11)	-5.9%	181	192	(11)	-5.9%	214	(33)	-15.4%
Total Deliveries	92	99	(7)	-7.1%	92	99	(7)	-7.1%	121	(29)	-24.0%
Medi-Cal %	83.70%	83.43%	0.26%	0.3%	83.70%	83.43%	0.26%	0.3%	79.34%	4.36%	5.5%
Case Mix Index											
Medicare	1.6067	1.6368	(0.0301)	-1.8%	1.6067	1.6368	(0.0301)	-1.8%	1.5477	0.0590	3.8%
Medi-Cal	1.2171	1.1975	0.0196	1.6%	1.2171	1.1975	0.0196	1.6%	1.0834	0.1337	12.3%
Overall	1.4048	1.3724	0.0324	2.4%	1.4048	1.3724	0.0324	2.4%	1.2909	0.1139	8.8%
Ancillary Services											
Inpatient											
Surgery Minutes	6,345	8,224	(1,879)	-22.8%	6,345	8,224	(1,879)	-22.8%	7,903	(1,558)	-19.7%
Surgery Cases	77	94	(17)	-17.9%	77	94	(17)	-17.9%	88	(11)	-12.5%
Imaging Procedures	1,515	1,404	111	7.9%	1,515	1,404	111	7.9%	1,340	175	13.1%
Outpatient											
Surgery Minutes	13,600	12,775	825	6.5%	13,600	12,775	825	6.5%	14,095	(495)	-3.5%
Surgery Cases	169	204	(35)	-17.1%	169	204	(35)	-17.1%	194	(25)	-12.9%
Endoscopy Procedures	209	192	18	9.1%	209	192	18	9.1%	195	14	7.2%
Imaging Procedures	3,504	3,886	(382)	-9.8%	3,504	3,886	(382)	-9.8%	3,588	(84)	-2.3%
MRI Procedures	268	302	(34)	-11.2%	268	302	(34)	-11.2%	319	(51)	-16.0%
CT Procedures	1,248	1,237	11	0.9%	1,248	1,237	11	0.9%	1,287	(39)	-3.0%
Ultrasound Procedures	1,361	1,244	117	9.4%	1,361	1,244	117	9.4%	1,263	98	7.8%
Lab Tests	32,923	32,140	783	2.4%	32,923	32,140	783	2.4%	31,964	959	3.0%
Dialysis	-	6	(6)	-100.0%	-	6	(6)	-100.0%	3	(3)	-100.0%

Sierra View Medical Center
Financial Statistics Summary Report
July 2024

Statistic	Jul-24 Actual	Jul-24 Budget	Jul-24 Over/ (Under)	Jul-24 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 24 YTD	Increase/ (Decrease) Jul-23	% Change
Cancer Treatment Center											
Chemo Treatments	2,419	1,924	495	25.7%	2,419	1,924	495	25.7%	1,176	1,243	105.7%
Radiation Treatments	2,432	1,836	596	32.5%	2,432	1,836	596	32.5%	2,088	344	16.5%
Cardiac Cath Lab											
Cath Lab IP Procedures	10	11	(1)	-11.1%	10	11	(1)	-11.1%	14	(4)	-28.6%
Cath Lab OP Procedures	26	30	(4)	-13.1%	26	30	(4)	-13.1%	32	(6)	-18.8%
Total Cardiac Cath Lab	36	41	(5)	-12.6%	36	41	(5)	-12.6%	46	(10)	-21.7%
Outpatient Visits											
Emergency	3,371	3,415	(44)	-1.3%	3,371	3,415	(44)	-1.3%	3,278	93	2.8%
Total Outpatient	13,844	13,994	(150)	-1.1%	13,844	13,994	(150)	-1.1%	12,500	1,344	10.8%
Staffing											
Paid FTE's	879.65	855.00	24.65	2.9%	879.65	855.00	24.65	2.9%	849.81	29.84	3.5%
Productive FTE's	730.04	734.21	(4.17)	-0.6%	730.04	734.21	(4.17)	-0.6%	722.83	7.21	1.0%
Paid FTE's/AOB	5.27	4.98	0.29	5.8%	5.27	4.98	0.29	5.8%	5.03	0.24	4.8%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	11,109	10,552	557	5.3%	11,109	10,552	557	5.3%	10,112	997	9.9%
Cost/Adj.Patient Day	2,671	2,647	24	0.9%	2,671	2,647	24	0.9%	2,514	157	6.2%
Revenue/Adj. Discharge	54,001	53,065	936	1.8%	54,001	53,065	936	1.8%	50,118	3,883	7.7%
Cost/Adj. Discharge	12,986	13,313	(328)	-2.5%	12,986	13,313	(328)	-2.5%	12,462	524	4.2%
Adj. Discharge	1,064	1,057	7	0.6%	1,064	1,057	7	0.6%	1,057	7	0.7%
Net Op. Gain/(Loss) %	-3.19%	-5.45%	2.26%	-41.4%	-3.19%	-5.45%	2.26%	-41.4%	-6.97%	3.78%	-54.2%
Net Op. Gain/(Loss) $	(427,527)	(728,022)	300,495	-41.3%	(427,527)	(728,022)	300,495	-41.3%	(858,631)	431,104	-50.2%
Gross Days in Accts Rec.	92.76	95.03	(2.26)	-2.4%	92.76	95.03	(2.26)	-2.4%	97.45	(4.69)	-4.8%
Net Days in Accts. Rec.	46.66	57.75	(11.08)	-19.2%	46.66	57.75	(11.08)	-19.2%	66.07	(19.41)	-29.4%

COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

	JUL 2024	JUN 2024
ASSETS		
CURRENT ASSETS:		
CASH & CASH EQUIVALENTS	$ 16,157,101	$ 23,036,803
SHORT-TERM INVESTMENTS	51,137	9,835
ASSETS LIMITED AS TO USE	65,251	68,541
PATIENT ACCOUNTS RECEIVABLE	180,089,543	184,617,734
LESS UNCOLLECTIBLES	(22,965,520)	(20,390,166)
CONTRACTUAL ALLOWANCES	(135,356,308)	(140,412,574)
OTHER RECEIVABLES	18,614,091	16,640,183
INVENTORIES	4,404,652	4,290,652
PREPAID EXPENSES AND DEPOSITS	2,804,461	2,301,439
LEASE RECEIVABLE - CURRENT	299,577	299,577
TOTAL CURRENT ASSETS	64,163,984	70,462,023
ASSETS LIMITED AS TO USE, LESS CURRENT REQUIREMENTS	32,124,334	36,365,602
LONG-TERM INVESTMENTS	132,908,911	128,735,361
PROPERTY, PLANT AND EQUIPMENT, NET	77,004,259	77,801,521
INTANGIBLE RIGHT OF USE ASSETS	411,329	423,316
SBITA RIGHT OF USE ASSETS	2,366,924	2,472,522
LEASE RECEIVABLE - LT	967,762	993,321
OTHER INVESTMENTS	250,000	250,000
PREPAID LOSS ON BONDS	1,489,553	1,510,532
TOTAL ASSETS	$ 311,687,057	$ 319,014,199

COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

	JUL 2024	JUN 2024
LIABILITIES AND FUND BALANCE		
CURRENT LIABILITIES:		
BOND INTEREST PAYABLE	$ 115,588	$ 783,700
CURRENT MATURITIES OF BONDS PAYABLE	4,235,000	4,055,000
CURRENT MATURITIES OF LONG TERM DEBT	2,057,015	1,201,171
ACCOUNTS PAYABLE AND ACCRUED EXPENSES	4,450,777	6,100,628
ACCRUED PAYROLL AND RELATED COSTS	6,801,504	8,418,736
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	3,584,136	3,656,945
LEASE LIABILITY - CURRENT	133,974	133,974
SBITA LIABILITY - CURRENT	1,272,203	1,272,203
TOTAL CURRENT LIABILITIES	22,650,196	25,622,357
SELF-INSURANCE RESERVES	1,125,026	1,159,085
CAPITAL LEASE LIAB LT	0	939,976
BONDS PAYABLE, LESS CURR REQT	33,275,000	37,510,000
BOND PREMIUM LIABILITY - LT	2,650,104	2,702,061
LEASE LIABILITY - LT	298,875	310,387
SBITA LIABILITY - LT	1,279,718	1,388,709
DEFERRED INFLOW - LEASES	1,197,644	1,223,945
TOTAL LIABILITIES	62,476,563	70,856,519
UNRESTRICTED FUND	248,157,679	248,157,679
PROFIT OR (LOSS)	1,052,815	0
TOTAL LIABILITIES AND FUND BALANCE	$ 311,687,057	$ 319,014,199

COMBINED INCOME STATEMENT FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

JUL 2024 ACTUAL	JUL 2024 BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE		Y-T-D ACTUAL	Y-T-D BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE
				***** OPERATING REVENUE *****				
5,148,669	5,253,784	105,115	(2)%	INPATIENT - NURSING	5,148,669	5,253,784	105,115	(2)%
18,071,735	17,396,292	(675,443)	4%	INPATIENT - ANCILLARY	18,071,735	17,396,292	(675,443)	4%
23,220,404	22,650,076	(570,328)	3%	TOTAL INPATIENT REVENUE	23,220,404	22,650,076	(570,328)	3%
34,238,311	33,463,072	(775,239)	2%	OUTPATIENT - ANCILLARY	34,238,311	33,463,072	(775,239)	2%
57,458,714	56,113,148	(1,345,566)	2%	TOTAL PATIENT REVENUE	57,458,714	56,113,148	(1,345,566)	2%
				DEDUCTIONS FROM REVENUE				
(15,695,489)	(18,243,309)	(2,547,820)	(14)%	MEDICARE	(15,695,489)	(18,243,309)	(2,547,820)	(14)%
(21,589,082)	(18,032,202)	3,556,880	20%	MEDI-CAL	(21,589,082)	(18,032,202)	3,556,880	20%
(3,162,169)	(6,660,852)	(3,498,683)	(53)%	OTHER/CHARITY	(3,162,169)	(6,660,852)	(3,498,683)	(53)%
(1,336,394)	(9,556)	1,326,838	13,885%	DISCOUNTS & ALLOWANCES	(1,336,394)	(9,556)	1,326,838	13,885%
(2,910,214)	(499,610)	2,410,604	483%	BAD DEBTS	(2,910,214)	(499,610)	2,410,604	483%
(44,693,347)	(43,445,529)	1,247,818	3%	TOTAL DEDUCTIONS	(44,693,347)	(43,445,529)	1,247,818	3%
12,765,367	12,667,619	(97,748)	1%	NET SERVICE REVENUE	12,765,367	12,667,619	(97,748)	1%
624,180	682,482	58,302	(9)%	OTHER OPERATING REVENUE	624,180	682,482	58,302	(9)%
13,389,548	13,350,101	(39,447)	0%	TOTAL OPERATING REVENUE	13,389,548	13,350,101	(39,447)	0%
				***** OPERATING EXPENSE *****				
5,823,453	5,555,013	268,440	5%	SALARIES	5,823,453	5,555,013	268,440	5%
562,051	676,357	(114,306)	(17)%	S&W PTO	562,051	676,357	(114,306)	(17)%
1,436,230	1,473,227	(36,997)	(3)%	EMPLOYEE BENEFITS	1,436,230	1,473,227	(36,997)	(3)%
1,286,192	1,424,318	(138,126)	(10)%	PROFESSIONAL FEES	1,286,192	1,424,318	(138,126)	(10)%
668,353	866,772	(198,420)	(23)%	PURCHASED SERVICES	668,353	866,772	(198,420)	(23)%
2,010,859	2,032,301	(21,442)	(1)%	SUPPLIES & EXPENSES	2,010,859	2,032,301	(21,442)	(1)%
273,499	266,447	7,052	3%	MAINTENANCE & REPAIRS	273,499	266,447	7,052	3%
243,777	277,064	(33,287)	(12)%	UTILITIES	243,777	277,064	(33,287)	(12)%
39,903	19,605	20,298	104%	RENT/LEASE	39,903	19,605	20,298	104%
148,231	121,228	27,003	22%	INSURANCE	148,231	121,228	27,003	22%
968,535	1,040,551	(72,016)	(7)%	DEPRECIATION/AMORTIZATION	968,535	1,040,551	(72,016)	(7)%
355,992	325,240	30,752	10%	OTHER EXPENSE	355,992	325,240	30,752	10%
0	0	0	0%	IMPAIRED COSTS	0	0	0	0%
13,817,075	14,078,123	(261,048)	(2)%	TOTAL OPERATING EXPENSE	13,817,075	14,078,123	(261,048)	(2)%
(427,527)	(728,022)	(300,495)	(41)%	NET GAIN/(LOSS) FROM OPERATIONS	(427,527)	(728,022)	(300,495)	(41)%
138,253	138,253	0	0%	DISTRICT TAXES	138,253	138,253	0	0%
425,006	343,454	(81,552)	24%	INVESTMENTS INCOME	425,006	343,454	(81,552)	24%
49,706	54,010	4,304	(8)%	OTHER NON OPERATING INCOME	49,706	54,010	4,304	(8)%
(77,538)	(80,572)	(3,035)	(4)%	INTEREST EXPENSE	(77,538)	(80,572)	(3,035)	(4)%
(56,816)	(36,954)	19,862	54%	NON-OPERATING EXPENSE	(56,816)	(36,954)	19,862	54%
478,612	418,191	(60,421)	14%	TOTAL NON-OPERATING INCOME	478,612	418,191	(60,421)	14%
51,084	(309,831)	(360,915)	(117)%	GAIN/(LOSS) BEFORE NET INCR/(DECR) FV INVSMT	51,084	(309,831)	(360,915)	(117)%
1,001,730	100,000	(901,730)	902%	NET INCR/(DECR) IN THE FAIR VALUE OF INVSTMT	1,001,730	100,000	(901,730)	902%
1,052,815	(209,831)	(1,262,646)	(602)%	NET GAIN/(LOSS)	1,052,815	(209,831)	(1,262,646)	(602)%

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
07/31/24

	CURRENT MONTH	YEAR TO DATE
Cash flows from operating activities:		
Operating Income/(Loss)	(427,527)	(427,527)
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation and amortization	968,535	968,535
Provision for bad debts	2,575,354	2,575,354
Change in assets and liabilities:		
Patient accounts receivable, net	(528,075)	(528,075)
Other receivables	(1,973,908)	(1,973,908)
Inventories	(114,000)	(114,000)
Prepaid expenses and deposits	(503,022)	(503,022)
Advance refunding of bonds payable, net	20,979	20,979
Accounts payable and accrued expenses	(1,649,852)	(1,649,852)
Deferred inflows - leases	(26,301)	(26,301)
Accrued payroll and related costs	(1,617,232)	(1,617,232)
Estimated third-party payor settlements	(72,809)	(72,809)
Self-insurance reserves	(34,059)	(34,059)
Total adjustments	(2,954,390)	(2,954,390)
Net cash provided by (used in) operating activities	(3,381,917)	(3,381,917)
Cash flows from noncapital financing activities:		
District tax revenues	138,253	138,253
Noncapital grants and contributions, net of other expenses	(19,185)	(19,185)
Net cash provided by (used in) noncapital financing activities	119,068	119,068
Cash flows from capital and related financing activities:		
Purchase of capital assets	(159,286)	(159,286)
Proceeds from lease receivable, net	25,559	25,559
Principal payments on debt borrowings	(4,055,000)	(4,055,000)
Interest payments	(785,531)	(785,531)
Net change in notes payable and lease liability	(99,037)	(99,037)
Net changes in assets limited as to use	4,244,558	4,244,558
Net cash provided by (used in) capital and related financing activities	(828,737)	(828,737)
Cash flows from investing activities:		
Net (purchase) or sale of investments	(3,171,820)	(3,171,820)
Investment income	425,006	425,006
Net cash provided by (used in) investing activities	(2,746,814)	(2,746,814)
Net increase (decrease) in cash and cash equivalents:	(6,838,400)	(6,838,400)
Cash and cash equivalents at beginning of month/year	23,046,638	23,046,638
Cash and cash equivalents at end of month	16,208,238	16,208,238

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
July 2024

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
Aug-23	11,411,456	2,278,509	13,689,964
Sep-23	11,153,141	297,374	11,450,515
Oct-23	10,806,912	1,614,798	12,421,710
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**

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