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

AGENDA
September 24, 2024

OPEN SESSION (5:00 PM)

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

Call to Order

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

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

II. Adjourn Open Session and go into Closed Session

CLOSED SESSION (5:01 PM)

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

III. Closed Session Business

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

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

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

2. Quality Division Update –Quality Report

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (1 Item). Estimated date of Disclosure: January 1, 2025

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (2 Items). Estimated date of Disclosure: September 1, 2026

E. Pursuant to Gov. Code Section 54956.9(d)(2): Conference with Legal Counsel; Anticipated Litigation; Pursuant to Gov. Code Section 54957(b): Discussion Regarding Confidential Personnel Matter. (2 items).

F. Pursuant to Gov. Code Section 54956.9(d)(2), Conference with Legal Counsel about recent work product (b)(1) and (b)(3)(F): significant exposure to litigation; privileged communication (1 Item).

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

IV. Adjourn Closed Session and go into Open Session

OPEN SESSION (5:30 PM)

V. Closed Session Action Taken

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

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

B. Quality Review

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

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

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

D. Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (2 Item).
Recommended Action: Information Only: No Action Taken

E. Conference with Legal Counsel; Anticipated Litigation (2 Items)
Recommended Action: Information Only; No Action Taken

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

VI. Public Comments

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

VII. Consent Agenda

Recommended Action: Approve Consent Agenda as presented

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

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

VIII. Approval of Minutes

A. **August 27, 2024 Minutes of the Regular Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove August 27, 2024 Minutes of the Regular Meeting of the Board of Directors

IX. Business Items

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

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

C. **Conflict of Interest Code**
Recommended Action: Approve/Disapprove Adoption of Conflict of Interest Code

X. CEO Report

XI. Announcements:

A. Regular Board of Directors Meeting – October 22, 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.

MEDICAL EXECUTIVE COMMITTEE	09/04/2024
BOARD OF DIRECTORS APPROVAL	
	09/24/2024
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
September 24, 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**
	• Care of Bronchoscopy Specimens	1-2	
	• Case Cart, Procedure Cards, Procedure Packs	3-5	
	• Compounded Sterile Preparation: Quality Assurance Program	6-10	
	• Cuff Pressure Measurements	11-12	
	• Exposure Control Plan – Bloodborne Pathogen Standard	13-39	
	• Formulary	40-45	
	• Intrafacility Patient Transport	46-51	
	• Medication Procurement, Storage, Distribution and Control	52-64	
	• Organ and Tissue Procurement and Donation	65-69	
	• Patient Self-Administered Medications	70-71	
	• Sterile Products: Education and Competency	72-78	

SUBJECT: **CARE OF BRONCHOSCOPY SPECIMENS**	SECTION:

PURPOSE:

The purpose of this policy is to provide guidance on what type of fixative can be used in submitting bronchoscopy specimens; and whether or not a fixative is needed.

POLICY:

Pathology/cytology specimens require fixative (Formalin or Saccomonno fixative). Lab specimens do NOT need a fixative.

Bronchoscopy specimens will be processed as physician requested.

AFFECTED AREAS/ PERSONNEL: *RN, ORT, RT, OR, ENDO, ENDOSCOPY TECHNICIANS*

EQUIPMENT:

- Specimen containers with/without fixative
- Non-sterile gloves
- Labels with patient name, MR#, date, time, mnemonic.

PROCEDURE:

1. If patient has a productive cough, have patient spit into **SACCOMONNO** specimen cup.
2. **BIOPSY**: Use a small container with **FORMALIN**. Immerse entire tissue biopsy in Formalin.
3. **BRUSHINGS:**
    a. PATHOLOGY/CYTOLOGY: Expose and cut wire, place in **SACCOMONNO**. Do **NOT** retract brush!
    b. LABORATORY: BAC-T CULTURES: Retract brush into sheath; send whole in wrapper. Label wire and package with patient information (sticker with name, MR#, date, time, and mnemonic.)
4. **ASPIRATIVE/WASHINGS**:
    a. LABORATORY: Send remaining in mucous trap with appropriate label.
5. **LABELING OF SPECIMENS**: Enter physician order for specimens into computer, obtain labels and place on proper specimens. For questions, call lab at extension 2457.

6. If the pathology/cytology specimen needs to processed as a STAT, place red "STAT" sticker on specimen.

REFERENCE:

- Thermo Scientific for Fixation of Cytology Specimen, 2015. Thermo Fisher. Retrieved from https://assets.thermofisher.com/TFS-Assets/APD/manuals/IS81848-RAS-Saccomanno-Fluid-IFU.pdf.

SUBJECT: **CASE CART, PROCEDURE CARDS, PROCEDURE PACKS**	SECTION: ***Provision of Care, Treatment & Services (PC)*** **Page 1 of 3**

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

PURPOSE:

To define the methodology used at Sierra View Medical Center for provision of appropriate sterile supplies and instrumentation for surgical procedures.

POLICY:
To provide an organized system for delivery of sterile supplies to the operating room suite. This includes both disposable and non-disposable supplies anticipated for use in specific surgical procedures determined by surgeon preference cards.

AFFECTED AREAS/ PERSONNEL: *OPERATING ROOM/CENTRAL PROCESSING REGISTERED NURSES (RN), OPERATING ROOM TECHS (ORT), AND CENTRAL PROCESSING PERSONNEL*

GENERAL GUIDELINES:

1. The case cart is an efficient means of travel for supplies in the operating room because it utilizes the optimum traffic flow:

   a. Example: clean dumbwaiter from Central Processing Department (CPD) → sterile core → surgical suite → peripheral corridor → clean-up room → dirty dumbwaiter to CPD decontamination

2. Case carts are metal wheeled vehicles with shelves that are used to deliver supplies, transport supplies within the OR department and return supplies to Central Processing. The carts travel between OR and Central Processing on a vertical dumbwaiter system with separate clean and dirty ports of entry.

3. Physician preference cards list the doctor's preference of routine, skin prep and solution, supplies, suture and technique for specific procedures. All members of the OR Staff are responsible for noting changes on the cards. Changes will be made in the computer by designated surgical staff. An updated copy will be placed in the black "Procedure Care" notebooks stored at the desk station across from OR 3.

4. A copy of the card is attached by Central Processing personnel to each case cart for use in preparing for and performing the case.

5. Soiled materials will not re-enter the sterile core area. The system allows for containment of contamination.

PROCEDURE:

1. Procedures are scheduled by the OR Schedulers. Procedure cards are printed in CPD by CPD tech in the afternoon on the day prior to the case cart preparation. Additionally, procedure cards for "add-on" cases are printed by CPD tech as they are scheduled.

2. Upon receiving the requests, Central Processing staff "picks the cases partially" by obtaining appropriate disposable procedure packs and other supplies from their stock, and places these on a clean case cart. If no CP supplies are needed or after the supplies are added to the cart, the procedure card is placed on the case cart and the cart is sent to OR. The case cart is sent up to the Surgery Department via the clean dumbwaiter and stored in the clean core or the back hall.

3. The surgical technicians in the OR place any remaining supplies and instrument tray(s) stored in the Surgery Department on the case cart prior to the beginning of the case. Each technician is responsible for picking their own cases and confirming that all instrumentation and sutures are available.

4. The case cart remains in the operating room suite throughout the entire surgical procedure and removed at the end of the case. The clean supplies are removed to the clean core prior to placing dirty supplies on the cart. The scrub and the circulator will work together to prepare the case cart for return to Central Processing by completing the following:

    a. ALL TRASH (regular in white bag, contaminated in red bag) and LINEN (green/blue bag) is secured in the designated plastic bagging. All bags will have date, room number and case order inscribed on them with marker. All fluids from surgical procedures will be contained in suction canisters. At the end of the case, isolyzer will be added to the suction canisters and then disposed in red bags with a goose neck tie to bag. All bags are placed on the top shelf of the case cart for removal from the operating suite.

    b. All knife blades and needles are secured and disposed into a sharps container.

    c. Open instrumentation not used for the case is placed back in the instrument tray and soiled instruments are placed in a basin. All instruments are in the "open" position. All sharp instruments are separated together to prevent injury. Instruments should be kept moist until they are cleaned. In the Clean-Up Room, a spray-on enzymatic agent is applied to the instruments to prevent debris from drying before covering with a plastic bag. The instruments are placed on the bottom shelf of the case cart.

    d. Prior to the cart leaving the operating room suite, the room is scanned to ensure all instrumentation, trash, and linens have been removed. The case cart is wheeled out the outside corridor door of the operating suite through the peripheral hallway directly to the dirty clean up room.

    e. The case cart, linen, and trash are sent down to Central Processing on the dirty dumbwaiter. The procedure card is returned with the case cart so that Central Processing knows which cases are completed and what instruments should be on the cart.

    f. The operating room suite is cleaned and prepared for the next procedure before the new case cart is brought into the room.

g. When surgical procedures are added to the daily schedule that require ordering a case cart from Central Processing and time is limited, the cart will be "picked" from surgery's back up supplies. Cesarean Section and Emergency Laparotomy carts are available at all times in the Surgery Department.

h. The Cesarean Section suite on the fourth floor follows Association of Perioperative Registered Nurses (AORN) standards for transport of supply to and from the area. Clean and dirty supplies are kept separate and are covered for transport to and from Central Processing, as there is no vertical dumbwaiter to that area.

i. The Cesarean Section suite is cleaned and left ready for the next case. Case carts are available in the hallway outside the suite and all necessary supplies are available in the OB-OR suite.

Case carts are hand cleaned with germicidal wipes before each use. Additionally, case carts are steam cleaned during each weekend case.

REFERENCES:

- Association of Perioperative Registered Nurses (AORN) Standards, Recommended Practices and Guidelines. Care and Cleaning of Surgical Instruments. (2024). https://aornguidelines.org/guidelines/content?sectionid=173736661&view=book#229134795.

- Association of Perioperative Registered Nurses (AORN). Outpatient Surgery Magazine. Case Carts Carry The Load. 2015. https://www.aorn.org/outpatient-surgery/articles/outpatient-surgery-magazine/2015/november/case-carts-carry-the-load

- Association of Surgical Technologist (AST). Guidelines for Environmental Practices. 2021. https://www.ast.org/uploadedFiles/Main_Site/Content/About_Us/ASTGuidelinesEnvironmentalPracticesintheOR.pdf

SUBJECT:	SECTION:
COMPOUNDED STERILE PREPARATION: QUALITY ASSURANCE PROGRAM	***Medication Management (MM)*** **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 pharmacy quality assurance practices related to the preparation of compounded sterile drug products.

DEFINITION:

Quality Assurance – For purposes of these guidelines, quality assurance is the set of activities used to ensure that the processes used in the preparation of sterile drug products lead to products that meet predetermined standards of quality.

BSC - Biological Safety Cabinet, 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.

CAI - Compounding aseptic isolator – A type of RABS that uses HEPA filtration to provide an ISO Class 5 unidirectional air environment designed for compounding of sterile non-HDs.

CACI - Compounding Aseptic Containment Isolator - is a unidirectional HEPA-filtered airflow isolator designed to provide worker protection from exposure to undesirable levels of airborne drug and to provide an aseptic environment for compounding sterile preparations, also known as sterile intravenous preparation hood.

CSP - Compounded Sterile Preparation

PEC - Primary engineering control - 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.

RABS - Restricted-access barrier system – 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

POLICY STATEMENT:

It is the policy of Sierra View Medical Center (SVMC) that all pharmacy preparations of compounded sterile products will follow accepted standards of practice by conducting regular quality assurance activities and testing.

PROCEDURE:

A. Quality Assurance will be implemented to evaluate the following:

1) Personnel Qualifications
   - See Sterile Products: Education and Competency

2) Personnel performance. The total number of errors will be reported in the following categories:

- Wrong Drug or solution
- Wrong Strength
- Wrong Label
- Wrong Expiration Date

3) Equipment and facilities

- Record of daily anteroom countertop sanitizations
- Record of daily cleanings and sanitizations of cleanroom floors
- Record of daily cleanings for PEC
- Record of weekly anteroom cleaning
- Record of weekly wall and ceiling cleaning
- Record of weekly shelf cleaning environment
- Record of daily CAI/BSC pressures and room pressures
- Record of monthly sporicidal cleaning

4) Environment

- Daily record of room temperature and humidity
- Daily record of refrigerator temperature
- Record airflow pressure differentials daily, where they are available, when open for patient care. During non-operational days, continuous monitoring will alarm for an out of range result and Engineering will alert the pharmacist on-call or the Pharmacist-in-Charge (PIC).
- In the event of a parameter excursion, personnel will follow the procedure outlined in: MEDICATION PROCUREMENT, STORAGE, DISTRIBUTION AND CONTROL

4) Pharmacy personnel will be trained annually on:

- Proper garbing (donning and doffing of personal protective equipment (PPE) while in the compounding areas)
- Proper cleaning/disinfecting/decontamination of compounding areas
- USP 797 Appendix V, "Sample Form for Assessing Cleaning and Disinfection Procedures" will be used as an education and competency training tool.

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Competency will be validated by written and visual observation and training records shall be retained.

5) Sterility Testing

- End product sampling will be performed at least quarterly.
- In the event of a positive culture, the following shall occur:
    - The pharmacy member that compounded the product will not be allowed to compound sterile IV products until:
        - Aseptic Technique Written Quiz is passed (considered passing score is 100%)
        - Broth Dilution testing of aseptic technique yields absence of microbiological contamination.
    - Infection Control and Quality will be notified.

6) Compounded sterile preparation analysis

- Randomly-selected compounded sterile preparations will be subjected to qualitative and quantitative analysis at least on a quarterly basis. Testing shall include:
    - Potency Testing
    - Endotoxin Testing
    - Particulate Matter Testing
    - Any products failing to meet minimum standards will be reviewed by the Pharmacist-in-Charge and the following corrective actions will be taken:
        - ☐ Failed Potency and/or Concentration Test:
            - Review procedure with personnel
            - Review master formula
            - Repeat procedure under Pharmacist-in-Charge's supervision
            - Resubmit for analysis
        - ☐ Failed Endotoxin Test:

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- The pharmacy member that compounded the product will not be allowed to compound sterile IV products until:
    - Aseptic Technique Written Quiz is passed
    - Broth Dilution testing of Aseptic Technique yields absence of microbiological contamination.
- Infection Control and Quality will be notified.

7) Recall procedures

- Recalls will be handled as per SVMC policy DRUG RECALL PROCEDURE.
- Per B&P 4127.1, Pharmacy will provide any recall notice for sterile drug products it has compounded to the Board within 12 hours of the notice.

8) Adverse Events and Complaints

- Adverse events related to CSPs will be reported into the hospital's incident reporting software for review.
    - Serious or unexpected adverse events with CSPs will be reported to the Food and Drug Administration (FDA) through the MedWatch program for human drugs.
- The PIC will review all complaints related to CSPs and determine if the complaint indicates a quality problem with CSP.
    - If a quality problem is discovered:
        - A corrective action plan will be initiated immediately, which may include:
            - A recall of all CSPs that may have been affected
            - A suspension of compounding
    - A written record of the complaint must be kept and contain:
        - The name of the complainant
        - Date received
        - Nature of complaint
        - Response to the complaint
        - Name and strength of the CSP, prescription number
        - Findings of investigation
        - Record of complaint must be kept so it is readily retrievable
        - A CSP returned with a complaint must be quarantined until it is destroyed AFTER the investigation.
    - Per B&P 4127.1, adverse effects reported or potentially attributable to a pharmacy's sterile drug product shall be reported to the Board of Pharmacy within 12 hours.

9) Validation of beyond-use-dates

- Beyond-use-dates will be reviewed periodically with a complete update of current manufacturers and/or peer-reviewed literature.

- Any changes identified in the interim time period will result in the immediate updating of the table found in GUIDELINES FOR PRODUCT DATING or STERILE PRODUCTS_EDUCATION AND COMPETENCY.

DOCUMENTATION:

A. Training record retention shall be maintained in employee files. Re-training will be performed per USP Chapter 797.

B. All compounding logs and chart records shall be retained for three years and shall be filed alphabetically by generic name.

C. RABS or BSCs shall be recertified by a qualified person every six months, whenever it is moved, or if filter damage is suspected. Specific tests are used to certify airflow velocity and HEPA filter integrity. Records of certification shall be retained for three years.

EDUCATION:

SVMC Staff: All pharmacists and pharmacy technicians will receive education regarding the indicators used to track quality assurance of pharmacy prepared sterile drug products. All pharmacy staff will sign an acknowledgement form indicating that they understand and will comply with the policy.

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Pharmacy Law: California Edition. (2023) San Clemente, California: Law Tech Publishing Group.
- USP 797. (n.d.). Retrieved March 20 6, 2023 from http://www.usp.org/compounding/general-chapter-797.

CROSS REFERENCES:

- Drug Recall Procedure – SVMC Policy and Procedures
- Medication Procurement, Storage, Distribution and Control – SVMC Policy and Procedures
- Guidelines for Product Dating – SVMC Policy and Procedures

SUBJECT: **CUFF PRESSURE MEASUREMENTS**	SECTION: **Page 1 of 2**

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

PURPOSE:

To define a consistent process for ensuring that artificial airway cuff pressures are measured and maintained at a safe and effective level.

POLICY:

Cuff pressures are monitored every shift and the pressure value documented on all endotracheal and tracheostomy tubes.

AFFECTED PERSONNEL/AREAS: *RESPIRATORY CARE SERVICES STAFF*

PROCEDURE:

1. Suction the patient both endotracheally and oropharyngeally.
2. Attach the monometer to the valve on the balloon.
3. Fill the manometer to the previously documented cuff pressure by injecting air via syringe into the manometer.
4. Ideal cuff pressure is 20-25 mmHg or less. If higher pressures are required to maintain a seal, the physician is to be notified immediately.

EQUIPMENT:

- Respiratory pressure manometer

INFECTION CONTROL:

- Standard precautions should be observed. Wipe the surface of the cufflator thoroughly with an alcohol-based, hospital approved disinfectant.

ASSESSMENT OF OUTCOME:

- A proper seal is indicated when:
  - In a mechanically ventilated patient, the delivered tidal volume is returned.
  - In a non-ventilated patient, the patient is not able to talk when the cuff is inflated.

REFERENCES:

- Evaluation of an Intervention to Maintain Endotracheal ... (n.d.). Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3506174/

- Posey Cufflator Application Instructions. (2021). Retrieved from https://f.hubspotusercontent40.net/hubfs/8218994/IFU/Securement%20Devices/Posey-Cufflator.pdf

SUBJECT: **EXPOSURE CONTROL PLAN – BLOODBORNE PATHOGEN STANDARD**	SECTION: **Page 1 of 27**

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

PURPOSE:

The Exposure Control Plan shall be made available to Sierra View Medical Center (SVMC) personnel and to the Chief of the Division of Occupational Safety and Health of the California Department of Industrial Relations or National Institute for Occupational Safety and Health (NIOSH) or their respective designee upon request for examination and copying.

POLICY:

1. SVMC has charged the Pharmacy and Therapeutics / Infection Prevention Committee with the overall responsibility for the Blood borne Pathogen Program in compliance with Occupational Safety and Health Administration (OSHA) Instruction 29 CFR 1910.1030. The Pharmacy and Therapeutics / Infection Prevention Council have the full support and authority of the Chief Executive Officer (CEO) to ensure compliance is maintained.

   SVMC complies with OSHA regulations including, but not limited to, the following:

   a. Determining exposure risks of personnel

   b. Providing protection against exposure risks

   c. Implementing a blood borne pathogen program

   d. Providing Hepatitis B vaccinations at no cost to personnel

   e. Providing in-service training by personnel with knowledge of this topic and being available to employees' requests for additional safety protection

   f. Being available to answer all employee questions

   The Pharmacy and Therapeutics / Infection Prevention Committee has overall responsibility for implementing the Plan and will review and maintain the Plan. The Plan will be submitted to the Pharmacy and Therapeutics / Infection Prevention Committee for review, revision as needed and approval on an annual basis. The Plan will also be reviewed/approved at other committees as deemed necessary.

2. The goals of the Exposure Control Plan are:

   a. To inform personnel of the contents of the OSHA standards as it applies to Hepatitis and Human Immunodeficiency Virus (HIV).

   b. To ensure employees receive information concerning infection prevention in the work place. This information includes epidemiology, clinical presentation, modes of transmission and prevention of blood borne disease / infection, specifically Human

Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and Hepatitis C Virus (HCV), as well as protective measures to prevent exposure, such as the use of personal protective equipment (PPE), clothing and safe work practices including Standard Precautions and vaccination protocol.

c. To ensure employees receive information concerning the hazards that they may be exposed to in the workplace. This information includes a comprehensive hazard communication program that incorporate container labeling and other forms of warnings, material safety data sheets and appropriate protective measures to employees.

3. The Plan shall be incorporated into the hospital's departmental policies and procedures, be reviewed, updated and approved annually, or as deemed necessary by the Infection Prevention Committee. Review and revision will reflect the following:

   a. New or modified tasks and procedures which affect occupational exposure.

   b. Progress in implementation of the use of needleless systems and sharps with engineered sharps injury protection.

   c. New or revised employee positions with occupational exposure.

   d. Review and evaluation of the exposure incidents which occurred since the previous update.

   e. Review and respond to information indicating that the Exposure Control Plan is deficient in any area.

4. Information presenting the scope, content and practical application of the Plan will be given to all persons covered by this Plan. Education will be provided annually and as deemed necessary. Documentation of training will be maintained.

5. Each department shall monitor compliance with the Plan, related practices, evaluate the need for further training, and provide training in consultation with Infection Prevention. Compliance with the Plan shall be incorporated into the individual employee evaluation process.

6. Hepatitis B vaccinations, at no cost to the employee, shall be offered to all employees who may be exposed to more than one infection risk per month (blood/body fluids), within ten (10) working days of assignment to exposure-prone duties. Employees who elect not to be vaccinated *must* sign a written declination form.

7. SVMC shall ensure that all medical evaluations and procedures, including the hepatitis B vaccine and vaccination series and post-exposure evaluation and follow-up, including prophylaxis, are:

   a. Made available at no cost to the employee

b. Made available to the employee at a reasonable time and place

c. Performed by or under the supervision of a licensed physician or by or under the supervision of another licensed healthcare professional

d. Provided according to recommendations of the U.S. Public Health Service current at the time these evaluations and procedures take place.

8. SVMC shall ensure that all laboratory tests are conducted by an accredited laboratory at no cost to the employee.

GENERAL FACTS ABOUT HIV AND HEPATITIS

1. Hepatitis Transmission

a. Hepatitis B (HBV)

OSHA estimates that about 75 to 110 of every 1,000 workers who are frequently exposed to blood or other potentially infectious materials (OPIM) will become infected with Hepatitis B (HBV) over the course of their working lifetimes.

HBV is a virulent infectious disease which claims an estimated 300,000 new cases every year. Over one million people in the U.S. are carriers of the disease.

HBV is most prevalent among intravenous drug users who share needles and through sexual contact among sexually active homosexual males and prostitutes. From these groups, it spreads to the community. HBV infects 18,000 healthcare employees per year who are usually infected through contact with blood borne pathogens via accidental needle stick injuries.

HBV symptoms resemble the flu in its early stages. More severe clinical illness has symptoms that often include jaundice, a loss of appetite, nausea, and elevated liver enzyme function tests.

b. Hepatitis C

Hepatitis C (HCV), also known previously as non-A, non-B hepatitis, is transmitted parenterally and is responsible for many cases of sporadic acute hepatitis.

HCV is now by far the most common cause of post-transfusion hepatitis.

HCV symptoms resemble the symptoms associated with HBV.

HCV can, like HBV, develop into a chronic carrier state.

2. Hepatitis Protection

Occupational Health and Safety Administration (OSHA) enforces the Center for Disease Control and Prevention (CDC) recommendations. OSHA presently requires every healthcare worker who is exposed to more than one infection risk per month to be offered a Hepatitis B vaccination, to be trained in pathogen safety, and given all necessary protective PPE. SVMC will require that high-risk employees provide proof of immunization or immunity or signed declination prior to employment.

Hepatitis B vaccine is administered in a three (3) dose series to all employees who have occupational exposure unless the employee has previously received the complete hepatitis B vaccination series, or antibody testing has revealed that the employee is immune, or the vaccine is contraindicated for medical reasons. The vaccination series will be offered within ten (10) days of hire.

NOTE: An employee who refuses vaccination must sign a declination form maintained in the Employee Health file.

Danger of infection from blood borne pathogens can be prevented or reduced in the healthcare setting by:

a. Using protection against body fluids during at-risk procedures including appropriate personal protective equipment, mechanical safety devices, *etc*.

b. Using disinfectants to reduce pathogens in the environment.

c. Taking thorough patient medical histories.

d. Washing hands between patient treatment contacts.

e. Using puncture-resistant sharps containers for needle disposal.

f. Correcting unsafe environment and work practices as they occur.

3. Human immunodeficiency virus/ acquired immunodeficiency syndrome (HIV / AIDS)

HIV / AIDS is not as contagious in a healthcare setting as HBV, but there is still no vaccine for prevention and no means of cure. It is transmitted through body fluids so healthcare workers are exposed to HIV in their daily routine.

OSHA requires that employees be trained in HIV prevention and be required to protect themselves during at-risk procedures. Training is included in, but not limited to, New Hire Orientation and Annual Orientation.

Symptoms of HIV infection are varied and may include fatigue, fever, weight loss, night sweats, rashes, mouth sores or pneumonia.

Because there is no inoculation against HIV / AIDS, CDC recommends and OSHA enforces the use of STANDARD PRECAUTIONS in *all* healthcare settings where exposure to potentially infectious materials may take place.

4. HIV / AIDS Transmission

HIV / AIDS is usually transmitted through blood and semen. It is most commonly seen in men who have sex with men (MSM) and IV drug users.

HIV / AIDS is transmitted sexually and through blood / body fluid exposure or perinatally from mother to child. HIV / AIDS is *not* transmitted through general contact with a carrier.

STANDARD PRECAUTIONS

A. Standard Precautions applies to ALL blood and body fluids, excluding sweat, regardless of the presence or absence of visible blood.

B. Standard Precautions incorporate infection prevention procedures that protect the patient as well as the employee from disease-causing pathogens.

C. The incorporation of Universal Precautions with Standard Precautions has been referred to as STANDARD PRECAUTIONS throughout this plan, as well as the Infection Control Program Manual.

D. Under STANDARD PRECAUTIONS, the assumption is that blood and body fluids from ALL patients is potentially infected with Human Immunodeficiency Virus (HIV)Hepatitis B virus (HBV), Hepatitis C virus (HCV) and other blood borne pathogens, and must be handled accordingly.

E. STANDARD PRECAUTIONS applies to:

1. ALL blood and body fluids that are visibly contaminated with blood,

2. ALL body fluids in situations where it is difficult or impossible to differentiate between body fluids, including (but not limited to) cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal and pericardial fluid, amniotic fluid, saliva in dental procedures, vaginal secretions and semen.

3. It does not include sweat, unless it is visibly contaminated with blood.

F. Contaminated items are defined as those items that contain liquid or semi-liquid blood or are caked with dried blood or OPIM that are capable of releasing these materials when handled or compressed.

G. SVMC practices Standard Precautions in its regular daily activities.

DEFINITIONS OF INFECTIOUS CONDITIONS

A. Infections need four simultaneous conditions for transmission. If you take any condition away, the danger of infection will be reduced or eliminated. The conditions which must exist simultaneously are:

1. A sufficiently large dose of infectious particles to constitute a dangerous quantity

2. A sufficient virulence, or deadliness, to be dangerous

3. A portal of entry, such as through an open cut or the nasal passages

4. A reduced resistance level of the host. For example: If a medical worker is tired, has the flu or a cold, he/she is more susceptible to infection.

INFECTIOUS DISEASES ARE PREVENTED BY REDUCING OR REMOVING ANY OF THESE CONDITIONS. FOR EXAMPLE:

- The use of gloves and masks will reduce or eliminate portals of entry.
- Regular handwashing and the use of disinfectants will remove or reduce the dose and virulence of the disease.
- The placement of sharps and needles into approved sharps containers and the avoidance of recapping needles will reduce needle stick portals of entry.

PERSONAL PROTECTIVE EQUIPMENT

Where occupational exposure remains after implementation of engineering and work practice control, SVMC shall provide, at no cost to the employee, appropriate personal protective equipment (PPE) such as, but not limited to, gloves, gowns, laboratory coats, face shields or masks and eye protections, mouthpieces, resuscitation bags, pocket masks, or other ventilation devices.

PPE will be considered "appropriate" only if it does not permit blood or other potentially infectious materials (OPIM) to pass through to or reach the employee's work clothes, undergarments, skin, eyes, mouth or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used.

SVMC shall ensure that the employee uses appropriate PPE unless the employee temporarily and briefly declined to use PPE when, under rare and extraordinary circumstances, it was the employee's professional judgment that in the specific instance its use would have prevented the delivery of health care or public safety services or would have posed an increased hazard to the safety of the worker or co-worker. When the employee makes this judgment, the circumstances shall be investigated and documented in order to determine whether changes can be instituted to prevent such occurrences in the future. The employer shall encourage employees to report all such instances without fear of reprisal.

SVMC provides PPE in the appropriate sizes for all employees. This PPE can be taken to the location where infectious materials are generated. PPE and protective clothing is provided commensurate with the exposure risks.

Hypoallergenic gloves, gloves liners, powderless gloves, or other similar alternatives shall be available to those employees who are found to be allergic to the gloves normally provided.

SVMC shall make provision for cleaning, laundering, and disposal of PPE at no cost to the employee.

The employer shall repair or replace PPE as needed to maintain its effectiveness at no cost to the employee.

If an employee feels more protection should be provided for certain procedures, he / she should make this request to either his / her immediate supervisor or agency management.

The use of protective clothing is an OSHA requirement and a requirement of SVMC. If the procedure requires it, or the manufacturer recommends its use, protective clothing must be used.

Clinical Laboratory Improvement Amendments (CLIA) laboratory rules may be stricter about laboratory garments. If rules conflict, *follow the law that is stricter*.

Disposal of Personal Protective Equipment

1. If a garment is penetrated by blood or OPIM, the garment shall be removed immediately or as soon as feasible.

2. All PPE shall be removed prior to leaving the work area.

3. When PPE is removed it shall be placed in an appropriate designated area or container for storage, washing, decontamination or disposal.

    a. Reusable PPE which is heavily soiled with body fluids shall be handled as little as possible and must be bagged at the location of use in leak proof bags.

4. When removing protective clothing, avoid contamination of exposed body parts.

Gloves

1. Types

   Three basic glove types are provided by SVMC:

   a. Sterile gloves for procedures involving contact with normally sterile areas of the body and invasive procedures. These gloves cannot be reused.

   b. Examination gloves for patient diagnostic procedures not requiring the use of sterile gloves and for routine infection prevention. These gloves cannot be reused.

   c. Utility gloves of strong latex / vinyl for maintenance and scrubbing work. These are reusable until they puncture, tear, or crack.

2. Glove protocol: Gloves shall be worn when it can be reasonably anticipated that the employee may have contact with blood, OPIM, mucous membranes, and non-intact skin; when performing vascular access procedures; and when handling or touching contaminated items or surfaces.

   a. After donning gloves, examine them for physical defects.

   b. Never wear the same pair of gloves with more than one patient or on more than one occasion.

   c. Discard gloves after each patient.

   d. Disposable (single use) gloves shall not be washed or decontaminated for re-use.

   e. Don gloves so they cover the cuff of your clothing if possible to reduce the area of skin exposure.

   f. If torn or punctured or their ability to function as a barrier is compromised, disposable (single use) gloves shall be replaced as soon as feasible. If contaminated, gloves shall be replaced as soon as practical.

   g. Remove gloves before removing mask and gown if worn.

   h. Wash hands after glove disposal.

Masks, Protective Eyewear / Goggles, and Face Shields

Masks in combination with eye protection devices such as goggles, glasses with solid side shields, or chin-length face shields, shall be worn whenever contamination of the eyes, nose or mouth can be reasonably anticipated from splashes, spray, spatter or droplets of blood or OPIM. They are not required for routine care.

Gowns / Aprons or Other Protective Body Clothing

1. Appropriate protective clothing such as, but not limited to, gowns, aprons, lab coats, or similar outer garments shall be worn in occupational exposure situations. The type and characteristics will depend upon the task and degree of exposure anticipated.

   NOTE: Gowns, aprons and/or lab coats are required when splashing, misting or aerosolization of blood or OPIM onto skin or clothing are anticipated.

   Resuscitation Equipment:

   Pocket masks, mouthpieces, resuscitation bags and / or other respiratory equipment are available for use in order to minimize exposure in case of emergency mouth-to-mouth resuscitation.

   NOTE: Surgical masks are *not* considered resuscitation equipment.

HANDWASHING

A. Wash hands regularly with liquid soap on the following occasions:

   1. Upon arriving at work
   2. Before gloving
   3. After gloves are removed
   4. Before and after each patient or during prolonged contact with one patient
   5. Before and after touching wounds
   6. After touching excretions / secretions
   7. Before and after performing invasive procedures
   8. Before handling medications
   9. Before and after eating, drinking or preparing food, smoking, etc.

10. After hands have touched a potentially contaminated surface

11. Before leaving the work area and upon return

12. Upon completing work shift

13. As soon as patient safety permits, when hands and other skin surfaces become contaminated with blood or body fluids

14. After any contact with one's own personal body fluids, using the toilet, blowing or wiping the nose, or similar incidents when soiled

B. Prior to invasive procedures, use of an antimicrobial soap scrub is recommended by the CDC. The CDC recommends the use of antimicrobial soap prior to invasive procedures, when caring for newborns, between caring for patients in high-risk units, and when caring for severely immunocompromised individuals or patients infected with virulent or epidemiologically important microorganisms. In healthcare settings where contagious diseases may be present, the use of antibacterial soap is required. It kills less pathogens but it is gentler to the skin than antimicrobial soap.

1. The policy at SVMC requires antimicrobial soap to be available in high risk patient care areas as well as isolation rooms.

C. Alcohol-based Hand Sanitizers/ Wipes

Alcohol-based hand sanitizers or wipes are available to all employees whose job performance may take them into areas where sinks are not readily available or accessible. Alcohol-based hand sanitizers or wipes disinfect the hands between patient contacts when handwashing is not possible; however, hand sanitizers and wipes do *not* replace handwashing. Handwashing must be performed as soon as handwashing facilities become available/accessible.

EXPOSURE INCIDENT OCCURRENCE

An exposure incident occurs when a patient's blood or body fluids may have gained entry into an employee during the performance of their job duties. Should this occur, the employee must follow these procedures:

A. Wash the exposed area with soap and running water.

B. Report the incident to the Supervisor immediately.

C. Complete all necessary forms to document the facts.

D. Fill out an Electronic Incident Report.

E. If possible, locate the source patient for a blood sample for serological testing for HIV, HBV and HCV.

F. Report to Employee Health Services or Emergency Room if after hours. Also, if after hours, notify the House Supervisor.

EXPOSURE INCIDENT FOLLOW-UP

Following a report of an exposure incident, SVMC shall make a confidential medical evaluation immediately available to the exposed employee.

A. The employer shall document the route(s) of exposure and the circumstances under which the exposure incident occurred.

B. The employer shall identify and document the source individual, unless the employer can establish that identification is infeasible or prohibited by state or local law.

1. The source individual's blood shall be tested as soon as feasible and after consent is obtained in order to determine HBV, HCV and HIV infectivity.
If consent is not obtained, the employer shall establish that legally required consent cannot be obtained. When the source individual's consent is not required by law, the source individual's blood, if available, shall be tested and the results documented.

2. When the source individual is already known to be infected with HBV, HCV or HIV, testing for the source individual's known HBV, HCV or HIV status need not be repeated.

3. Results of the source individual's testing shall be made available to the exposed employee, and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.

C. SVMC shall provide for collection and testing of the employee's blood for HBV, HCV and HIV serological status.

1. The exposed employee's blood shall be collected as soon as feasible and tested after consent is obtained.

2. If the exposed employee consents to a baseline blood collection but not to HIV testing, the blood sample should be preserved for at least 90 days. If, within 90 days of the exposure incident, the employee elects to have the baseline sample tested, such testing shall be done as soon as feasible.

3. Additional collection and testing shall be made available as deemed appropriate on a case-by-case basis.

D. SVMC shall provide for post-exposure prophylaxis, when medically indicated.

E. SVMC shall provide for counseling and evaluation of reported illnesses.

F. Information provided to Healthcare Professionals:

1. SVMC shall ensure that the healthcare professional responsible for the employee's Hepatitis B vaccination is provided a copy of this regulation.

2. SVMC shall ensure that the health professional evaluating an employee after an exposure incident shall be provided the following information:

   a. A copy of this regulation

   b. A description of the exposed employee's duties as they relate to the exposure incident

   c. Documentation of the route(s) of exposure and circumstances under which exposure occurred

   d. Results of the source individual's blood testing, if available

   e. All medical records relevant to the appropriate treatment of the employee including vaccination status which are the employer's responsibility to maintain

G. Healthcare Professional's Written Opinion

SVMC shall obtain and provide the employee with a copy of the evaluating healthcare professional's written opinion within fifteen (15) days of the completion of the evaluation.

1. The healthcare professional's written opinion for Hepatitis B vaccination shall be limited to whether hepatitis B vaccination is indicated for an employee, and if the employee has received such vaccination.

2. The healthcare professional's written opinion for post-exposure evaluation and follow-up shall be limited to the following information:

   a. That the employee has been informed of the results of the evaluation

   b. That the employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment

3. All other findings or diagnoses shall remain confidential and shall not be included in the written report.

H. Medical Recordkeeping

Medical records required by blood borne pathogen standard shall be maintained by employer's occupational health provider.

SHARPS INJURY LOG

SVMC's Employee Health Department shall establish and maintain a Sharps Injury Log, which is a record of each exposure incident involving a sharp. The exposure incident shall be recorded on the log within fourteen (14) days of the date the incident is reported to the employer. The information recorded shall include the following information, if known or reasonably available:

A. Type and brand of sharp involved in the exposure incident.

B. A description of the exposure incident which shall include:

1. Job classification of the exposed employee
2. Work area where the exposure incident occurred
3. The procedure that the exposed employee was performing at the time of the incident
4. How the incident occurred
5. The body part involved in the exposure incident
6. If the sharp had engineered sharp injury protection, whether the protective mechanism was activated, and whether the injury occurred before the protective mechanism was activated, during activation of the mechanism or after activation of the mechanism.
7. If the sharp had no engineered sharps injury protection, the injured employee's opinion as to whether and how such a mechanism could have prevented the injury
8. The employee's opinion about whether any other engineering, administrative or work practice control could have prevented the injury

EXPOSURE RESPONSE, PREVENTION AND CONTROL

The Exposure Control Plan is designed to minimize or eliminate employee exposure to blood borne pathogens for those who are potentially exposed at least once per month. These employees are protected by SVMC with safety measures identified below, according to the Blood borne Pathogen Standard of December 6, 1991, which was amended January 15, 1999.

SVMC

1. Reviews major tasks and procedures performed by personnel and identifies all high risk exposure incidents, and how frequently exposure incidents occur per month.

2. Ensures that all major tasks and procedures done by each employee is reviewed and potential exposure incidents identified.

3. Provides employees who are exposed to blood pathogens, at least once per month:

   a. Safety training in blood borne pathogens

   b. the protective clothing required by OSHA against pathogen exposure

   c. written safety information from the contents of the agency health and safety manuals

4. Provides for periodic evaluation of the frequency, types and brand(s) of sharps involved in exposure incidents documented in the Sharps Injury Log.

   NOTE: Frequency of use may be approximated by any reasonable and effective method.

5. Provides for the identification of currently available engineering controls and selecting such controls, where appropriate, for the procedures performed by employees in their respective work areas.

6. Provides for documenting patient safety determinations.

7. Provides for obtaining the active involvement of employees in reviewing and updating the exposure control plan with respect to the procedures performed by employees in their respective work areas.

8. Ensures that a copy of the Exposure Control Plan is accessible to employees.

9. Shall prepare an exposure determination form. This exposure determination form shall contain the following:

   a. A list of all job classifications in which employees have occupational exposure

   b. A list of job classifications in which some employees have occupational exposure

c. A list of all tasks and procedures or groups of closely related tasks and procedures in which occupational exposure occurs. This exposure determination shall be made without regard to the use of personal protective equipment.

A. Methods of Compliance

1. General – Standard Precautions shall be observed to prevent contact with blood or OPIM. Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids shall be considered potentially infectious materials.

2. Engineering and Work Practice Controls – General Requirements:

a. Engineering and work practice controls shall be used to eliminate or minimize employee exposure

b. Engineering controls shall be reviewed and maintained or replaced on a regular basis to ensure their effectiveness

c. Routine work practice controls shall be evaluated and updated on a regular basis to ensure their effectiveness

d. All procedures involving blood or other potentially infectious materials shall be performed in such a manner as to minimize splashing, spraying, spattering, and generation of droplets of these substances.

3. Engineering and Work Practice Controls – Specific Requirements:

a. Needleless Systems. Needleless systems shall be used for:

- Withdrawal of body fluids after initial venous or arterial access is established
- Administration of medications or fluids
- Any other procedure involving the potential for an exposure incident for which a needleless system is available as an alternative to the use of needle devices

b. Needle Devices. If needleless systems cannot be used, needles with engineered safety devices to prevent sharps injury shall be used for:

- Withdrawal of body fluids
- Accessing a vein or artery

- Administration of medications or fluids

EXCEPTIONS:

- Market Availability. The engineering control is not required if it is not available in the marketplace.

- Patient Safety. The engineering control is not required if a licensed healthcare professional directly involved in a patient's care determines, in the reasonable exercise of clinical judgment, that use of the engineering control will jeopardize the patient's safety or the success of a medical, dental or nursing procedure involving the patient. The determination shall be documented.

- Safety Performance. The engineering control is not required if the employer can demonstrate by means of objective product evaluation criteria that the engineering control is not more effective in preventing exposure incidents than the alternative used by the employer.

- Availability of Safety Performance Information. The engineering control is not required if the employer can demonstrate that reasonably specific and reliable information is not available on the safety performance of the engineering control for the employer's procedures, and that the employer is actively determining by means of objective product evaluation criteria whether use of the engineering control will reduce the risk of exposure incidents occurring in the employer's workplace.

4. Prohibited Practice

a Shearing or breaking contaminated needles and other contaminated sharps is prohibited.

b Contaminated sharps shall not be bent, recapped, or removed from devices.

EXCEPTION: Contaminated sharps may be bent, recapped or removed from devices if the procedure is performed using a mechanical device or a one-handed technique, and it can be demonstrated by the employer that no alternative is feasible or that such action is required by a specific medical or dental procedure.

c Sharps that are contaminated with blood or OPIM shall not be stored or processed in a manner that requires employees to reach by hand into the containers where these sharps have been placed.

d Disposable sharps shall be used.

e Broken glassware, which may be contaminated, shall not be picked up directly with the hands. It shall be cleaned up using mechanical means, such as a brush and dust pan, tongs, or forceps.

f The contents of sharps containers shall not be accessed unless properly reprocessed or decontaminated.

g Sharps containers shall not be opened, emptied or cleaned manually or in any other manner which would expose employees to the risk of sharps injury.

h Activities such as eating, drinking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is reasonable likelihood of occupational exposure.

i Food and drink shall not be kept in refrigerators, freezers, shelves, cabinets or on countertops or bench tops where blood or OPIM are present.

B. Requirements for Handling Contaminated Sharps

All procedures involving the use of sharps in connection with patient care, such as withdrawing body fluids, accessing a vein or artery or administering vaccines, medications or fluids shall be performed using effective patient handling techniques and other methods designed to minimize the risk of a sharps injury.

Immediately place contaminated sharps in puncture resistant, leak proof containers.

At all times during the use of sharps, containers for contaminated sharps shall be:

1. Easily accessible to personnel and located as close as is feasible to the immediate area where sharps are used or can be reasonably anticipated to be found.

2. Maintained upright throughout use, where feasible.

3. Replaced as necessary to prevent overfilling.

C. Sharps Containers for Contaminated Sharps:

1. All sharps containers for contaminated sharps shall be:

a. Rigid

b. Puncture resistant

c. Leak proof on the sides and bottom

d. Portable, if portability is necessary to ensure easy access by the user

e. Labeled appropriately with the universal biohazard symbol

2. If discarded sharps are not to be reused, the sharps container shall also be closeable and sealable so that when sealed, the container is leak resistant and incapable of being reopened without great difficulty.

D. Regulated Waste.

The EPA and the State Health Department administer regulated waste disposal laws in the environment **outside** the agency; OSHA administers laws **within** the agency. SVMC rigidly adheres to both.

1. General

Handling, storage, treatment and disposal of all regulated waste shall be in accordance with Health and Safety Code Chapter 6.1, Sections 117600 through 118360, and other applicable regulations of the United States and the State of California (including political subdivisions). The actual treatment and disposal of the regulated waste generated by SVMC shall be the responsibility of Stericycle, Inc., a contract biohazardous waste contractor.

Regulated waste policies must be understood by *all* personnel handling such waste.

Once regulated waste is disinfected, it is no longer considered "infectious" and may be disposed of as regular solid waste *unless* it contains sharps or dangerous materials.

2. Disposal of Sharps Containers

When any container of contaminated sharps is moved from the area of use for the purpose of disposal, the container shall be:

a. Placed in a secondary container if leakage is possible. The secondary container shall be:

- Closeable

- Constructed to contain all contents and prevent leakage during handling, storage, transport or shipping
- Labeled appropriately with universal biohazard symbol

b. Disposal of other Regulated Waste. Regulated Waste not consisting of sharps shall be disposed of in containers which are:

- Closeable
- Constructed to contain all contents
- Labeled appropriately and color-coded
- Closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping

c. If outside contamination of a container or regulated waste occurs, it shall be placed in a secondary container. The secondary container shall be:

- Closeable
- Constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping
- Labeled appropriately and color-coded
- Closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport or shipping

E. Handling Specimens of Blood or Other Infectious Material

1. Specimens of blood or OPIM shall be placed in a container that prevents leakage during collection, handling, processing, storage, transport, or shipping.

   Care shall be taken to avoid contamination of the outside of the container or the laboratory slip.

2. The container for storage, transport or shipping shall be labeled or color-coded and closed prior to being stored, transported, or shipped.

3. If outside contamination of the primary container occurs, the primary container shall be placed within a second container that prevents leakage during collection, handling, processing, storage, transport, or shipping and is labeled or color-coded.

4. If the specimen could puncture the primary container, the primary container shall be placed within a secondary container that is puncture resistant in addition to the above characteristics.

F. Servicing or Shipping Contaminated Equipment

Equipment that may become contaminated with blood or OPIM shall be examined prior to servicing or shipping and shall be decontaminated as necessary, unless the employer can demonstrate that decontamination of such equipment or portions of such equipment is not feasible.

1. A readily observable label shall be attached to the equipment stating which portions remain contaminated.

2. Information concerning any remaining contamination shall be conveyed to all affected personnel, the servicing representative, and / or manufacturer, as appropriate, prior to handling, servicing, or shipping so that appropriate precautions will be taken.

G. Cleaning and Decontamination of the Worksite / Housekeeping

Cleaning and decontamination of the worksite / housekeeping is addressed in this policy because many safety and health injuries occur as a result of inadequate cleaning, repair and maintenance.

1. General Requirements

a. Employers shall ensure that the worksite is maintained in a clean and sanitary condition.

b. Employers shall determine and implement an appropriate written schedule for cleaning and decontamination of the worksite.

c. The method of cleaning or decontamination used shall be effective and shall be appropriate for the specific setting as well as the type of soil or contamination present and the type of surface or equipment to be treated.

d. All equipment, environmental and work surfaces shall be cleaned and decontaminated after contact with blood or OPIM no later than at the end of the visit. The cleaning and decontamination of equipment and work surfaces may be required more often than is specified below.

2. Specific Requirements

a. Contaminated Work Surfaces. Contaminated work surfaces shall be cleaned and decontaminated immediately or as soon as feasible when:

- Surfaces become overtly contaminated
- There is a spill of blood or OPIM
- Apply hospital-level tuberculocidal disinfectant or fresh bleach solution (1:10) on blood spills
- If bleach solutions are used, the solution must be refreshed every 2 days. Once diluted, bleach solutions lose disinfecting strength rapidly.
- After procedures are completed
- At the end of the visit, if the surface may have become contaminated since last cleaning

b. Receptacles. All bins, pails, cans, and similar receptacles intended for reuse which have a likelihood for becoming contaminated with blood or OPIM shall be inspected and decontaminated on a regularly scheduled basis and cleaned and decontaminated immediately or as soon as feasible upon visible contamination.

c. Instruments. In most cases, disposable instruments shall be used; however, if reusable medical instruments are used, they shall be cleaned with a disinfectant (hospital level – tuberculocidal) before being processed.

d. Protective Coverings. Protective coverings, such as plastic wrap, aluminum foil, or imperviously-backed absorbent paper used to cover equipment and environmental surfaces, shall be removed and replaced as soon as feasible when they become overtly contaminated or at the end of patient care if they may have become contaminated.

e. Physical Area. All places of employment, passageways, storerooms and service areas must be kept clean and orderly and in a sanitary condition.

f. Physical Patient Care Area. Floor must be kept clean and dry. The cleaning in rooms and / or areas where blood or OPIM may be present must be as frequent as necessary to maintain a decontaminated status, giving due regard to the amount and type of contaminants present.

H. Hygiene

1. SVMC shall provide handwashing facilities that are readily accessible to employees.

2. When provision of handwashing facilities is not feasible, the employer shall provide either an appropriate antiseptic hand cleanser (or alcohol-based hand sanitizer) in conjunction with clean paper towels or antiseptic towelettes. When antiseptic hand cleaners or towelettes are used, hands shall be washed with soap and running water as soon as is feasible.

   SVMC shall ensure that employees wash their hands immediately or as soon as feasible after removal of gloves or OPIM.

3. SVMC shall ensure that employees wash hands and any other skin with soap and water, or flush mucous membranes with water immediately or as soon as feasible following contact of such body areas with blood or other potentially infectious material.

I. Laundry

1. Contaminated laundry shall be handled as little as possible with a minimum of agitation.

2. Whenever contaminated laundry is wet and presents a reasonable likelihood of soaking through or leakage when bundled, gloves should be worn and it should be transported in a manner which prevents soak-through, leakage of fluids to the exterior or contamination of the environment.

3. In keeping with Universal / Standard Precautions, all linen will be handled in the same manner as if potentially infectious.

INDIVIDUALS COVERED BY THE PLAN

The Exposure Control Plan practiced at SVMC applies to the following health care providers:

- Full-time, part-time, contract and temporary employees (nursing personnel, medical staff, and support staff) who have direct contact or whose duties are likely to bring them in contact with blood or body fluids of patients or patient specimens.
- Students and trainees, including those from health professional schools; students from other programs; institutions or universities; and post-graduate trainees with clinical responsibilities.
- Volunteers.
- Research personnel whose duties include processing specimens of human blood or body fluids.

TRAINING DOCUMENTATION

All high risk healthcare workers must receive education about precautionary measures, epidemiology, modes of transmission and prevention of HIV/HBV/HCV, and other associated infectious agents. SVMC provides this education at New Hire Orientation, during Annual Orientation, and when deemed necessary.

Training regarding the location and proper use of personal protective equipment, safe work practices, Standard / Universal Precautions, tagging, housekeeping to prevent contamination and needle stick or body fluid exposure procedures must also be carried out.

Training is a continuous responsibility and will occur formally on-hire and annually thereafter as well as informally during the work day with special instructions in certain situations or special departmental in service gatherings (5-minute huddles, etc.). Documentation of training will be maintained by the Staff Development Department.

All regulatory agencies (OSHA, The Joint Commission, Title 22) require documentation of and maintenance of orientation and annual training records related to Infection Control, Standard / Universal Precautions and OSHA Regulations. OSHA standards are the most specific and include the main elements required by The Joint Commission and Title 22. A plan for recordkeeping that will be maintained by the agency for five (5) years and shall include as a minimum, the following information:

- The dates of the training sessions.
- The contents of a summary of the training sessions.
- The names of the persons conducting the training.
- The names of all persons attending the training sessions.

A mechanism for maintaining records of rotation individuals shall be established by the primary educational facility, i.e., records of nursing students are maintained by their school.

All records are available to the employee, his representative, representatives from OSHA or other accrediting bodies.

IDENTIFICATION OF WORKERS "WHOSE REASONABLY ANTICIPATED DUTIES" MAY RESULT IN EXPOSURE TO BLOODBORNE PATHOGENS

RISK EXPOSURE CATEGORIES

Category 1: HIGH RISK – Individuals whose duties are likely to bring them in contact with blood or OPIM.

Category 2: LOW RISK – Individuals whose duties are not likely to bring them in contact with blood or OPIM.

Category 3: NO RISK – Individuals whose duties do not bring them in contact with blood or OPIM.

All positions within the hospital which have direct patient care contact which may involve exposure to blood or OPIM or involve transportation of infectious waste or laboratory specimens have been designated to be "high risk".

Positions, which have direct patient care contact that is not likely to involve exposure to blood or body fluids such as social services, have been designated as "low risk".

Administrative personnel and clerical support personnel, who have no direct patient care contact, have been designated as "no risk".

Administration – All positions	Category 3
Biomedical – All positions	Category 2
Cardiopulmonary Services – All positions	Category 1
Central Processing – All positions	Category 1
Communications – All positions	Category 3
Data Processing – All positions	Category 3
Dietary – All positions	Category 3
Employee Health Services	
All positions	Category 1
Financial Services	
All positions	Category 3
Housekeeping	
Manager	Category 3
All other positions	Category 1
Human Resources	
All positions	Category 3

Infection Control	Category 1
Laboratory	
Manager	Category 2
All other positions	Category 1
Laundry	
All positions	Category 1
Maintenance	
Carpenter	Category 3
Plumber	Category 1
Painter	Category 3
Air conditioning mechanic	Category 3
All other positions	Category 3
Materials Management	
All positions	Category 3
Medical Records	
All positions	Category 3
Medical Staff Services	
Medical Director	Category 2
All other positions	Category 3
Medical Staff	
All positions	Category 1
Nursing Services	
Nursing Service Administration	Category 3
Administrative Manager	Category 3
Clinical Manager	Category 2
Clerks	Category 3
Hospital Service Aide	Category 2

Ward Clerk	Category 2
All other positions	Category 1
Outpatient Services	
Clerk	Category 2
All other positions	Category 1
Patient Accounting – All positions	Category 3
Pharmacy – All positions	Category 3
Physical Therapy – All positions	Category 2
Quality Management – All positions	Category 3
Radiology (including Nuclear Medicine)	
Manager	Category 2
All other positions	Category 1
Risk Management – All positions	Category 3
Social Services – All positions	Category 3
Staff Development	
Clinical Instructor, R.N.	Category 2
Clerk	Category 3
Utilization Review / Case Management – All positions	Category 3
Volunteer Services	
Those with patient contact or potential exposure to blood or other potentially infectious materials	Category 2
All other positions	Category 3

NOTE: HOUSE-WIDE POLICY:

- An employee with a draining skin lesion shall not work in direct patient care requiring physical contact.

- Non-intact skin or hands or forearms (i.e., a cut, abrasion, dry skin lesions) shall be covered with an appropriate barrier.

- Each specialty department may have additional guidelines based upon the type of activities performed. For detailed guidance, see Departmental Specific Infection Prevention Policies and Procedures.

REFERENCES:

- California Code of Regulations, Title 22 – Social Security, Division 5 – Licensing and Certification of Health Facilities. Chapter 1 General Acute Care Hospitals, Article 7. ***Cal. Code Regs. Tit. 22, § 70739 - Infection Control Program***. *Accessed July 2024*, https://www.law.cornell.edu/regulations/california/22-CCR-70739

- *Occupational Safety and Health Administration (OSHA). Code of Federal Regulations, 29 CFR 1910.1030 – Bloodborne Pathogens. Accessed July 2024. https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030*

- Occupational Safety and Health Administration (OSHA). Federal Registers Hazard Communication Standard Publication. *Accessed July 2024*. https://www.osha.gov/hazcom

- California Code of Regulations, Title 8, Section 5193 - Industrial Relations, Records on Training and Transfer of Training Records. Subchapter 7 General Industry Safety Orders. ***Title 8, CCR § 5193 Handling of Blood.*** *Accessed July 2024*, https://www.dir.ca.gov/title8/5193.html

CROSS REFERENCES:

- HANDWASHING
- BLOODBORNE PATHOGEN EXPOSURE PROTOCOL FOR HEALTHCARE WORKERS
- ANNUAL INFECTION PREVENTION PLAN

SUBJECT: **FORMULARY**	SECTION: **Page 1 of 6**

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

PURPOSE:

To provide an ongoing process whereby the Pharmacy Department and the medical staff of Sierra View Medical Center (SVMC), working through the activities of the Pharmacy and Therapeutics (P&T) Committee, evaluates and selects those drug products considered to be the most useful in patient care according to need, effectiveness, safety and cost.

DEFINITION:

Formulary: An approved list of medications that can be used in all patient care areas of Sierra View Medical Center.

POLICY STATEMENT:

It is the policy of Sierra View Medical Center that the maintenance and updating of the formulary of approved medications is the responsibility of the Department of Pharmacy Services via the Pharmacy and Therapeutics (P&T) Committee.

PROCEDURE:

A. The Formulary:

1. Will be compiled and maintained by the Pharmacy Service under the general direction of the Pharmacy and Therapeutics Committee.

2. Will be distributed appropriately to members of the medical staff, nursing staff and other professionals, so that it may be immediately available to them, either in printed form, via the SVMC intranet, or via SVMC website.

3. Will be revised, and approved by the medical staff annually.

4. Will consist of a listing of all drugs and pharmaceutical agents, legend and non-legend, in general use in the Medical Center, which contains:

    a. An alphabetical listing with generic and trade name references

    b. A code key that will note use restrictions

When drugs are added to the SVMC formulary, they are approved for all FDA-approved indications and for all age groups.

B. Changes to the Formulary

1. Additions, deletions or other changes to the Formulary will be made only with the approval of the Pharmacy and Therapeutics Committee

2. Additions

- Persons desiring additions will complete a form, "Application for Addition to the Sierra View Medical Center Formulary"
- The request is submitted to the Committee through the Pharmacy or a Committee member.
- The requesting person may be required to appear before the Committee for clarification of the nature of the drug and its use.
- The medication request is read into the minutes of the Pharmacy and Therapeutics Committee.
- A subcommittee to review additions shall be formed to consist of the/their sponsor, a Clinical Pharmacist and any other interested individuals.
- A review of the medication is required before medications will be added to the Formulary which consists of at least the following:
  - Formulary Item
  - Recommendation
  - Pharmacological Action/Comparison
  - Drug Interactions
  - Formulary Impact
  - Safety Data (including sentinel events)
  - Economic Impact
  - Summary
  - References

The clinical summary will be used as a tool to inform the professional staffs of the Medical Center about the approved medications.

Education must be given when necessary to all staff involved, including nursing, medical residents, and pharmacy staffs.

3. Deletions:

   - Shall be made for drug items which are no longer used, which have become obsolete, which have been replaced with superior agents, or which should be deleted for other reasons, including newly discovered safety information.

   - The Director or a senior pharmacist will bring such drugs to the attention of the Committee immediately for newly discovered safety issues, but no less than annually for all other time the entire formulary is reviewed.

4. Monitoring:

   - Any new addition to the formulary will be monitored over the next 12 months for reports of untoward side effects or adverse reactions which may require a re-evaluation of formulary status.

   - New reports of adverse reactions, warnings, precautions, and other safety concerns for established formulary medications will be reviewed, and proactively identified for possible reevaluation of formulary status.

   - Additions, deletions, evaluation data, and other important topics will be presented to the medical staff through a newsletter of the Pharmacy and Therapeutics, which will be published approximately quarterly.

     Shortages to items on formulary will be evaluated by pharmacy personel. An email with information on shortages & alternatives will be distributed to providers on an as needed basis.

5. Clinical Informatics/ACS will be notified of any formulary changes once they are approved and education has been provided, as appropriate, so the electronic pharmacy and ordering systems can be updated to reflect the changes/shortages.

ADDENDUMS:

"Application for Addition to the Sierra View Medical Center Formulary" Formulary 2018 Drug List

REFERENCES:

- Hospital accreditation standards. (2024). Oak Brook, IL: Joint Commission Resources.
  - MM.02.01.01 EP2

- American Society Hospital Pharmacists Best Practices.(2018). Retrieved from http://digital.ashp.org/ASHP_Best_Practices_2015-2016.

Addendum A
PHARMACY AND THERAPEUTICS COMMITTEEAPPLICATION FOR ADDITION TO THE SIERRA VIEW MEDIAL CENTER FORMULARY

INSTRUCTIONS:

- Formulary application is restricted to medical and surgical staff members, and clinical pharmacists.
- Department chairman or department director co-signature is required.
- Use sound sources of information. [Example: Review articles, drug information sources (Micromedex), or practice guidelines]. Expert consultants in the therapeutic area of interest may also be very useful.
- Return this form to the Director of Pharmacy.
- The sponsoring member or clinical pharmacist must be present at the committee meeting for the request to be evaluated.

PHARMACY AND THERAPEUTICS COMMITTEE
APPLICATION FOR ADDITION TO THE SIERRA VIEW MEDICAL CENTER FORMULARY

PLEASE COMPLETE THE FOLLOWING INFORMATION:

FORMULARY ITEM:

Generic Name:

Trade Name:

Dosage Form:

Cost per usual treatment day:

PHARMACOLOGY:

Therapeutic Class:

Mechanism of Action:

Uses:

FDA Approved Indications:

Non FDA Approved Indications:

Primary Medical Use Area & population served (Highest Volume):

Circle those that apply: Neonatal Pediatric Adult Geriatric

Expected Volume of Use (# of treatment courses per month or per year):

COMPARISON TO OTHER AGENTS ON THE FORMULARY:

What agents on the SVMC Formulary are currently utilized to treat patients with similar indications to the drug being requested?

What advantages does this agent provide over the treatments (efficacy, adverse effects, convenience, cost, DDI's)?

Are the agents on the SVMC Formulary which should be considered for deletion if this item is approved?

Are their agents on SVMC Formulary for same product with differing concentration? If so state clinical reason for need of additional concentration & steps to prevent errors or mix ups.

SAFETY DATA:

Have there been any reports, including sentinel event advisories, of serious adverse effects from the use of this agent?

Does this agent pose any potential risk to patients or employees (via errors or abuse potential) at SVMC either medically or due to packaging or dose form idiosyncrasies?
Is the drug on the NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings list?
Circle one: Yes or No

If yes please circle corresponding group.
Group 1 (Antineoplastic)
Group 2 (Non-Antineoplastic with criteria for hazardous drug)
Group 3 (Adverse reproductive risks)

COST DATA:

What will be the usual dose, duration of therapy and cost per treatment course for this agent?

Compare costs, direct and indirect, that may occur with addition of this agent.

ADJUNCTIVE TREATMENT MORE LESS UNKNOWN

ADJUNCTIVE

MONITORING
(LABS, X-RAYS)

HOSPITALIZATION

PATIENT OUTCOME ASSESSMENT:

Will patient outcome be improved by this agent?

Yes_____ No____

If yes, in what regard (cure-rate, disease prevention, decreased hospitalization and use of resources, fewer complications, quality of life).

ADDITIONAL INFORMATION:

Was this application prompted by a representative of the drug's manufacturer?

Yes_____ No____

Do you have a financial interest in having this drug added to the formulary?

Yes_____ No____

_____ _____
SVMC Faculty or Pharmacist Date

_____ _____
Department Chairman /Director Date

SUBJECT: **INTRAFACILITY PATIENT TRANSPORT**	SECTION: ***Provision of Care, Treatment and Services (PC)*** **Page 1 of 6**

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

PURPOSE:

To provide guidelines to be followed when transporting a patient within the Sierra View Medical Center campus.

POLICY:

Intrafacility transport of patients will be done in a safe and orderly manner by trained personnel appropriate to the acuity/stability of the patient.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

PROCEDURE:

HOUSEWIDE:

1. If the patient is being moved for any reason other than patient request, be sure the patient is made aware of the move and the reason for it.

2. Confirm time patient will be arriving with receiving department. If the patient is being moved to another unit, ascertain that the receiving unit is ready to receive the patient prior to transport.

3. If patient is being permanently transferred to a different department, complete the Personal Belongings Check List; take all their belongings, equipment, chart, and medications with them and provide to patient's nurse.

4. Assess and provide for specialty equipment prior to transport.

5. Obtain proper mode of transportation for the patient. Fall risk patients will be transported on a bed or gurney. Other patients may be transported by wheelchair if their condition permits.

6. Transfer the patient to the new room, assist with the transfer of the patient to the bed and make sure patient safety needs are met. Example: oxygen, IVs, suction, etc. is attached as needed.

7. When moving patient from one destination to another, the sending personnel will introduce the patient and/or family to receiving personnel.

8. Observe safety procedures at all times when transporting patients. Bed/gurney side rails should be in the "UP" position when bed/gurney is used to transport.

9. If a patient meets fall risk criteria, be sure that staff in the receiving department have been informed prior to leaving the patient in their care.

10. Patients will never be left unattended at any time at SVMC. As examples:

    a. During transport of patient

    b. In-between or during procedures

11. The appropriate health care personnel should accompany and remain with the patient during transfer as deemed necessary per nursing judgment; e.g. (1) The Registered Nurse (RN), if there are IV meds requiring constant titration or the patient is in unstable condition and (2) Respiratory Therapist (RT) when airway/breathing difficulty exists and their presence is necessary. Post code blue/white patients being admitted to ICU or transferring to higher level of care will always have a RN and RT present during transport; otherwise will follow hospital wide protocol already in place.

12. All patients scheduled for transport to a procedure and requiring Fi02 50% (6-7L) or greater will be evaluated by both the patient's RN and RT. They will collegially determine that the patient is safe for transport and if the RT should be in attendance during transport. Minimally the following will be evaluated together:

    a. Stable vital signs

    b. Type of delivery device

    c. Initial flow rate

    d. Adequate oxygen source and supply for transport

13. Volunteers may transport patients/visitors in the following circumstance:

    a. When a person arrives in the lobby and needs to be transported via wheelchair to a hospital department.

    b. Transport of any patient/visitor will be at the discretion of the volunteer.

    c. Volunteers may at their discretion, transport non-laboring patients arriving to the hospital to the Maternal Child Health department by wheelchair.

    d. After a patient is discharged from the hospital, they may take the patient by wheelchair to the lobby, unless they have been identified as a fall risk.

    e. Volunteers may only *assist* healthcare personnel during transport of patients from one department to another (never alone).

    f. Volunteers may assist visitors at any time.

Volunteers may assist other healthcare workers in the transport of a patient that is in a bed or gurney at their discretion.

14. "Ticket to Ride" process will be followed for all inpatients transported for procedures without an RN, and by assistive personal, to facilitate proper handoff to the receiving department.

    a. Ensure entire "Ticket to Ride" is filled out and discussed with employee transporting patient to next destination.

    b. Refer to SBAR policy for RN to RN hand off.

15. A proper SBAR hand off will occur with all permanent patient transfers from one department to another, prior to departure to receiving department.

16. The following positions are defined as assistive personnel in terms of patient transport:

    a. Employees of SVMC working in a clinical department.

    b. Certified nursing assistant (CNA), Radiology Transport Aide, and nursing students.

UNIT SPECIFIC

1. ***Medical / Surgical/ Med-Tele Pt.***

    a. ADULTS

    - Patients may be transported by assistive personnel if condition warrants.
    - Patients admitted to a cardiac monitored bed will be transported with a cardiac monitor (unless documented otherwise by the attending physician.)

    b. PEDIATRICS (To other departments except Surgical Services):

    - Newborn to 4 years old of age will be transported in a crib/gurney, bassinette or may be held by parents/legal guardian in a wheelchair.
    - Children over 4 years of age will be transferred in a wheelchair unless they have been identified as a fall risk or procedure requires gurney transport.
    - Any child transported with an IV will have enough fluid for one hour. If the procedure is to last more than one hour, a nurse must go to the department to check the IV for proper functioning and refill the buretrol every hour as necessary.

2. ***Telemetry***

   a. Patients admitted to a cardiac monitored bed will be transported with continuous cardiac monitoring unless the admitting physician has an order allowing the patient to be transported without cardiac monitoring.

   b. Telemetry patients will be transported with continuous cardiac monitoring to all procedures or testing. Assistive personnel may transport patients with continuous cardiac monitoring except:

   - Telemetry patients on a cardiac drip such as Cardizem or Amiodarone.
   - Any hemodynamically unstable arrhythmia within the last 24 hours.
   - Hemodynamically unstable within the last 24 hours.

3. ***Intensive Care Unit***

   a. All patients being permanently transferred to other departments from the ICU will be transported to the receiving unit at the level of care consistent with that unit and the condition of the patient.

   b. ICU patients will be transported by a Critical Care registered nurse (RN) for any testing / procedures and remain with the patient during their procedures to provide the level of care necessary for the patient. Any procedures requiring the ICU RN to remain off their unit for more than 30 minutes will be prearranged with the ICU Charge Nurse and department personnel where patient procedure is to be completed to ensure safe coverage of remaining ICU patients for a longer period of time.

   c. ICU patients will be transported on a cardiac monitor and accompanied by an ICU RN with current ACLS training.

4. ***OR/PACU/Flex Care/Endoscopy***

   a. Patients may be transported by assistive personnel to Telemetry, Medical/Surgical and Maternal Child Health departments.

   b. Patients transported to ICU must be transported by an RN with a cardiac monitor. Patients to be transported to the OR will be transported by personnel appropriate to the situation. (Critical patients with necessary equipment and staff; e.g., RN, RT).

   c. All patients transported to/from Endoscopy will be transported at the level of care consistent with that unit and the condition of the patient.

d. Children less than 4 years of age will be transported in a crib/gurney with raised side rails or wheelchair, in their caregiver's arms, and accompanied by surgery staff.

e. Children 4 years or older will be transported on a gurney. The gurney must have side rails in the raised position.

5. ***Cancer Treatment Center (CTC)***

a. Patients requiring gurney transport should be transported to or from the CTC through assistance of a medical transport company in line with the needs of the patient.

6. ***Dialysis***

a. All patients transported to/from dialysis will be transported at the level of care consistent with that unit and the condition of the patient.

7. ***Maternal Child Health***

a. Volunteers at their discretion may transport expectant patients arriving to the hospital to the Maternal Child Health Department by wheelchair.

All patients sent to Radiology will be accompanied by support or nursing staff at the nurse's discretion.

b. NICU patients will be transported by an RN for any testing/procedures and remain with the patient during their procedures to provide the level of care necessary for the patient.

8. ***Emergency Department***

a. Patients admitted to a cardiac monitored bed will be transported with continuous cardiac monitoring and IV access.

b. Patients being admitted to the ICU will be accompanied by an RN and other appropriate healthcare personnel.

Assistive personnel may transport patients with continuous cardiac monitoring to the CDU if deemed appropriate by the RN and ED MD.

c. Patients presenting to the ED in labor may be transported to the Maternal Child Health Department by assistive personnel if deemed safe to do so by the ED MD, with a brief medical or nursing examination.

9. ***Respiratory Care Department:***

a. Please contact respiratory care department prior to transport when the patient is:

1. Mechanically ventilated patient.

2. All mechanically ventilated patients should be accompanied by a respiratory care practitioner during the entire transport.

3. On non- invasive equipment such as Bi-Pap, CPAP.

10. ***Imaging Services:***

All patients transported to/from Imaging Services (Radiology, CT, MRI, Ultrasound, Cardiac Echo, Nuclear Medicine) shall be transported at the level of care consistent with that unit and the condition of the patient.

REFERENCE:

- California Code of Regulations (2021). Title 22. §70215(a)(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:

- HAND-OFF COMMUNICATION– Patient Care Services Policy & Procedure Manual
- FALL PREVENTION (ADULT AND PEDIATRIC)– Patient Care Services Policy & Procedure Manual

SUBJECT: **MEDICATION PROCUREMENT, STORAGE, DISTRIBUTION AND CONTROL**	SECTION: ***Medication Management (MM)*** **Page 1 of 13**

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

PURPOSE:

To ensure the safe and appropriate use of drug products and drug-related devices at Sierra View Medical Center.

POLICY:

The Pharmacy Department in collaboration and consultation with other professionals, departments and interdisciplinary committees, with approval by the medical staff, is directly responsible for the control and distribution of all stocks of drugs within the organization.

Under this policy, drugs and drug-related devices include, but are not limited to large and small volume injections, orally, topically or intravenous medications, radiopharmaceuticals, diagnostic agents including radiopaque contrast media, anesthetic gases, respiratory therapy drugs, biotechnologically produced drugs,, drugs brought into the hospital by patients or family, and other chemicals and biological substances administered to patients to evoke or enhance pharmacologic responses.

Control and distribution shall include procurement, recordkeeping, storage and inventory control, compounding, packaging, labeling and disposition.

AFFECTED AREAS/PERSONNEL:

PHARMACY, NURSING, RESPIRATORY THERAPY, DIAGNOSTIC IMAGING, MEDICAL STAFF

PROCEDURE:

I. Procurement

A. The Pharmacist in Charge is responsible for maintaining standards to ensure the quality of all pharmaceuticals used at SVMC. The Pharmacy Department is responsible for the procurement of all pharmaceuticals with the following exceptions:

Large and small volume intravenous solutions without additives.

B. The PIC is responsible for specifications as to the quality, quantity and source of supply of all drugs used in the hospital. Special consideration is given to the current ASHP Guidelines for Drug Distribution and Control, as well as the USP-NF. The Pharmacist in Charge evaluates the acceptability of manufacturers and distributors. Said pharmacist has the authority to reject a particular drug product or supplier if quality is an issue.

C. Procedure:

1. Restocking Pyxis machines will be performed at times scheduled by the Pyxis administrator at the direction of the Pharmacist in Charge. The restock quantities will be based on reports generated by the system to reach pre-set par levels. All individuals that retrieve medications from these systems have a responsibility to ensure accurate dispensation to preserve the integrity of the restocking system. Inaccuracies will be reported to SVMC's error reporting system.

2. Requirements for medications and supplies are determined by a combined list of replacements from pharmacy stock and/or by evaluating minimum and maximum levels on high cost and/or fast moving items on a daily basis. Pharmaceuticals are ordered through the wholesaler's computer interface.

3. When the order is received, the contents of the order are verified against the invoice and/or stickers. All items are stickered and placed into stock. Special handling items i.e., refrigerated.

4. Hazardous drugs will be received and stored in areas designated for HD medications.

5. Controlled substances are checked in and placed in the controlled substances safe in accordance with separate policy (see Controlled Substance Policy).

6. Invoices are matched with purchase orders and original forms and given to the pharmacy buyer for processing. Copies are retained in the pharmacy and originals are coded and forwarded to accounts payable for processing.

7. Items not ordered through the wholesaler, (i.e., IV solutions, blood fraction Products, other specialty items) are matched to the packing receipt and given to the pharmacy buyer for processing.

II. Storage and Control

A. All Pharmaceuticals are stored according to the manufacturer' recommendations or, in the absence of such recommendations, according to a pharmacist's instructions. In addition, all pharmaceuticals are stored under proper environmental conditions (i.e., proper temperature, light, humidity, conditions of sanitation and segregation). Storage areas must be secure, fixtures and equipment used to store drugs will be constructed to limit access only to designated and authorized personnel. Proper consideration is given to the safe storage of poisons and flammable compounds. Internal medications are stored separately from external medications. Non-medications and flammables are not to be stored in medication refrigerators.

1. Room Temperature – Room temperature, as it applies to medication storage shall be between 15°C (59°F) and 30°C (86°F). Medication rooms and drug storage area temperatures will be maintained within this range. Plant Maintenance will notify pharmacy if the temperature in the storage area falls below or is above this specified range. Medications will be relocated to another storage area until the problem is corrected. The pharmacist will be consulted to insure proper relocation.

2. Refrigerator Temperature - Refrigerator temperature, as it applies to medication storage shall be between 2.2°C (36°F) and 7.7°C (46°F). Medication refrigerator temperatures will be maintained within this range. If the temperature is not within the specified range, both the Pharmacy and Plant Maintenance will be notified immediately. Medications will be relocated to another storage area until the problem is corrected. The pharmacist will be consulted to insure the proper relocation of medications. Action(s) taken will be documented either directly on the Refrigerator Temperature Log or in the temperature monitoring software system.

3. Freezer Temperature - Freezer temperature, as it applies to medication storage shall be below -1°F to -50° F) for all pharmaceuticals requiring freezer storage except Cervidil which shall be stored separately in a freezer with the temperature range of -4° F to 14° F. Medication freezer temperatures will be maintained within this range. . If the temperature is not within the specified range, both the Pharmacy and Plant Maintenance will be notified immediately. Medications will be relocated to another storage area until the problem is corrected. The pharmacist will be consulted to insure the proper relocation of medications. Action(s) taken will be documented either directly on the Freezer Temperature Log or in the temperature monitoring software system. "Frozen" antibiotics will be maintained at a temperature not to exceed manufacturer recommendations.

   Note: *Only freezers rated for cryogenic temperatures (below -20°C) are acceptable for medication storage. Freezer compartments of refrigerators are not acceptable for medication storage.*

   Each refrigerator/freezer will have a serviceable thermometer or other temperature-recording device capable of monitoring temperatures within the range required.

   Wireless monitoring system that actively records temperatures every fifteen minutes, twenty-four hours a day, seven days a week will alert engineering to any temperature excursions. Engineering will then in turn contact the pharmacy during normal business hours or the on-call pharmacist if excursions occur after normal business hours.

4. All refrigerators and freezers in the pharmacy are connected to back up emergency power so that in the event of a power failure medication storage temperature will be maintained in an acceptable range.

5. All stored medications & the components used in their preparation are labeled with the contents, expiration date, and any applicable warnings.

4. Return to Storage

a. Nursing

i. Medications issued by the pharmacy (not obtained from Pyxis) that are discontinued by the physician or upon discharge will be returned to pharmacy. These medications are to be placed in the designated box labeled "return to pharmacy".

ii. Medications obtained from Pyxis that are unopened and not used can be returned to the "return bin" in Pyxis.

b. Pharmacy

i. Medications returned to pharmacy will be removed from the designated pharmacy return boxes by the pharmacy staff during regularly scheduled rounds.

ii. Unused and unopened medications issued by the pharmacy will be credited to the proper patient's account regardless of the ability to re-issue that medication to another patient.

iii. Medications that are expired or close to expiration will be disposed of according to PHARMACEUTICAL WASTE policy.

iv. Medications removed from Pyxis during monthly floor inspections that are expired or close to expiration will be disposed of according to HAZARDOUS MATERIALS AND WASTE MANAGEMENT PLAN.

III. Control and Security/Accountability

A. Pharmacy – The pharmacy is locked at all times. Only pharmacists will have keys to the pharmacy. During the hours, which the pharmacy is open; pharmacy technical personnel have limited access to the pharmacy during normal pharmacy hours through a pass coded, lock system, while under the supervision of a pharmacist. Non-Pharmacy personnel must have permission from an on duty pharmacist to enter the pharmacy.

B. Controlled Substances – All controlled substances of schedules C-II through C-V will be under a double lock system. A lockable door (i.e., outside door of a medication room or main pharmacy) qualifies as one lock. Within the main pharmacy, controlled substances of schedules C-II through C-IV will be under a double lock system. Procedures for documentation and recording can be found under ("Pharmacy – Controlled Substances Procedures and/or Nursing – Controlled Substances – Procurement, Administration and Documentation).

C. Medication Rooms – Medication rooms are to remain locked at all times. Only authorized personnel will have access to medication rooms. Authorized personnel will include, but are not limited to Registered Nurses, Licensed Vocational Nurses, and Respiratory Therapists. Other hospital employees who access any medication room must be given authorization and must be observed by nursing or pharmacy staff.

D. Pyxis – Lockable medication cabinets are used to store unit-of-use medications in the patient medication dose system. These medication cabinets will be locked when not attended. Access to medication cabinets will be limited to licensed nursing and pharmacy personnel. The Pyxis cabinets maintain control and storage of medications for various nursing units and keeps specific documentation of all transactions in regards to distribution and dispensing.

E. Large and Small Volume IV Solutions – Certain plain IV solutions are purchased and distributed by the materials management department. These solutions are stored either in the materials management department (considered a limited access area) or in the medication rooms in specific patient care areas. Distribution and control of these solutions are under the guidelines of the pharmacy medication distribution system. These solutions are inspected monthly by pharmacy when completing unit/area inspections.

F. Radiopaque Contrast Media – Radiographic contrast media is purchased by pharmacy, stored and used by the diagnostic imaging department. These medications are controlled with limited access. These medications are inspected monthly by pharmacy when completing unit/area inspections.

G. Radiopharmaceuticals – Radiopharmaceuticals are ordered from a certified/licensed distributor and delivered directly to the "hot lab" in Nuclear Medicine. Policies, procedures and protocols for handling, administration and disposition of radiopharmaceuticals are maintained by the Nuclear Medicine Department of Diagnostic Imaging Services. The Manager of Pharmacy confers with the Chief Nuclear Medicine Technologist annually to review these policies, procedures and protocols.

Drug Samples – Drug samples are not allowed at SVMC under any circumstances.

H. Pharmaceutical Sales Representatives – All representatives MUST sign-in with the pharmacy and are ONLY allowed in the pharmacy unless access to other areas in the hospital is approved.

IV. Inspection and Disposition

A. Inspections – All units and/or areas where medications are used or stored will be inspected by pharmacy staff under the direct supervision of a pharmacist no less frequently than every 30 days. The pharmacy staff during such inspections will ensure that at a minimum:

1. Individual patient medications, except those that have been left at the patient's bedside are returned to pharmacy for appropriate disposition.

2. All drug labels are legible and in compliance with state and federal regulation.
3. Test agents, germicides, disinfectants and other household substances are stored separately from drugs.

4. External use drugs are segregated from drugs for internal use.

5. Drugs are stored at appropriate temperatures.

6. Drugs are accessible only to responsible personnel designated by the hospital.

7. Drugs are not kept in stock after the expiration date on the label and no contaminated or deteriorated drugs shall be available for use.

Findings of unit/area inspections and corrective action(s) required, if any, are discussed with the unit/area supervisor. The unit/area supervisor will acknowledge this by signing the inspection form along with the pharmacist conducting the inspection. A report of findings is provided for the V.P. of Patient Care Services and/or the Chief Nursing Officer. Documentation of inspections is retained for 3 years.

B. Return and Disposal of Medications:

All expired or contaminated medications will be quarantined from Pharmacy stock and sent to a certified pharmaceutical recovery service that is under contract with the facility. The quarantined medications shall be logged into a record (drug return log) that contains at least but not limited to the following information: the date quarantined, name and strength of the medication, its NDC (national drug code) number, quantity, lot number, and the signature of the pharmacy staff that quarantined the medication. The contracted recovery service will conform to FDA and DEA guidelines. The recovery service will meet the following service guidelines:

1. Registered Pharmacist on staff.
2. Be a licensed DEA Registrant.
3. Be DEP/EPA registered large quantity hazardous waste generator.
4. Utilize a licensed hazardous waste transporter.
5. Utilize a licensed hazardous waste processing firm for incineration of disposable products.
6. Maintain general liability insurance.
7. Field Service Technicians are bonded and have Power of Attorney to handle narcotics.
8. Provide documentation or return and/or disposal in accordance with FDA and DEA guidelines.

Copies of the recovery service company's current Controlled Substances Registration Certificate, State Restricted Prescription Drug Distributor License and Department of Environmental Protection DEP/EPA ID Certificate will be maintained in the recovery services binder.

At least quarterly, or more frequently as required the recovery company will be notified to send a Field Service Technician to the Pharmacy to inventory and prepare returned items for shipping.

The recovery service Field Service Technician will segregate controlled substances (C-II through C-V) from non-controlled substances. Schedule II medications will be written up on a DEA Form 222. Schedule III, IV and V medications will be recorded on a Controlled Substances Inventory and Transfer. The original of the DEA Form 222 and the Controlled Substances Inventory and Transfer forms will be retained in the Pharmacy and Copies will be sealed with the separated medications and used as a packing list. Duplicate copies will be sent to the recovery service by the Field Service Technician. All non-controlled substances returned according to the drug return log shall be inventoried, signed, and dated by the recovery service field service technician.

The recovery service Field Service Technician will generate a shipping bill and seal all containers for shipping through a bonded transport service.

Upon receipt of the boxed medications, the recovery service will generate the following documentation:

- Credit Tracking Report – for all items being returned to manufacturers for credit by total Calculated Return Value.
- Manufacturer Return Report – details all items returned by NDC #, description, lot #, expiration date, price and quantity by manufacturer.
- Disposal Report – details all items sent for destruction (incineration) by NDC #, description, lot #, expiration date, price and quantity by manufacturer.
- Disposal Report (Hazardous) – details all hazardous items sent for destruction (incineration) by NDC #, description, lot #, expiration date, price and quantity by manufacturer.
- Controlled Substance Inventory Schedule III – V Destruction Certificate - certifies incineration of schedule III – V medications.
- Copy of the Waste Manifest for Schedule C-II through C-V.
- Schedule Medication Incineration Certificate

The above documentation is maintained in the recovery services binder in the pharmacy and reconciled. Original copy of DEA form 222 is mailed to the DEA.

Waste Management and Accountability (On-site disposal)

Disposal of medication waste within the department shall be controlled and accountability held by the Pharmacist in Charge. Pharmacy Staff shall dispose of waste in a manner that is consistent and complies with state and federal regulations.

C. Wasting of Medications
(1) Controlled substances will be wasted as per SVMC's CONTROLLED SUBSTANCES policy.

(2) Non controlled medications will be wasted as per SVMC's PHARMACEUTICAL WASTE policy.

V. Distribution of Medications

The pharmacy will dispense all drugs in single unit of use (unit dose) packaging whenever practical and placed in automated dispensing machines.

A. Medications are contained in, and administered from, single unit or unit dose packages.

B. Medications are dispensed in ready-to-administer form to the extent possible.

C. For medications not available in an automated dispensing machine, not more than a 72 hours supply of doses is provided to or available at the patient-care area at any time.

D. A patient medication profile is concurrently maintained in the pharmacy for each patient.

VI. Blood Derivatives

Blood derivative products such as albumin, gamma globulin, immune globulin, etc., are procured and dispensed exclusively by the pharmacy department. Rh_o (D) Immune Globulin is procured by the pharmacy department and distributed to the Laboratory Blood Bank. The blood bank tracks the receipt and dispensing to patients by lot number, using the same procedure as tracking human blood.

VII. Guidelines For Product Dating

All medications at SVMC will be stored in accordance with the most recent guidelines as established by the United States Pharmacopeia (USP) and The National Formulary (NF), and recommendations form the Centers for Disease Control and Prevention (CDC). Consideration is given to the American Society of Health System Pharmacist (ASHP) practice standards.

General Guidelines:

All multi-dose *INJECTABLE* medication containers will be refrigerated after opening, unless specifically labeled "*Do Not Refrigerate*".

Form Specific Guidelines:

1. Injectable:

   a. Ampules – Discard immediately after use. Always use a filter straw.

   b. Single Dose Vials – Discard immediately after use.

   c. Multi-Dose Vials – Discard when empty, when suspected or visible contamination occurs, or if unopened when the manufacturer's expiration date is reached. If opened, use 28 days as expiration or as recommended by manufacturer's guidelines.

   d. Insulin products- 28 days after opening. Must label with expiration date.

2. IV Solutions – Admixed

a. Mixed on the unit/patient care area – 4 hours after mixing.

b. Mixed in the Pharmacy – As indicated on the IV labels by the pharmacist.

3. IV Solutions – Unmixed

   a. IVPB's and LVP's over 100ml– 30 days after removal of the moisture protective wrapping.

   b. IVPB under 100ml- 15 days after removal of the moisture protective wrapping.

4. Irrigation Solutions

   a. Sterile Saline & Water – 24 hours from opening.

5. EENT Solutions- 1 year after opening or manufacturer's expiration date whichever is first.

   a. Nasal solutions/sprays

   b. Ophthalmic

   c. Otic

6. Nitroglycerin

   a. Sublingual – 6 months after opening.

7. Oral Liquids & Solids

   a. Non-repackaged – manufacturer's expiration date.

   b. Re-packaged – 1 year from date of repackaging or manufacturer's expiration date, whichever is shortest.

8. Topicals- 1 year after opening or manufacturer's expiration date, whichever is first.

   a. Solutions – manufacturer's expiration date if not repackaged or opened.

   b. Ointments, Creams

9. Non-sterile Compounded Medications

a. Orals & Topicals – consult either, Remington's Pharmaceutical Sciences, U.S. Pharmacopeia or medical literature for sterility, stability data. May not be more than 1 year from date of compounding.

VIII. Drug Supply Chain Security Act

As of August of 2023, the FDA has signaled a delay in enforcement action until November 27th, 2024 as they have acknowledged that U.S interoperable systems may need additional time to stabilize and be fully interoperable. SVMC will continue our efforts to work with our third party software to implement the necessary measures and follow the below process to satisfy the enhanced drug distribution security requirements as our partners come online with their systems.

Trading Partner Verification

A. SVMC will maintain a complete list of drug suppliers and other trading partners. Any company from which SVMC buys pharmaceutical products or to which pharmaceutical products are sold may be a trading partner and their license must be verified prior to business taking place.
B. Prior to doing business with a new supplier or trading partner, SVMC will check the state and/or federal registration licensure status of each by one of the following methods.
    a. Type in the company name in the federal database and look up the address for the facility with which business will be conducted: http://www.accessdata.fda.gov/scripts/cder/wdd3plreporting/index.cfm
        i. Each facility will have its own license. Make sure an out of state supplier is authorized and licensed to sell pharmaceuticals in California.
    b. Check California Board of Pharmacy for licensure verification
    c. Ask supplier to provide a copy of their state or federal license or registration. The document should reflect authorization to sell products in California
    d. Document the supplier's licensure expiration data and make a note to review prior to its expiration.
C. SVMC will check the licensure or registration of any new supplier or trading partner prior to purchasing with the supplier.

Transaction Data Capture and Maintenance

1. SVMC will utilize software (Tracelink) for receiving, storing, and retrieving the transaction data of prescription drugs as defined by 503(b) (1) for six years after the transaction.
2. Before accepting delivery of an order, SVMC will review the transaction data to confirm that it matches the physical product received. After acceptance within Tracelink, store the data for future reference as required by DSCSA. This will be held and searchable/retrievable on demand for 6 years.
3. Exempt from the definition of "prescription drugs" are the following:
    a. Intravenous drug that, by its formulation is intended for the replenishment of fluids and electrolytes (such as sodium, chloride and potassium) or calories (such as dextrose or amino acids).
    b. Intravenous drug used to maintain equilibrium of water and minerals in the body, such a dialysis solution.

c. A product intended for irrigation or reconstitution
d. Medical gases
e. Contrast agents or "imaging agents"
f. Medications that may be purchased as OTC (over the counter).

Product Resales

I. At the time of a sale of product to another pharmacy, SVMC will use Tracelink to complete the following actions:
   a) Make a copy of the prior Transaction information & History
   b) Add the new transaction information from the pending sale to the document. New information should include; order date, ship date, product information (name, strength, dosage), NDC, container size, number of containers, lot number, expiration date, your pharmacy name and address and the purchaser's name and address.
   c) Add a transaction statement by including the following language: "Seller has complied with each applicable subsection of FDCA Sec. 581(27)(A)-(G)."
   d) Send the revised transaction data long with the sold product but maintain a copy for SVMC files.
   e) Retain outgoing data for sold products in Tracelink for 6 years.

Suspect Product Investigation

II. A suspect product is one that there is reasonable belief the product may be counterfeit, stolen, unintentionally adulterated, obtained fraudulently, or otherwise unfit and would cause potential harm or death.

III. In the course of normal daily responsibilities, SVMC staff will remain alert for visual clues that a product appears different or is suspect. This includes review of any information which may give SVMC staff a reason to suspect that a supplier may be untrustworthy or fraudulent (e.g state license expired, inconsistent customer service or product delivery, etc.). Supplier behavior or any inquiry by state or federal authorities all may be reason to suspect a product and start an investigation, even if the product does not appear counterfeit.

IV. Suspect product will be managed via the Tracelink application & the following actions should take place.
   a) Inform the PIC about the suspect product.
   b) Place the item in quarantine & clearly mark the product as such. Place product in a temperature appropriate lockable location away from normal inventory.
   c) Conduct an investigation of the suspect product, which should be completed timely as required by DSCSA (within a few days).
   d) Inspect the product carefully & review transaction data. Inquire from trading partner for clarification as needed. Additionally the manufacturer should be reached out to for assistance with determining product legitimacy.
   e) Notify the supplier, the FDA, and the state Board of Pharmacy if evidence of fraud or tampering. To notify the FDA, use Form 3911, which can be located here: http://www.accessdata.fda.gov/scripts/cder/email/drugnotification.cfm. The form should be emailed to FDA at DrugNotifications@fda.hhs.gov.

f) SVMC will keep a product sample and await further instructions from either the FDA, state board of pharmacy, manufacturer or supplier.
g) Records of documentation of the investigation will be maintained for an additional 6 years.

REFERENCES:

- "Best Practices for Health-System Pharmacy, Positions and Practice Standards of ASHP", American Society of Health System Pharmacists, 1999 – 2000, ASHP Technical Assistance Bulletin on Hospital Drug Distribution and Control, pp. 74 – 82.
- FDA's role in Drug Recalls, from https://www.fda.gov/drugs/drug-recalls/fdas-role-drug-recalls, access on March 21st, 2022. -
- "Guideline for Prevention of Intravascular Device-Related Infections", Public Health Service, U.S., Department of Health and Human Services, Centers for Disease Control and Prevention, Am J Infect Control 1996;24:262-93.
- The Joint Commission (2024). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- The United States Pharmacopeia, 24th Rev., and The National Formulary, 19th Ed. (USP24/NF19) Supplement, 1999; 25:2589-90.
- "Revised USP Standards for Product Dating, Packaging, and Temperature Monitoring", Am J Health-Syst Pharm, Vol 57, Aug 1, 2000:1441-1445.
- State of California, Title 22, § 70263 – 70269
- "Self-Assessment Manual for Proper Management of Medical Waste", The Self-Assessment Project Partnership between the Ca. Dept. of Health Services and the California Healthcare Association. March 16, 1999, Second Ed. Revised, pp 13-14.

CROSS REFERENCES:

- Pharmacy Manual – "Controlled Substances"

SUBJECT: **ORGAN AND TISSUE PROCUREMENT AND DONATION**	SECTION: ***Ethics, Rights & Responsibilities (RI)*** **Page 1 of 5**

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

PURPOSE:

To outline procedures to facilitate organ, tissue, and eye donation that ensure compliance with federal, state, and regulatory agency requirements related to the identification, notification, evaluation, and request for organ/tissue donation.

To provide the best possible opportunity for an informed decision regarding organ and tissue donation by each family and to ensure that first-person authorization is honored.

DEFINITIONS:

1. Donation after Brain Death (DBD) – Organ donation takes place from a donor who has been declared brain dead according to current standards of practice for neurologic death and applicable hospital policy. This donor is maintained on the ventilator until the time of organ removal.
2. Donation after Circulatory Death (DCD) - Organ donation takes place from a donor after planned withdrawal of life sustaining therapies and after irreversible cessation of circulatory and respiratory functions has been observed and documented by the attending physician according to current standards of practice and applicable hospital policy. This patient is on ventilator support, and the Authorizing Party (AP), or the patient themselves, has made the decision to withdraw life support independently of the decision to donate organs.
3. Tissue Donor – Tissue donation (skin, bone, tendons, veins, eyes, heart valves) takes place from a donor after irreversible cessation of circulatory and respiratory functions, according to current standards of practice and applicable hospital policy. This patient may, or may not, have first been an organ donor.
4. Document of Gift - A donor card or other record, as described in the California Revised Uniform Anatomical Gift Act ("CAUAGA") CA. Health & Safety Code § 7150 *et seq*., used to make an anatomical gift. The term includes a statement or symbol on a driver's license, identification card, donor registry, and advance directive. Documents of Gift cannot be revoked by any person other than the donor.
5. First Person Authorization (FPA) – Authorization given by means of a Document of Gift as the person's autonomous and legally binding testamentary directive to donate anatomic gifts for the purpose of transplantation, therapy, or research
6. Third- Party Authorization - Authorization for donation given in the absence of a donor's Document of Gift, made by the highest available individual named in CA-UAGA Section 7150.40(a), also known as the Authorizing Party

POLICY:

A. It is the policy of Sierra View Medical Center (SVMC) to comply with California Health and Safety Code § 7184. Sierra View endorses organ and tissue donation for transplantation or medical science/research and encourages the utilization of its resources and efforts by its employees and medical staff to ensure that Donor Network West (DNW) is notified in a timely manner of individuals whose death is imminent or who have died in the hospital. This policy endorses and respects the rights, values, and beliefs of the organ and tissue donor families and designated donors.

B. Sierra View promotes the saving of lives and an improved quality of life through organ/tissue donation.

C. Donor Network West will:
   a. Determine the medical sustainability for donation of all individuals whose death is imminent or who have died
   b. Consult applicable donor registries on each medically suitable referral, and will convey designated donor status to the hospital and legal authorizing part whenever a Patients Document of Gift is located on a registry.
   c. Make the request for authorization for donation from the appropriate person of each potential donor, whose death is imminent or who has died, or inform the appropriate responsible party of their loved ones donor designation.

D. Sierra View will:
   a. Promote the saving of lives and promote an improved quality of life through organ/tissue donation.
   b. Support all families during and after the death of their family member and to facilitate the gift of organ/tissue donation.
   c. Uphold Donor Designation (First Person Authorization) when presented with a Document of Gift.

AFFECTED PERSONNEL/AREAS: *Hospital and Donor Network West staff*

PROCEDURE:

A. Notification to Donor Network West
   a. Sierra View will notify Donor Network West in a timely manner of all individuals whose death is imminent or who have died.
      i. Imminent death is defined as a ventilated patient with a non-survivable illness/injury or for whom a physician has ordered withdrawal of life-sustaining therapies.
   b. The designated person reporting the potential donor will provide DNW with the patient's medical record, and present the patient information.
   c. After presenting information to DNW, the designated person reporting from SVMC will document:
      i. Date and time call was made
      ii. Name of coordinator receiving information on behalf of DNW
      iii. Referral number provided by DNW coordinator
      iv. Outcome of referral (if available)

B. Evaluation of potential donors
   a. Donor Network West will determine the medical suitability for donation.
      i. Medical suitability for DBD and DCD will typically be determined by means of an on-site evaluation by a Donor Network West Specialist.
      ii. In the case of potential DCD donors, the health care team and Donor Network West will jointly determine the likelihood of cardio-respiratory death occurring within 90-120 minutes following withdrawal of mechanical ventilation.
      iii. Medical suitability for tissue donation will be determined by means of a telephone evaluation by a Donor Network West Specialist.

b. Sierra View will document suitability for donation on the appropriate hospital form and retain it in the medical record.

C. Evaluation and maintenance of potential donors
   a. Sierra View shall not withdraw any measures that are necessary to maintain the medical suitability of the potential donor until Donor Network West has had the opportunity to check the patient's donor registry status, assess suitability for donation, and effectuate the wishes of the donor. Donor Network West will inform the Notifying Person of First Person Authorization. If the donor does not have a Document of Gift, Donor Network West will approach the donor's legal authorizing party and obtain authorization for donation according to 7150.65, California Health and Safety Code.

D. Donor designation
   a. Donor Network West and Sierra View are bound to honor the decedent's request pursuant to California state law.
   b. First person authorization
      i. When the patient is found to have a donor designation on a registry or another valid Document of Gift, there is no authorization (consent) sought from family or any other person.
      ii. Donor Network West will provide a copy of the Document of Gift to the hospital for the patient medical record
   c. Third party donation
      i. In those instances where there is no Document of Gift, Donor Network West shall coordinate an appropriately timed request for donation with those who are legally entitled to authorize donation. All requests for donation will be made by Donor Network West in collaboration with hospital staff.
      ii. In the absence of First Person Authorization via donor designation such as donor registration or other Document of Gift, the approach for donation will be made of the person authorized to make an anatomical gift on behalf of the decedent, in order of priority, as established by law. In the case of a competent patient who self-determines withdrawal of life support, the request for donation will be made of the patient.
   d. All information related to donation and provided to the family of a potential donor is the responsibility of Donor Network West.

E. Declaration of death
   a. DBD-The patient will be declared dead after irreversible cessation of brain function is determined, according to the current standard of practice, applicable state law, and hospital policy. In the body of the progress note in the patient's permanent medical record, a death note will be written by the physician or designee, documenting date and time of death and the method used to determine brain death (clinical exam with apnea, any ancillary testing).
   b. DCD- The patient will be declared dead after irreversible cessation of cardio- respiratory function according to the current standard of practice, applicable state law, and hospital policy. The physician or designee will document in the body of the progress note the date and time of death for the permanent medical record.

F. DBD Organ Donation

a. Sierra View will contact Donor Network West in a timely manner of patient meeting criteria for imminent death or when brain death is being evaluated. Donor Network West staff will arrive on-site to evaluate all potential DBD organ donors.
b. DBD requires pronouncement of brain death as well as maintenance of physiologic support (oxygenation, perfusion fluid/electrolyte balance, etc.) up to the time of organ recovery.
c. Donor Network West staff will explain the donation opportunity in detail, make the request, and obtain authorization or document first person authorization.
    i. A copy of the Donor Network West authorization form will be retained in the hospital medical record. Donor Network West will provide a Donor Family Resource Guide and a copy of the authorization form to the authorizing party, or in the case where the Donor has a Document of Gift, a copy of the acknowledgment form.
d. Donor Network West will assume care of the patient only after the patient has been declared dead and authorization has been obtained.
e. After authorization, discharge patient and re-admit to Donor Network West (according to the applicable procedure) in order to separate donation related charges from the bill for patient care charges.

G. DCD Organ Donation
a. Sierra View staff shall contact Donor Network West for ventilated patients where there is a plan to discuss withdrawal of ventilator/vasopressor support with the legal healthcare decision-maker. If, after initial telephone screening, the patient is determined to be a candidate for DCD, Donor Network West staff will arrive on-site for further evaluation. Donor Network West will determine final suitability for DCD donation and, together with the health care team, determine the likelihood that the patient will expire within 90-120 minutes of withdrawal of life support.
b. Sierra View will coordinate a conversation with Donor Network West and the patient/ person legally authorized to make a donation to inform them either of the opportunity for donation, or, in the case of First Person Authorization, of the timing and plans for recovery of the gift. Donor Network West is responsible for explaining the donation opportunity, the entire donation procedure, and for obtaining authorization or notification.
    i. A copy of the Donor Network West authorization form will be retained in the hospital medical record. Donor Network West will provide a Family Resource Guide and a copy of the authorization form to the legally authorizing party.
c. Donor Network West will act as a resource to the physician/healthcare team in planning and coordinating the donation but will assume no responsibility for care until the patient is pronounced dead by the attending physician or designee.

H. Tissue Donation/Recovery
a. Sierra View will contact Donor Network West within one hour after cardiopulmonary death.
b. Tissues include bone, skin, ligaments, tendons, fascia lata, eyes/corneas, and heart for valves.
c. If tissue donation is occurring without organ donation, oxygenation and perfusion of organs is not required.

I. Recovery of Organs and Tissues
   a. The Donor Network West or tissue/eye bank specialist will arrange the scheduling of operating room time for the surgical recovery of organs and/or tissues with the appropriate hospital personnel. Donor Network West retains the option to transfer a prospective DBD donor to another facility for organ and/or tissue recovery.
      i. All DBD organ recoveries require an operating room with support personnel including anesthesia, circulating nurse, and surgical technician.
      ii. All DCD organ recoveries require an operating room with support personnel to include a circulating nurse, surgical technician, and respiratory therapist. The withdrawal of ventilator support may take place in the ICU, PACU, or the OR. This is determined on a case by case basis depending upon the needs of the family, which organs are to be recovered, and the proximity of the ICU to the OR, etc. Ideally, the ICU nurse caring for the patient will accompany the patient in the case of an OR withdrawal to administer comfort care and provide continuity through end-of-life.

J. Coroner/Medical Examiners
   a. Donor Network West is responsible for obtaining release for donation from the Coroner or Medical Examiner.

REFERENCES:

California Code, Health and Safety Code - HSC § 7184 | findlaw.(n.d.). https://codes.findlaw.com/ca/health-and-safety-code/hsc-sect-7184.html

Donor Network West. (2022, August). *Sample hospital policy on organ and tissue donation.* Donor Network West. https://www.donornetworkwest.org/

Organ Donation Alliance. (2024, August 16). *California uniform anatomical gift act ("CAUAGA").* The Alliance. https://www.organdonationalliance.org/uaga/california/

CROSS REFERENCES:

Diagnosis of Death by Neurologic Criteria

SUBJECT: **PATIENT SELF-ADMINISTERED MEDICATIONS**	SECTION: *Care of the Patient (TX)* **Page 1 of 2**

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

PURPOSE:

To establish a safe and effective method for self-administration of medications by the patient.

POLICY:

1. A limited number of medications may be self-administered by the patient upon direct order of a physician.

2. Medications shall not be left at the patient's bedside for self-administration unless specifically ordered by the patient's physician.

AFFECTED AREAS/PERSONNEL: *NURSING; PHARMACY*

PROCEDURE:

1. Medications that patients may self-administer and keep at their bedside may include:

   a. Antacids

   b. Ophthalmic drops

   c. Throat lozenges

   d. Mouthwashes

   e. Inhaled medications

   f. Topical ointments/creams/lotion

2. Bedside medications shall meet all labeling, record keeping and storage requirements and shall be kept in possession of the patient. Drugs listed in Schedule II, III, IV, and V of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended, shall not be left at the bedside except as ordered to be given in a Patient Controlled Analgesia pump (PCA).

3. If the patient's own medications are used, please refer to the "Patient's Own Medications" policy.

4. The nurse shall be responsible for instructing and teaching the patient and family/caregiver how to self-administer his/her medications and shall include:

   a. The name, indication and mechanism of action of the medications to be administered;

   b. The dose, route and frequency of administration;

   c. The expected actions and side effects of the medications to be administered;

d. Methods of monitoring the effects of the medications.

5. The nurse shall evaluate the competency of the patient's ability of self-administration of medications. If the nurse determines that the patient is not able to self-administer medications, the prescribing physician is to be notified.

6. The nurse shall document the self-administered medications on the patient's medication administration record (e-MAR) as reported by the patient. Each dose of medication taken must be documented.

7. Medications returned to the pharmacy from the patient's bedside are considered unusable and will be disposed.

REFERENCE:

- Hospital Accreditation Standards. (2024). Oak Brook, IL: Joint Commission Resources, Inc.

SUBJECT: **STERILE PRODUCTS:EDUCATION AND COMPETENCY**	SECTION: **Page 1 of 7**

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

PURPOSE:

To provide the necessary training and education of pharmacy personnel to promote preparation of pharmacy-prepared sterile products.

DEFINITIONS:

Validation: Documented evidence providing a high degree of assurance that a specific process will consistently produce a product meeting its predetermined specifications and quality attributes.

USP 797- United States Pharmacopeia (USP) is a quality organization that publishes acceptable standards for sterile preparations and "797" refers to the chapter that deals with sterile product quality benchmarking.

Category 1 CSP- A compounded sterile preparation (CSP) assigned a beyond use date (BUD) of 12 hours or less at controlled room temperature or 24 hours or less refrigerated. All sterile products compounded in the hospital pharmacy will not exceed a BUD of 12 hours as they are prepared in a segregated compounding area.

Category 2 CSP- A CSP assigned a BUD of greater than 12 hours at controlled room temperature or greater than 24 hours refrigerated that is compounded in accordance with all applicable standards found in USP 797.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) that the Pharmacist in Charge shall ensure that all personnel engaging in preparation and handling of sterile products will have training and demonstrated competence in the safe handling and compounding of sterile drug preparations. All sterile products will be prepared according to USP 797 standards by appropriately trained pharmacy personnel.

AFFECTED PERSONNEL/AREAS: *PHARMACY*

PROCEDURE:

A. Initial and annual education shall include at the minimum:

1. USP 797 and 800: Pharmacy personnel preparing or dispensing sterile products will receive didactic and experiential training. Personnel shall read core competencies assigned by the PIC and take a test based on the contents. A passing score will be 90%.

2. Calculations and terminology: A written test on calculations and terminology will be required annually and maintained in personnel files. A passing score is 90%.

3. Education of core skills shall include a review of:

    a. Contamination of critical area/ environmental monitoring

b. Proper use or movement of PEC, equipment, and supplies

c. Compounding and documentation

d. Quality assurance procedures as outlined in COMPOUNDED STERILE PREPARATION:QUALITY ASSURANCE PROGRAM

e. Non-pharmacy and pharmacy personnel cleaning

f. Process validation

g. Aseptic technique

h. Proper hand hygiene, gowning, gloving and garbing technique

i. General conduct

j. Decontamination (where applicable), cleaning, disinfecting, and maintaining of the PEC, equipment, and controlled area.

k. Principles of High Efficiency Particulate Air (HEPA) filtered air

B. Initial and bi-annual (every 6 months) competencies shall include at the minimum:

1. Garbing and Hand Hygiene

i. Initial evaluation will be done immediately following initial hand hygiene and garbing procedure, each individual shall complete a gloved fingertip and thumb (GFT) sampling procedure (zero CFUs both hands) at least three times before being initially allowed to compound sterile drugs.

ii. Sampling must occur after garbing but before applying sterile 70% IPA to gloves.

2. Aseptic manipulation confirming sterile technique shall also be performed every 6 months. This process evaluates practical skills of personnel's sterile technique by utilizing a culture from multiple aseptic procedures upon a sterile broth medium, i.e., media fill test.

i. Surface sampling immediately after aseptic manipulation

C. Recertification of competencies including GFT sampling, media fill, garbing and hand hygiene, aseptic technique shall be done every 6 months after initial competency.

- Subsequent GFT sampling will be done once, not thrice like during the initial evaluation. Failure is indicated if the samples exceed 3 CFUs total.
- A visual observation will be conducted and documented.
- All records will be maintained on file in the pharmacy for at least three years.

D. Personnel who fail written tests regarding hand hygiene, garbing, and aseptic technique; gloved fingertip sampling; or media-fill test;

1. Must undergo immediate requalification and pass with 90% before they can resume compounding.

E. Personnel who fail any visual observation of hand hygiene, garbing, and aseptic technique; gloved fingertip sampling; or media-fill test;

1. Must repeat and pass the evaluation in the deficient area(s) before they can resume compounding.

F. After a pause in compounding-related activities (including but not limited to compounding & quality assurance monitoring)- Personnel who have not compounded in 6 months must be requalified. If the pause exceeds 6 months, that person will be treated as a new employee.

G. Competencies can be completed in approximately 8 weeks before the due date.

a. Competency for Core skills must be at least every 12 months and include the following: Hand hygiene, garbing, cleaning & disinfection, calculations, measuring & mixing, aseptic technique, sterility, use of equipment, documentation of the compounding process, principles of unidirectional airflow within the ISO Class 5 area, proper use of PEC's & principles of movement of materials & personnel within the compounding area.

b. Competency in Garbing/Hand Hygiene (including GFT) & aseptic manipulation (media fill with post GFT and Surface sampling) must be completed by compounding personnel at least once every 6 months.

H. Routine performance checks shall occur to ensure adherence to aseptic policies and procedures.

I. All policies and procedures pertaining to sterile compounding shall be reviewed by all staff annually or when there are changes to any of the policies. All staff shall sign off on education of these policies and acknowledge that any material failure to follow the policies and procedures shall constitute a basis for disciplinary action by SVMC and/or the Board of Pharmacy.

J. Personnel Cleansing and Garbing

1. Personnel experiencing rashes, sunburns, weeping sores, oozing tattoos, conjunctivitis, or active respiratory infections or other communicable diseases shall not compound sterile products until their conditions have resolved.

2. Compounding personnel shall not wear cosmetics, hand, wrist, or other visible jewelry, artificial nails, or extenders. Cover any jewelry that cannot be removed. Natural nails shall be kept neat and trimmed. Remove head phones, ear buds, cell phones, bandanas, coats, hats, jackets, scarves, sweaters, and vests while compounding.

3. In preparation for entering the ante room, personnel shall first don shoe covers, hair covers, and facial covers.

4. Hand Hygiene

   a. Remove debris from under fingernails, if present. Use a nail cleaner (pick) under warm water.
   b. Hands and forearms shall be washed vigorously with soap and water for at least 30 seconds.
   c. Dry hands and forearms up to the elbows with low-lint disposable towels.
   d. Immediately before donning sterile gloves, apply a suitable alcohol-based hand rub, Sterillium©. Allow a sufficient time and amount of product to keep hands wet for manufacturer specified application time, at least 3 minutes.
   e. Allow hands to dry thoroughly before donning sterile gloves.
   f. After donning sterile gloves, apply sterile alcohol 70% to outside of gloves and allow alcohol to dry.

5. Gowns

   a. For a Category 1 & 2: Low-lint garment (non-shedding) with sleeves that fit snugly around the wrists and an enclosed neck (e.g., gown or coverall)

   b. Visibly soiled gowns must be changed immediately. Gowns and garbing items must be segregated and stored before use in an enclosure to prevent contamination (away from sinks to avoid splashing).

   c. If compounding Category 1 and Category 2 CSPs, gowns may be reused within the same shift by the same person if the gown is maintained in a classified area or adjacent to, or within, the SCA in a manner that prevents contamination. This privilege does not apply to hazardous drugs.

6. Garbing and de-garbing shall not occur in the ante-area at the same time.

7. After gowning, sterile gloves shall be donned. If sterile sleeves are used, then they are donned after sterile gloves.

8. Once inside the compounding area, hands will be disinfected with an alcohol-based hand scrub.

9. Gloves will be disinfected with 70% IPA prior to entering the glovebox and anytime hands are removed and placed back into the glovebox.

10. Gloves that are in contact with non-sterile surfaces will be disinfected with 70% isopropyl alcohol.

K. Doffing Procedure when Exiting Hazardous Drug Compounding Area

i. Remove outer pair of HD gloves and place in HD waste container.
ii. Remove outer pair of booties and place in yellow HD waste container.
iii. Remove the HD gown and place in yellow HD waste container.
iv. Remove inner pair of HD gloves and place in HD waste container.
v. Exit HD buffer room, enter clean side of anteroom, and go to the sink.
vi. Remove bouffant/mask and discard in yellow HD waste container under the sink.
vii. Wash hands as stated above.
viii. Remove booties and step across LOD.
ix. Use Sterillium© gel.

L. Conduct

1. Food, drinks, and cardboard will not be permitted in the SCA or cleanroom suites.

2. Actions such as talking and coughing should be directed OUT of the SEC.

3. Unnecessary motion in the SEC should be avoided to minimize turbulence of air flow.

4. Activities in the SEC should only be related to procedures for parenteral preparations.

M. On cleaning the SCA, pharmacy personnel will be trained on:

1. Using the appropriately-labeled cleaner and disinfectant for the types of surface to be cleaned (floor, wall, etc.)

2. Following garbing procedures when cleaning in the SCA.

3. Mopping floors with a pharmacy-specific mop used ONLY for floors. The mopping should start at the wall opposite the entry room door. Mop the floor with even strokes toward the operator. The applied agent (Ecolab- hospital grade germicidal) shall remain visibly wet for 10 minutes, i.e., dwell time.

4. Cleaning the sink and all contact surfaces.

5. Cleaning of walls top to bottom, ceilings left to right toward the operator.

6. Cleaning of shelves, bins, buffer area chair, exterior of trash bins.

7. Documenting all cleaning.

N. On cleaning the CAI/hood, pharmacy personnel will be trained as follows:

1. When properly garbed, the pharmacy technician will, at a minimum twice a day, when there is a spill, or prior to preparing a new sterile product:

a. Wipe down the entire CAI/Hood chamber with sterile water.

- Using long strokes left to right on the bottom and top surfaces and long strokes top to bottom progressing towards the operator on the vertical sides of the CAI/Hood.

- This process will be repeated with 70% sterile alcohol and sporicidal agent approved by designated person, such as Peridox© or Decon-Spore.

b. This procedure will be used for the application of germicidal and sporicidal agents (sporicidal agent approved by designated person, such as Peridox© or Decon-Spore) with a dwell time of at least 3 minutes) as well. The daily, weekly and monthly cleanings shall NOT overlap and will be performed separately.

O. Cleaning competencies will be assessed with a written test and a visual observation annually. Records will be kept for three years.

P. Record Keeping

Records of training and demonstrated competency shall be maintained for each individual for at least three years.

Q. Whenever a change in a policy or procedure occurs, the pharmacist-in-charge will notify the staff via a meeting or an email. Staff shall sign off to acknowledge the change(s) with the 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.

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.). Retrieved July 9, 2024, from http://www.usp.org/compounding/general-chapter-797.
- USP 800. (n.d.). Retrieved July 9, 2024, from http://www.usp.org/compounding/general-chapter-hazardous-drugs-handling-healthcare.

CROSS REFERENCES:

COMPOUNDED STERILE PREPARATION: QUALITY ASSURANCE PROGRAM

Senior Leadership Team	9/24/2024
Board of Director's Approval	
Bindusagar Reddy, MD, Chairman	9/24/2024

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
September 24, 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
Forms		Approve ↓
• 022428 Urology Office Note	1	
• 025546 Uroflow and Bladder Scan	2	
Policies:		
• Bereavement Leave	3-4	
• Coding Productivity and Quality Standards	5-12	
• Criteria for Transfusion Review	13-15	
• Pre-Employment, Annual/Periodic and Fitness for Duty	16-23	
Plans:		
• Annual Evaluation for the Effectiveness of the Environment of Care (EC), Emergency Operations Plan (EOP) & Life Safety (LS) Management Programs	24-38	

Date of Visit: _____
Allergies: _____
BMI: _____
Nocturnal Urination: _____
Daytime Urination: _____
Dysuria: _____
Hematuria: _____
Hx Bladder Suspension: _____
UTI: _____
HX Stone: _____
Incontinence: _____
Frequency: _____

Family Hx. Prostate Cancer: _____
Diabetes Mellitus: _____
Hypertension: _____
Heart Disease: _____
Glaucoma: _____
Bleeding Disorder: _____
Abdominal Pain: _____
Smoke: _____ Alcohol: _____

GENERAL	YES	NO	PULMONARY	YES	NO	PSYCHIATRIC	YES	NO
Fever or chills			Cough			Depressed Mood		
Weight Changes			Shortness of breath			**MUSCULOSKELETAL**		
HEENT			**HEMATOLOGY**			Joint pain		
Vision difficulties			Easy bruising			Muscle pain		
Hearing difficulties			Unusual bleeding			**NEUROLOGICAL**		
CARDIOVASCULAR			**SKIN**			Numbness		
Chest pain or discomfort			Rash			Tingling		
Dizziness			Itching			Weakness		
Palpitations								

DATE LABS OBTAINED:

BUN :_____ Serum Creatinine: _____ G.F.R.: _____ Date of PSA:_____ PSA Value:_____

HT: _____ WT: _____ BP: _____ P: _____ RR:_____ TEMP: _____

PAIN: Y/N 1 2 3 4 5 6 7 8 9 ALLERGIES: _____ FALL RISK: Y/N

PHARMACY: _____

Medication:	Dosage (Specifiy MG or MCG)	Taken	Dr. Order:

Print Name: _____ Date/Time: _____

Signature: _____

SIERRA VIEW MEDICAL CENTER
Porterville, California 93257

PATIENT'S LABEL

Date of Scan: _____

Pre Op Diagnoses: _____

Diagnosis: _____

Post-OP Diagnosis: _____

Procedure: Unroflow And Bladder Scan

Interpretation:

_____

_____

_____

_____

_____

_____

_____

Physician Signature: _____ **Date:** _____ **Time:** _____

SUBJECT: **BEREAVEMENT LEAVE**	SECTION: **Page 1 of 2**

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

PURPOSE:

To define the requirements and procedures for Sierra View Medical Center (SVMC)'s bereavement leave process.

POLICY:

Provide paid time away from work for bereavement of defined family members.

DEFINITIONS:

1. **Eligible Employees:**

   Full-time exempt and non-exempt employees are eligible for leaves of absence for bereavement of immediate family members.

   Part-time, per-diem and temporary employees are not eligible for paid time off under this policy. However, these employees may request unpaid days off as described below and/or a leave of absence if more time is needed.

   Probationary employees are not eligible for paid time off under this policy until they have been here for 90 days. However, these employees may request up to five (5) unpaid days off if they have been here for at least 30 days.

   Employees may request a personal leave of absence in situations where time away from work for bereavement purposes exceeds five (5) days for either eligible or ineligible staff as defined above. For additional details, please refer to the policy, Leave of Absence – Personal.

2. **Immediate Family Members:**

   For purposes of this policy, immediate family is defined as:

   Spouse: Means a person who is legally married to another person, including same-sex couples.
   Child: Means a biological, adopted, or foster child, a stepchild, a legal ward, a child of a domestic partner, or a person to whom the employee stands in loco parents.
   Parent: Means a biological, foster, or adoptive parent, a parent-in-law, a stepparent, a legal guardian, or other person who stood in loco parentis to the employee when the employee was a child.
   Sibling: Means a person related to another person by blood, adoption, or affinity through a common legal or biological parent.
   Grandparent: Means a parent of the employee's parent.
   Grandchild: Means a child of the employee's child.
   Domestic partner: Has the same meaning as defined in Section 297 of the Family Code.

Parent-in-law: Means the parent of a spouse or domestic partner.

AFFECTED PERSONNEL/AREAS: *ALL ELIGIBLE FULL-TIME EMPLOYEES*

PROCEDURE:

Conditions for Bereavement Leave:

Eligible employees receive three (3) paid scheduled working days off. However, employees can take up to 5 days total upon death of a family member as defined above.

Three (3) of the five (5) Scheduled days off are paid at the employee's base hourly rate of pay, excluding holidays, and do not contribute to overtime, and/or premium rates.

Bereavement leave must be taken within three (3) months of the day of death or funeral. Days do not have to be taken consecutively. If days are not used during this period, they are forfeited.

Department Leader, or their designee, retain the right to request and receive written verification of the death.

Employees granted statutory or non-statutory leave or personal leaves of absence are not eligible to receive compensation for bereavement leaves. An exception exists where an employee is granted a statutory leave of absence for an immediate (eligible) family member and that family member deceases. The statutory leave ends with the date of death and bereavement leave begins.

Employees requesting bereavement pay must follow their department's call-in and attendance procedures. Notification of bereavement leave must be directed to the Department's Directors or their designee. Notification by any other individual than the employee will not be accepted as sufficient notification under this policy and will result in an attendance occurrence.

Department Leader, or their designee, are responsible for administering and recording days away from work for bereavement purposes. Paid and unpaid time is reported using UKG time reporting procedures. The pay code to be used is "compassion pay".

CROSS REFERENCES:

- Leave of Absence – Personal Policy

PURPOSE:

To outline expectations and processes for monitoring productivity and quality standards for coding within the Health Information Management (HIM) Department.

AFFECTED PERSONNEL/AREAS: *HIM CODING STAFF*

PROCEDURE:

A. **Coding Productivity**

1. **Productive Hours:**

a. All coders are expected to be consistently productive throughout their shift. Non-productive activities should be kept to a minimum. Employees are allowed two fifteen (15) minute breaks per day and one thirty (30) minute lunch break. All personal and non-productive activities should be done during these allowed breaks.

b. Productive hours are defined as regular hours plus overtime hours paid per Kronos less approved downtime hours.

c. Downtime hours are given for non-productive hours that are beyond the control of the coder. Examples are:

i. Education hours: Time granted for department approved educational sessions. Education must be approved prior to employee attending the session.

ii. Department Meetings: Time granted for approved department meetings.

iii. Computer downtime: Time granted for system crashes, extreme slowdowns, PC issues or other problems related to technical equipment. If downtime is anticipated, such as with planned system upgrades or go lives, then working hours will be reassigned to avoid any downtime. If downtime is unexpected, employees must immediately notify a member of the management team. Management will determine how much downtime can be claimed on a case by case basis. If necessary, employees may be sent home until the problems are resolved. The management team will determine if employees will be allowed to work to make up lost time or not.

2. **Charts per Hour:**

   a. All coders are expected to meet a targeted average number of charts per day. The actual target of finalized charts per day will vary, depending on the type of chart being coded.

      i. Expected minutes per chart and number of charts to be completed daily will follow industry standards which are subject to change and will be reviewed, at a minimum, annually. Coders will be updated with the new standards as they change. For example, inpatient (Acute/OB) – 20 minutes per chart, 21 charts per day, for a standard 8 hour work day.

   b. Targeted (finalized) charts per hour will be calculated by utilizing the data repository report for finalized accounts compared to the Coder productivity worksheet.

   c. Coders are expected to meet productivity as follows:

      i. 106% - 120% target is met – exceptional standard

      ii. 100% - 105% target is met – exceeds standards

      iii. 95% - 99% target is met – meeting standard

      iv. Below 95% target is not met – not meeting standard

3. **Quality Coding**

   a. **Quality Reviews:**

      i. The Coding Lead will be responsible for conducting coding quality review for each individual coder. Results and any identified opportunities for improvement will be documented and shared with each individual coder at least two times annually to review for coding quality.

      ii. Coding accuracy rate is calculated based on periodic sample reviews done on each coders work and may include any combination of the following review types:

         a) Focused review of DRG's, ICD, CPT or HCPC codes identified by Compliance or HIM for 100% review

            i) Focused reviews – Coder will code medical records. If the code assigned is on the focused review list, the coder will place the account on hold and refer the account by using the task messaging system within Meditech to the

Coding Lead. In the event that the accounts are being coded off the worklist, the coder will notify the Coding Lead through the 3M coding system. The Coding Lead will review the account and send a message back to the coder with the findings.

b) Random sample audits for coding and or DRG accuracy review

i) Random reviews will be conducted twice a year, at a minimum, on a random sample of charts. Individual results will be shared with the coder at the completion of the audit or during annual performance evaluations.

c) External audit reviews from any sample of coder's work (such as RAC audit charts, payer denials, any or all internal and external audits performed where a coder is identified).

i) Internal and External reviews will be performed periodically by either the coding lead or through a contracted service. Individual results will be shared with the coder, when available and included as part of the individual coder quality results for annual performance reviews.

d) Audits may be completed when identified error patterns or trends are found through data analysis, identifying missing medical complications and/or comorbidities that need to be queried before coding is completed.

e) Reviews may be indicated more frequently and/or problem area- focused based on results of periodic quality reviews.

b. **Quality Review Procedures**

i. The Coding Lead will print the coding summary sheet from Meditech. The Coding Lead or contracted coding auditor will "recode" the chart and compare coding utilizing the 3M Stand-a-lone grouper. A coding quality review form will be utilized for each record providing the final coding for all diagnosis, procedures and final DRG. The results of each review will be placed on the Coding Quality Summary form to calculate the overall accuracy rate for the coder. Results will be shared with each coder as soon as possible after the audit and annually as part of the employee's annual performance review.

ii. The following information will be documented on the Post Audit vs. Pre Audit Code Worksheet by the Coding Lead or contracted coding auditor:

a. Account Number

b. Coder Identification

c. Reviewer

d. Admission Date

e. Discharge Date

f. Review Date

g. Patient Class

h. Listing of all codes assigned by the coder and any codes changed

i. Comments supporting changes and/or rationale for changes to include documentation, coding guidelines, or other detail needed to educate the coder.

j. Summary of findings/number of errors that include:

- If the DRG changed
- If the principal diagnosis changed
- Number of diagnosis codes added
- Number of diagnosis codes deleted
- Number of procedure codes added
- Number of procedure codes deleted
- Total number of codes
- Number of codes changed
- Error rate (percent of number of codes changed divided by the total number of codes).
- Accuracy rate (percent of the number of codes not changed divided by the total number of codes).

iii. The coder will have one work week to review the changes suggested by the Coding Lead or contracted coding auditor.

iv. The coder will document one of the following on the bottom of the Post Audit vs. Pre-Audit worksheet:

a) That they agree with the changes and have updated the system and finalized the account.

b) That they disagree with the changes, but have updated the system and finalized the account.

c) That they disagree with the changes and request a second review. The chart will not be finalized until the second review is completed. Requests for second review will be completed by the Director or Manager.

v. All coding quality review feedback forms must be signed by the coder, dated and returned to the Coding Lead or designees within one week of receipt.

vi. The Coding Lead will review the response(s) with the coder. The final code decision lies with the Coding Lead.

vii. The coder will be notified of the decision and the coder will update the system and finalize the account.

viii. The Coding Lead will document and track individual coder and department wide results.

C. Elements reviewed:

i. The Coding Lead will review some or all of the following elements of each coded account:

a) DRG or APC assigned

b) Principal diagnosis code assigned

c) ICD-9/10 diagnosis code(s) assigned

d) Principal procedure code assigned

e) ICD-9/10 procedure code(s) assigned

f) Present on Admission (POA) status assigned

g) CPT code(s) assigned

h) Modifiers assigned

i) HCPCS codes assigned

j) Discharge status

k) Query Opportunities

ii. Coding accuracy rate is calculated as follows:

Total elements assigned correctly by employee	475
Divided by total assigned correctly by employee	500
Percent of accuracy	95%

iii. The expected quality standards for coding are as follows:

96% - 100% - exceeds standards
93% - 95% - meeting standards
Below 93% - not meeting standards

B. **Retrospective Inpatient Query Process**

1. Coders should generate a query when the documentation is conflicting, incomplete, ambiguous, or inconsistent. Retrospective queries are required when this type of documentation impacts DRG assignment, severity of illness and risk of mortality, the Present on Admission indicators (POA), or if a diagnosis cannot be coded with the documentation provided.

2. Documentation queries should be sent using approved query templates.

3. Queries are not to be reformatted or reworded from the standard language on the query template unless facility policy allows modification.

4. When a query is initiated at the time of coding, the encounter is placed on hold. If after 7 days, the query is not answered, refer to the Coding Lead.

5. The Retrospective Query is part of the permanent medical record.

C. **Disciplinary Actions**

1. New employees are expected to meet productivity and quality standards before the end of their introductory period (90 days).

2. Employees who have difficulty meeting these standards will be educated by the Coding Lead or designee to help them improve their performance.

3. Coders will be audited a minimum of two times a year. If any coder falls below 93% during their 6 month review, they will be given training opportunities. The coder will be reviewed in 3 months to ensure their quality standards are increasing.

4. Any coder who fails to meet the following productivity and quality standards may be placed on a Performance Accountability and Commitment Plan (PACP):

   a. All coders who fail to meet the monthly average productivity standard of 95% and/or
   b. Any coder who falls below the 93% minimum quality standard

D. **Employee Performance Monitoring**

1. The coder's productivity will be monitored monthly. Results of productivity monitoring will be shared with the individual coder.

2. The coders quality will be monitored two times a year, at a minimum, or more frequently as identified through coding audit results noted in routine focused reviews, and random internal and external audits per section 2 of this policy. Results of productivity and quality monitoring will be shared with the individual coder as soon as possible following completion of an audit and at least annually during the employee's annual performance appraisal.

3. Monthly productivity statistics will be reported to the director for inclusion in the HIM key indicators report for the department as a whole.

E. **Performance Accountability and Commitment Plan (PACP)**

1. Productivity and/or quality monitoring will occur as outlined above.

2. An employee who does not meet the prescribed standards, as demonstrated by productivity and quality monitoring will be placed on a PACP.

3. The PACP format utilized by SVMC Human Resources will be utilized.

4. An employee who does not meet the standards by end of the PACP time period will be subject to the next step of the corrective action.

5. An employee that successfully completes a PACP, but then demonstrates performance issues for up to a year following completion of the plan, will be subject to the next step of corrective action.

REFERENCES:

- AHIMA Coding Productivity Standards. Retrieved from: http://journal.ahima.org/2016/05/02/ahima-studying-icd-10-impact-on-coding-productivity/

CROSS REFERENCES:

- PERFORMANCE ACCOUNTABILITY AND COMMITMENT

SUBJECT: **CRITERIA FOR TRANSFUSION REVIEW**	SECTION: **Page 1 of 3**

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

PURPOSE:

Transfusion audits provide reviews of policies and practices to ensure safe and appropriate transfusions

CRITERIA FOR TRANSFUSION REVIEW:

Appropriate Use of Red Blood Cells:

- Hypovolemia due to blood loss evidenced by significant change in blood pressure or pulse, or orthostatic change in blood pressure.
- Symptomatic anemia whatever the cause if no other therapy is likely to correct the anemia.
- Anemia requiring correction perioperatively (hematocrit < 24% or hemoglobin less than 8 gm/d).
- Non-trauma or non-cardiac surgical patient receiving red blood cells when blood loss does NOT exceed 15% - 20% of the total blood volume. (Review criteria, refer record to Radiology-Pathology Committee)

Appropriate Use of Fresh Frozen Plasma:

- History or clinical course suggestive of a coagulopathy due to deficiencies of soluble coagulation factors, and prothrombin time (PT) > 18 seconds, partial thromboplastin time (PTT) > 45 seconds or studies pending, in a patient with significant bleeding.
- Intravascular volume depletion due to active bleeding documented by replacement of blood volume once within several hours.
- Antithrombin III deficiency state for patients about to undergo surgery or who require heparin for treatment of thrombosis.
- Immediate reversal of warfarin effect in patients who are actively bleeding or who are about to undergo emergency surgery.
- Inpatients with thrombotic thrombocytopenic purpura.
- Protime and PTT or specific coagulation factor assay to be obtained immediately prior to and within four (4) hours post transfusion.
- Transfusion of fresh frozen plasma units without confirmation of a clotting factor deficiency. (Review criteria - refer record to Rad-Path committee)

Appropriate Use of Platelets:

- Platelet count < 20,000/ul with or without active bleeding.
- Platelet count < 50,000/ul with active bleeding consistent with platelet deficit or when patient is receiving chemotherapy with or without active bleeding.
- Platelet count < 50,000/ul in patients undergoing major surgery.
- Transfusion of platelets without first obtaining a platelet count indicating a thrombocytopenia that warrants transfusion. (Review criteria - refer to Rad-Path committee)
- Transfusion of platelets in numbers that do not correspond, over a 24 hour period, to the appropriate amount to maintain at least a minimum platelet count. (Review criteria - refer record to physician peer review/committee)

Appropriate Use of Cryoprecipitate:

- Decreased Factor VIII level documented by appropriate laboratory data.
- von Willebrand's disease documented by a positive or suggestive history and appropriate laboratory testing.
- Hypofibrinogenemia <150 documented by history or clinical course suggestive of decreased fibrinogen or history of active bleeding and laboratory documentation of low fibrinogen.

Appropriate Use of Whole Blood:

- Same as for packed cells, see above, when reasons are documented in the clinical record.

Appropriate Use of Autologous Blood:

- Same as for packed cells, see above, when reasons are documented in the clinical record.
- Transfusion back to patient if Hgb is 11 gm or lower, at the discretion of the ordering physician.
- Last phlebotomy at least 72 hours before procedure.
- Documentation that the patient has been placed on oral iron supplement.
- Transfusion of autologous blood resulting in post transfusion CHF. (Review criteria - refer record to Rad-Path committee)

Directed Donor Blood Criteria:

- ABO and Rh grouping

- Antibody screening
- Antibody screening for Hepatitis B antigen
- Screening for HIV Antibody

* ***Directed donor blood collection is not performed at this facility. All directed donor collection is performed through the Central California Blood Bank, with criteria met as stated above.***

Specific Blood Use Requiring Review:

1. All transfusions are reviewed with special emphasis on:
    a. Transfusions of more than one (1) platelet aphoresis or 12 single platelet concentrates in a 24-hour period.
    b. Mortality associated with transfusion.
    c. Adverse effects associated with transfusion.
    d. Appropriateness and necessity of transfusion.

AFFECTED AREAS/PERSONNEL: *ALL CLINICAL EMPLOYEES*

REFERENCES

- Fung, Mark E (2023). Association for the Advancement of Blood & Biotherapies, Technical Manual (21st Edition).
- Association for the Advancement of Blood & Biotherapies (2022). Standards for Blood Banks and Transfusion Services (33rd Edition).
- The Joint Commission (2023). Laboratory Accreditation. PI.01.01.01. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **PRE-EMPLOYMENT, ANNUAL/PERIODIC AND FITNESS FOR DUTY EVALUATIONS**	SECTION: **Page 1 of 8**

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

PURPOSE:

To define the pre-placement, annual and periodic requirements for protecting the health and safety of employees and patients.

POLICY:

Pre-placement, annual/periodic and fitness for duty health screenings are performed on current and prospective employees to ensure they are free of communicable disease and to determine their physical and mental ability to perform within a job classification without endangering their own health and safety, the health and safety of patients, or their fellow employees.

AFFECTED AREAS/PERSONNEL: *ALL SIERRA VIEW MEDICAL CENTER (SVMC) EMPLOYEES*

PRE-PLACEMENT REQUIREMENTS

A. An offer of employment is contingent upon successful completion of the pre-placement process. All required screenings are provided by SVMC free of charge and does not reimburse these fees if the applicant elects to complete these services offsite.

1. Clearance is based on findings related to screening test results, the history and physical findings, and the applicant's ability to perform within the essential requirements of the job description and essential physical demands of the position.

B. All prospective employees must complete a history, physical, and required screening tests prior to the date of hire.

C. The history, physical and screening includes, but is not limited to, the following:

Performed by a designated Medical Practitioner

1. Completion of a health history.
2. Examination based on significant findings in the health history and vital signs.
3. Visual acuity and color vision testing.

Performed at SVMC's Employee Health Department

1. Tuberculosis screening.
2. Evaluation of immunization status for vaccine preventable diseases related to the potential for occupational exposure.

3. Drug screening for safety sensitive positions.

4. Mask Fit Test

5. Examinations and/or tests identified to be necessary for the determination of the ability of the applicant to perform the essential duties of the position offered.

   a. Additional records such as disability ratings and permanent restrictions may be required prior to determination of the prospective employee's ability to perform in a specific position.

D. Accommodation of prospective employees unable to perform within the requirements of the job description will be evaluated in compliance within Americans with Disabilities Act (ADA) regulations.

1. The Human Resources Representative and Department Director will be included in the determination of accommodations or the inability of the facility to accommodate a prospective employee.

E. Failure to provide information regarding prior or current injuries and/or illness, whether work related or not, may be sufficient grounds for withholding clearance for employment or immediate release from employment.

F. Those applicants that will be 100% remote and who reside more than two hours away, SVMC will reimburse for any pre-employment health screenings with a valid receipt. 100% remote applicants will not be required to comply with the TB Screening and Vaccination requirements.

ANNUAL AND PERIODIC EVALUATION/SCREENINGS– RETURN TO WORK-FITNESS FOR DUTY-JOB TRANSFER

A. Annual and/or periodic evaluations and screenings are provided in the following conditions, but not limited to:

1. Required by Regulation from local, state and federal recommendations or mandates For those job categories or departments that require screening as outlined in the regulatory requirements and SVMC's policies, procedures and practices.

2. Fitness for Duty: At the request of Human Resources/Employee Health Services (EHS) who have a valid concern that an employee is working in an unsafe manner that could cause harm to self or others, has a physical or mental impairment, or following a significant change in health due to a serious health condition.

3. Request for Accommodation: At the request of an employee who seeks a job restriction or job accommodation.

4. Job Transfer: When a job transfer is made to a position that is significantly different in scope and skills, the employee must be cleared through Employee Health prior to placement.

    a. Assessment is made to determine the ability of the employee to perform the essential functions of the job, job accommodations, need for education, and communicable disease surveillance.

5. New baseline screening for infectious diseases may be added to annual evaluations to meet infection prevention criteria.

6. Screenings for infectious diseases may be required periodically due to emergency disasters and pandemics.

B. Evaluations for the above conditions may include:

1. **Personal health review.**

    a. A review of illnesses during the past year, especially absences due to illness, to verify, to the extent reasonably possible, that an individual is able to continue performing assigned duties and continues to be free of infectious disease.

2. **Screening Test** as indicated by response to the health review, as required by regulations or job duties. May include:

    a. Breath, blood and/or urine drug screen.

    b. Blood alcohol level

    c. Tuberculin screening.

    d. Other diagnostic/screening tests.

    e. Respirator fit testing.

    f. Other medical surveillance

C. Human Resources and Employee Health Services (EHS) will evaluate with the employee, any noted restrictions and the ability of SVMC to accommodate them. If it is determined that the employee is unable to perform assigned duties, or no reasonable accommodation can be made, the Department Director will be advised.

TUBERCULOSIS SCREENING - INITIAL-PERIODIC-ANNUAL

A. TB Surveillance is performed during the pre-placement exam and at least annually **(in the month of May)** to screen all SVMC Employees for Latent Tuberculosis Infection (LTBI). All employees must complete required skin testing or screening questionnaire for positive convertors each May.

1. Tuberculin Skin Test (TST) done at another facility will be accepted if completed between January and May of the current year.

2. On those occasions where the employee chooses to have TST read by a trained individual other than EHS, it is the responsibility of the employee to provide EHS with documentation.

3. After May 31, non-compliant employees will be placed on administrative leave.

B. Tuberculin Skin Testing/TST (Mantoux technique), questionnaire and/or chest x-ray (if there is a history of a positive skin test), are current methods for screening for tuberculosis.

1. A TST Mantoux will be placed for pre-employment, annualand post exposure for employees that have had negative TST in the past. A baseline TST completed elsewhere will be accepted as part of the 2 step onboarding requirement if completed within 2 weeks of start date.

2. Pregnancy is NOT cause for deferring TSTs.

C. For employees with a history of a positive TST, the TB questionnaire will be reviewed by the employee health nurse and employees with questionable signs and symptoms for tuberculosis will be sent for a chest x-ray.

D. At time of hire, if it has been more than 12 months since a TST was placed, or documentation of TST within the last 12 months cannot be provided, the prospective employee will have another TST (2-Step TST) placed at least one week but no longer than 3 weeks after the first negative test. If the employee fails to have completed this by the end of the third week, they will be removed from the schedule.

E. Employees who convert from negative to positive results from TST or have an initial positive test will be evaluated and treated according to guidelines from the California Department of Public Health.

1. If a skin test is positive, a chest x-ray will be performed to determine evidence of active TB. Current positive reactors are required to have a chest x-ray when symptoms are present during their annual questionnaire screening.

a. Prospective employees in the new hire process will be directed to follow-up with their health care provider or county of residence for possible treatment of latent TB. New hires with a previous positive will complete a baseline questionnaire and X-ray within two weeks of start date. SVMC will accept a prior X-ray as long as it is less than three (3) months old from hire date per TCPH department's recommendation.

b. If the potential employee has symptoms of active TB or a chest X-ray suggestive of active TB, they will not be cleared to work and will be sent directly to their healthcare provider or the County Health Department.

- Documentation of findings and any necessary treatment for active disease will be completed before the prospective employee will be considered for placement, and they will be referred to their primary care physician.

VACCINE PREVENTABLE DISEASES – IMMUNIZATIONS

A. All employees are tested for and offered immunizations to vaccinate against preventable diseases without cost, if determined to be susceptible to these diseases.

Employees will be required to sign consent for each vaccine administered or sign the declination if they are determined to be susceptible but decline immunization.

If an employee declines a vaccine for a disease they have been determined to be susceptible to, they may later request to be vaccinated.

B. Education regarding the benefits of vaccination and the potential health consequences of disease or illness for themselves, their family members, and patients is provided. The current Vaccine Information Statement (VIS) on the vaccine is provided and the employee is given an opportunity to ask any questions related to the vaccine.

C. Failure to complete mandatory testing, immunizations, or declination documentation within 90 days of hire will result in removal from the schedule or suspension until completed.

D. Immunization is provided for employees as follows:

1. **Tdap** (Tetanus, Diphtheria and Acellular Pertussis)

   a. One (1) time if no prior Tdap.

2. **MMR** (Measles, Mumps and Rubella,)

a. Two (2) doses of MMR given at least 28 days apart if Rubeola titer is not sufficient.

b. One (1) dose of MMR if Rubella titer or mumps is not sufficient.

3. **Varicella** (Chickenpox)

a. Two (2) doses given at least 4 weeks apart, if titer is not sufficient.

4. **Hepatitis B** Vaccine is available to all employees.

a. Three (3) doses of vaccine administered over a six-month period.

b. A hepatitis B antibody screen will be done one (1) month after the third dose.

c. Those not responding to the vaccine will be given the option of a booster or repeating the series.

d. Employees may decline the vaccine and may receive the vaccine at any time following declination.

5. **Influenza Vaccine**

a. Annually, every employee must either be vaccinated, provide documentation of vaccination, or sign a written declination.

b. For the safety of patients, visitors and other healthcare workers employees who decline vaccination will be required to wear a surgical mask at all times while on hospital premises for the duration of the flu season as designated by Infection Prevention, but no sooner than March 31st.

6. Other vaccines or medications available will be administered during outbreaks or as advised by the Infection Prevention Committee/Advisor.

DRUG SCREENING

A. All drug and alcohol tests, pre-placement and reasonable suspicion are administered according to National Institute on Drug Abuse standards.

1. Federal standards are recognized when determining results of a drug or alcohol test.

2. Positive results are reviewed by the contracted Medical Review Officer (MRO).

3. If the MRO confirms a positive result, Employee Health Services will notify Human Resources:

   a. The applicant is not eligible for hire and Human Resources will communicate withdrawal of the job offer.

   b. The employee for reasonable suspicion testing is positive and Human Resources will take the appropriate action.
   (*For more information please refer to the policy on "Drug and Alcohol in the Workplace")*

COMPLIANCE

SVMC employees, at time of hire, agree to participate, as directed, in emergencies and community disasters during scheduled and unscheduled hours. As a designated disaster service worker, SVMC employees are required to assist in times of need pursuant to the California Emergency Services Act. (Gov.t Code 3100, 3102.) Given the level of risk to infectious diseases during pandemics, SVMC employees are expected to comply with local, state, and federal regulatory recommendations and mandates as outlined by the regulatory agency. Failure to do so can constitute a safety risk which will be evaluated by Risk Management and Human Resources.

Employees who fail to comply with the required health evaluations, screenings, and fitness for duty evaluations as outlined in this policy on a routine basis, and in periodic times of health disasters, present a safety risk to themselves or others. Employees failing to comply may be subject to disciplinary action up to and including separation.

REFERENCES:

- California Code of Regulations, Title 22, §70723., 2017.
- Centers for Disease Control and Prevention (CDC) (2023): Tuberculosis. Retrieved on 8/19/24 from https://www.cdc.gov/tb-healthcare-settings/hcp/screening-testing/baseline-testing.html
- Centers for Disease Control and Prevention (CDC) (2024) : Guideline for infection Control in Health Care Personnel. https://www.cdc.gov/infection-control/about/index.html
- Center for Disease Control and Prevention (CDC) (2023) Vaccine and Immunizations, Current VISs Retrieved on 8/19/24. https;//www.cdc.gov/vaccines/hcp/vis/current-vis.html

- The Joint Commission, (2024). 2024 hospital accreditation standards. Oak Brook, Illinois.

California Department of Public Health (2018) Licensing and Certification. Retrieved on 8/19/24 from https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/Title-22-for-Use-of-TST.aspx

CROSS REFERENCES:

- DRUGS AND ALCOHOL IN THE WORKPLACE Link
- EQUAL EMPLOYMENT OPPORTUNITY Link
- REASONABLE ACCOMODATIONS Link

Sierra View Medical Center

ANNUAL EVALUATION FOR THE EFFECTIVENESS OF THE ENVIRONMENT OF CARE (EC), EMERGENCY OPERATIONS PLAN (EOP) & LIFE SAFETY (LS) MANAGEMENT PROGRAMS

January 1, 2023 – December 31, 2023

This annual evaluation of the objectives, scope, performance and effectiveness of Sierra View Medical Center's Environment of Care, Life Safety and Emergency Management programs applies to Sierra View Medical Center and all affiliated properties and all locations where patient care is provided.
Performance monitoring data is tracked using the Osborne Engineering Inc. Environment of Care Benchmarking database. The database provides Sierra View Medical Center with comparative data in 89 areas of performance within the Environment of Care. Sierra View Medical Center was within the national target results in 87 of those areas, the Medical Center was rated above the national target results in 5 areas with only 2 areas being rated below national target results.

I. SAFETY MANAGEMENT

A. Objective:

The objective of the Safety Management Plan is to describe processes and mechanisms by which the organization strives to provide a physical environment free of hazards and manage staff activities to reduce the risk of injuries.

B. Scope:

The Safety Management Plan and related policies and procedures extend to the Sierra View Medical Center, Wound Healing Center, Ambulatory Surgery Department, Cancer Treatment Center, Urology Clinic, Cardiac Cath Lab, Sierra View Community Health Center (SVCHC), Surgery Clinic, Physical Therapy and the hospitals departments located in the Medical Office Building (Diagnostic Radiology, Mammography, Ultrasound, Laboratory and Patient Accounting). The scope of the Safety Management Plan is current and appropriate.

C. Performance and Effectiveness:

The Safety Committee at Sierra View Medical Center includes members from various hospital departments including Nursing, Clinical Services, Medical Staff, Human Resources, Risk Management, Administration and Support Services. The Environment of Care/Safety and Security Manager chair the meetings. The Safety Committee meets at least on a quarterly basis.

A standard agenda is used at Committee meetings and the agenda includes reports from each of the chapters of the Environment of Care (EC). Safety Policies and Procedures are reviewed at least every three years.

All new employees attend hospital orientation, which includes Environment of Care education and training.

Environmental tours are performed routinely. The committee meets at least every quarter to review the findings of the Environmental tours. Patient care areas are inspected every six months and non-patient care areas are inspected every twelve months. The Accreditation & Regulatory Affairs Coordinator coordinates the inspections through the Huron Rounding program. Follow-up actions are taken as needed by Facilities, Environmental Services, and/or Nursing Unit and Department Directors. Documented follow-up action is maintained and stored in the Huron Rounding program

Performance monitoring data is tracked using the Osborne Engineering Inc. Environment of Care Benchmarking database. 14 performance monitors were within control limits in 2023 (i.e., within one standard deviation of the database mean). 1 area rated below target results, High OSHA Lost Workday Injury/Illness quarterly rate. The current set of performance monitors will continue to be monitored in 2024.

The database provides Sierra View Medical Center with comparative data in over eighty areas of performance within the Environment of Care. 15 areas of Safety performance are benchmarked. The 15 areas focus on both patient safety and worker safety.

Significant issues addressed during 2023 in the Safety Management Program via the Safety Committee are listed below:

- Commonly cited deficiencies identified during Environmental tours include:
  a. Corridor clutter and high storage.
  b. Stained ceiling tiles.
  c. Expired supplies.

- A revised Safety Management Plan was approved and adopted in 2023. The revised plan addresses the changes within the 2023 EC Standards of The Joint Commission.

The Safety Management Program is deemed effective based on the following data and criteria:

- Performance Monitoring Data and Benchmarking Results
- Environmental Tour Results
- Response and Tracking of recalled products and medications
- Training and Education Results
- Safety Committee Activity

D. Review of 2023 Goal:

- Work to lower Patient Slips and Falls Resulting in Class III Injuries (Moderate Injuries). *The facility saw a drop from the 93rd percentile to within the National Target Results; 2023 saw no incidents in this category.*

E. Goal for 2024:

- Work to lower the OSHA Lost Workday Injury/Illness quarterly rate to the 50th percentile in the Osborne Engineering Benchmarking database. *Review and assess with Risk Management.*

II SECURITY MANAGEMENT

A. Objective:

The objective of the Security Management Plan is to establish and maintain an environment, which protects property and all staff, patients and visitors from harm.

B. Scope:

The Security Management Plan and related policies and procedures extend to the Sierra View Medical Center, Cancer Treatment Center, Wound Healing Center, Ambulatory Surgery Department, Urology Clinic, and Cardiac Cath Lab, Sierra View Community Health Center (SVCHC), Surgery Clinic, Physical Therapy and the hospitals departments located in the Medical Office Building (Diagnostic Radiology, Mammography, Ultrasound, Laboratory, and Patient Accounting). The scope of the Security Management Plan is current and appropriate.

C. Performance and Effectiveness:

The Security Department investigates security incidents involving patients, visitors, personnel or property. Security personnel patrol the facility on a 24 hour / 7 day per week basis. Through a risk assessment, the Environmental Safety/Security Officer has identified sensitive areas of the facility and recommended enhanced measures to increase security of those areas. An excellent working relationship is maintained with the Porterville Police Department. The Security Supervisor participates in new employee orientation with assistance from security leadership to make new staff aware of the facility and ways to avoid potential incidents.

The Safety Committee using the Osborne Engineering, Inc. Environment of Care Benchmarking database tracks performance-monitoring data. Sierra View Medical Center's security staffing level exceeded control limits (i.e., w/i one standard deviation of the database mean). Security staffing for 2023 averaged 3.65 FTE's per 100,000 square feet of buildings including parking which placed the facility at the 76th percentile.

The benchmarking database provides Sierra View Medical Center with comparative data in over eighty areas of performance within the Environment of Care. Thirteen areas of Security performance are benchmarked.

Significant issues addressed during 2023 in the Security Management Program via the Safety Committee are listed below:

- Review all security incident rates and statistics

- Review results of all Code Gray (Violent Patient/Visitor) and Code Strong (Hospital Lockdown) and Code Green (Missing Patient) incidents
- Revised Security Management Plan adopted to comply with the 2023 Joint Commission Standards

The Security Management Program is deemed effective based on the following data and criteria:

- Performance Monitoring Data and Benchmarking Results
- Security Vulnerability Analysis Review
- Security Incident Reports
- Training and Education Results
- Safety Committee review of incidents
- Revised Security Management Plan adopted

D. Review of 2023 Goal:

- Work to reduce Assault and Batteries Against Patients, Employees and Visitors to the 50th percentile in the Osborne Engineering benchmarking database. *Although the facility did not reach its 50th percentile goal, we saw a significant decrease from the 92nd percentile down to the 63rd percentile which is within the national target goals.*

E. Goal for 2024:

- Work to reduce the number of Incidents of Property Damage & Vandalism/100,000 Total Square Feet to the 50th percentile in the Osborne Engineering Benchmarking Database. The current rate is the 66th percentile.

  Meet with On-Site Security to assess the current situation.

III HAZARDOUS MATERIALS AND WASTE MANAGEMENT

A. Objective:

The objective of the Hazardous Materials and Hazardous Waste Management Program is to establish and maintain the safe control of hazardous materials and to reduce the incidence of occupational illness and injury related to hazardous materials and wastes.

B. Scope:

The Hazardous Materials and Hazardous Wastes Management Plan and related policies and procedures extend to the Sierra View Medical Center, Cancer Treatment Center, Wound Healing Center, Ambulatory Surgery Department, Urology Clinic, and Cardiac Cath Lab, Sierra View Community Health Center (SVCHC), Surgery Clinic, Physical Therapy and the hospitals departments located in the Medical Office Building (Diagnostic Radiology, Mammography, Ultrasound, Laboratory, and Patient Accounting). The scope of the Hazardous Materials and Hazardous Wastes Management Plan remains current and appropriate.

C. Performance and Effectiveness:

Safety Data Sheets (SDS) are available on the hospital intranet in all areas of the hospital. A vendor disposes medical waste off-site and no problems were noted.

Performance monitoring data is tracked using the Osborne Engineering, Inc. Environment of Care Benchmarking database. Of the 12 monitored areas, 11 Hazardous Materials and Hazardous Wastes performance data results were within control limits (i.e., w/i one standard deviation of the database mean) with Cost of Medical Waste Disposal/Adjusted Patient Day/Quarter being the only performance monitor outside of the database target results.

The database provides Sierra View Medical Center with comparative data in over eighty areas of performance within the Environment of Care. Eleven areas of Hazardous Materials and Wastes performance are benchmarked.

Significant issues addressed during 2023 in the Hazardous Materials and Hazardous Wastes Management Program via the Safety Committee listed below:

- Revised Hazardous Materials and Hazardous Waste Management Plan adopted
- Tulare County EH&S inspected and reviewed hazardous materials business plan and hazardous materials inventory, no violations
- Hazardous materials disposed of in 2023 maintained required manifests.

The Hazardous Materials and Wastes Management Program have been deemed effective based on the following data and criteria:

- Performance Monitoring and Benchmarking Data Results
- Training and Education Results
- Safety Committee Activity

D. Review of 2023 Goal:

- Work with staff to reduce the cost of Medical Waste Disposal/Adjusted Patient Day/Quarter. *This goal was not met and we will continue working to reach target results.*

E. Goal for 2024:

- Continue working with staff to reduce the cost of Medical Waste Disposal/Adjusted Patient Day/Quarter. The current rate is in the 95th percentile. *Meet with the Manager of Environmental Services to develop a plan to reduce cost.*

IV EMERGENCY MANAGEMENT PROGRAM/EMERGENCY OPERATIONS PLAN

A. Objective:

The objective of the Sierra View Medical Center Emergency Management Program is to establish and maintain an effective response to emergencies within the organization or in the community that would suddenly and significantly affect the need for Sierra View's services, or its ability to provide these services for extended periods, up to ninety-six hours.

B. Scope:

The Emergency Operations Plan and related policies and procedures extend to the Sierra View Medical Center, Cancer Treatment Center, Wound Healing Center, Ambulatory Surgery Department, Urology Clinic, and Cardiac Cath Lab, Sierra View Community Health Center (SVCHC),

Surgery Clinic, Physical Therapy and the hospitals departments located in the Medical Office Building (Diagnostic Radiology, Mammography, Ultrasound, Laboratory, and Patient Accounting). The scope of the Emergency Management Program and Emergency Operations Plan (EOP) remains current and appropriate.

C. Performance and Effectiveness:

Real world events and performance data were reviewed and monitored for improvements in the Hospital's Emergency Management Program.

The Central California Healthcare Coalition met in July 2023 to review and revise the Hazard Vulnerability Analysis to identify events that by scoring matrix have a potential to occur. Representatives from Tulare County, Fresno County, Kings County, Sierra View Medical Center, Adventist Tulare Medical Center, Kaweah Health, Porterville Developmental Center, Tulare County Sheriff's Office, Red Cross and local Religious Leaders participated in the process.

Performance monitoring data is tracked using the Osborne Engineering Inc. Environment of Care Benchmarking database. All Emergency Management performance data results were within control limits (i.e., w/i one standard deviation of the database mean) or exceeded database performance. In particular, Sierra View has exceptional on-site storage of potable water for use during disasters and on site food supplies.

The database provides Sierra View Medical Center with comparative data in over eighty areas of performance within the Environment of Care. Nine areas of Emergency Management performance are benchmarked.

Significant issues addressed during 2023 in the Emergency Management Program via the Safety Committee are listed below:

- Emergency Management implementation requirements
- Hazard Vulnerability Analysis was affirmed with changes
- Participation in disaster planning with the County of Tulare Emergency Preparedness program
- California Health Alert Network (CAHAN) participation

The Emergency Management Program is deemed effective based on the following data and criteria:

- Continued HRSA Grant Compliance.
- Performance Monitoring of HVA and Benchmarking Data Results
- Emergency Management Actual Events
- Training and Education Results
- Disaster Equipment owned and maintained by organization
- Hazard Vulnerability Analysis revised with changes

D. Review of 2023 Goal:

- Work with offsite Clinic Leaders to perform required Emergency Management Drills. *This goal was met with an Active Shooter Drill at the Terra Bella Clinic in May of 2023 along with Earthquake drills at multiple outpatient areas.*

E. Goal for 2024:

- Begin coordinating with Tulare County Public Health/Emergency Services on performing a community wide drill to meet Joint commission standards.

V. LIFE SAFETY MANAGEMENT

A. Objective:

The objective of the Life Safety Management Plan is for the organization to establish and maintain programs and facilities which provide a fire safe environment.

B. Scope:

The Life Safety Management Plan and related policies and procedures extend to the Sierra View Medical Center, Cancer Treatment Center, Wound Healing Center, Ambulatory Surgery Department, Urology Clinic, Cardiac Cath Lab, Sierra View Community Health Center (SVCHC), Surgery Clinic, Physical Therapy and the hospitals departments located in the Medical Office Building (Diagnostic Radiology, Mammography, Ultrasound, Laboratory, and Patient Accounting). The scope of the Life Safety Management Plan is current and appropriate.

C. Performance and Effectiveness:

As per the NFPA 101 Life Safety Code, the facility is designed to protect people and property from fire and other products of combustion. This is accomplished through a variety of programs.

As part of new employee orientation, general fire safety principles and techniques are covered. This includes proper use of emergency codes, telephone numbers, fire extinguishing techniques and evacuation procedures. Emergency procedures are in place which addresses specific roles and responsibilities of personnel at and away from a fire's point of origin and building compartmentalization procedures.

Fire drills are conducted at least once per shift per quarter in all buildings. Fire drills are conducted as required and drills were unannounced. In addition, staff is interviewed during fire drills for proper response.

Annual fire safety training is provided to employees in addition to training which is provided during fire drills, employee orientation and annual training. It is noted that staff training regarding fire response is deemed effective based on the results of fire drills, annual training, and new employee orientation.

In compliance with Joint Commission standards, regular inspection and testing of fire protection and life safety systems are done by qualified individuals.

The Facilities Department is responsible for all life safety systems inspection testing and maintenance. All inspection and testing documents are located in the Environment of Care/Safety & Security Managers office.

Performance monitoring data is tracked using the Osborne Engineering Inc. Environment of Care Benchmarking database. All Life Safety Management performance data results were within control limits (i.e., w/i one standard deviation of the database mean).

The database provides Sierra View Medical Center with comparative data in over eighty areas of performance within the Environment of Care. Ten areas of Life Safety Management performance are benchmarked.

Additional noteworthy actions taken during 2023 include the following:

- Environment of Care Committee worked on reducing hallway clutter
- Life Safety Management Plan was revised and adopted
- All life safety systems inspected and tested as required in 2023
- Hot Work Permit Program continues to be utilized and successful.
- Interim Life Safety Measures (ILSM) utilized when appropriate.

The Life Safety Management Program is deemed effective based on the following data and criteria:

- Performance Monitoring Data Results
- Review of Fire Drills completed
- Training and Education Results
- Safety Committee Activity
- Building Inspection for Life Safety Code Compliance
- Inspection, Testing and Maintenance Results of Life Safety Systems

D. Review of 2023 Goal:

- Complete the Fire Alarm System Upgrade and test all devices to ensure full coverage of the main facility. *This goal has been met and the new fire alarm was fully tested before going online.*

E. Goal for 2024:

- Confirm that all Evacuation Maps throughout the main facility and outpatient buildings are accurate and up to date. *Perform an audit of evacuation maps during EOC rounds.*

VI. MEDICAL EQUIPMENT MANAGEMENT

A. Objective:

The objective of the Medical Equipment Management Plan is to promote the safe and effective use of medical equipment and to properly maintain and inspect such equipment on a regular basis.

B. Scope:

The Medical Equipment Management Plan and related policies and procedures extend to the Sierra View Medical Center, Cancer Treatment Center, Wound Healing Center, Ambulatory Surgery Department, Urology Clinic, Cardiac Cath Lab, Sierra View Community Health Center (SVCHC), Surgery Clinic, Physical Therapy and the hospitals departments located in the Medical Office Building (Diagnostic Radiology, Mammography, Ultrasound, Laboratory, and Patient Accounting). The scope of the Medical Equipment Management Plan is current and appropriate.

C. Performance and Effectiveness:

Sierra View utilizes a contractual management arrangement with Renovo Solutions Inc. to provide ongoing biomedical services, ensure preventive maintenance and recommend program improvements.

This contracted biomedical service applies to the hospital as well as diagnostic equipment. Biomedical or engineering personnel for basic electrical safety and correct operating performance as per manufacturer's specifications inspect equipment entering the facility. The Biomedical vendor utilizes an inventory with sticker program to ensure preventive maintenance (P.M.) and inspections are done as scheduled.

A representative from Renovo Solutions Inc. makes presentations to the Safety Committee and reports Preventive Maintenance compliance and any user errors on a regular basis. If required, in services are scheduled for appropriate staff.

Performance monitoring data is tracked using the Osborne Engineering, Inc. Environment of Care Benchmarking database. All Medical Equipment Management performance data results were within control limits (i.e., w/i one standard deviation of the database mean).

The database provides Sierra View Medical Center with comparative data in over eighty areas of performance within the Environment of Care. Eleven areas of Medical Equipment performance are benchmarked.

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
DISCLOSURE CATEGORIES

Category 1. A designated position in this category must report all investments, business positions, and sources of income, including receipt of gifts, loans, and travel payments. Additionally, individuals designated in this category must report all interests in real property located entirely or partly within the District's jurisdiction or boundaries, or within two miles of this District's jurisdiction or boundaries or of any land owned or used by this District. Such interests include any leasehold, ownership interests or option to acquire such interest in real property.

Category 2. A designated position in this category must report all investments, business positions, and sources of income, including receipt of gifts, loans, and travel payments.

Category 3. A designated position in this category must report all interests in real property located entirely or partly within the District's jurisdiction or boundaries, or within two miles of this District's jurisdiction or boundaries or of any land owned or used by this District. Such interests include any leasehold, ownership interests or option to acquire such interest in real property.

Category 4. A designated position in this category must report investments and business positions in business entities and income, including receipt of gifts, loans, and travel payments, from sources that are of the type that within the previous two years has

a. Provided services, equipment, leased space, materials, or supplies to Sierra View;
b. Filed a lawsuit and/or claim, or have a suit/claim pending, against Sierra View;

Additional noteworthy actions taken during 2023 include the following:

- Monitoring preventative maintenance results
- Keeping track of and responding to medical equipment recalls and notifications
- Incoming equipment inspections
- Medical Equipment Management Plan revised and adopted

The Medical Equipment Management Program is deemed effective based on the following data and criteria:

- Performance Monitoring and Benchmarking Data Results
- Training and Education Results
- Safety Committee Activity
- Inspection, Testing and Maintenance Results of Medical Equipment

D. Review of 2023 Goal:

- Work with Renovo to ensure that the Preventative Maintenance Rate for Non-Life Support Equipment stays at 100%. *This goal was met as the completion percentage in the 1st quarter of 2023 was 95% and was raised to 100% by the 4th quarter of 2023.*

E. Goal for 2024:

- 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.

VII. UTILITIES MANAGEMENT

A. Objective:

The objective of the Utilities Management Plan is to establish and maintain reliable utility systems to provide an effective environment for patients, visitors and staff.

B. Scope:

The Utility Systems Management Plan and related policies and procedures extend to the Sierra View Medical Center, Wound Healing Center, Ambulatory Surgery Department, Urology Clinic,

Cardiac Cath Lab, Sierra View Community Health Center (SVCHC), Surgery Clinic, Physical Therapy and the hospitals departments located in the Medical Office Building (Diagnostic Radiology, Mammography, Ultrasound, Laboratory, and Patient Accounting). The scope of the Utility Systems Management Plan is current and appropriate.

C. Performance and Effectiveness:

Preventative maintenance is provided on an on-going basis to all utility systems including, but not limited to, the following:

1. Electrical Distribution
2. Emergency Power
3. Heating, Ventilating and Air Conditioning
4. Plumbing
5. Boiler and Steam
6. Piped Medical Gases and Vacuum Systems
7. Elevators

Preventative maintenance (P.M.) is provided as detailed in the hospital's Utilities Management Program. At least a 100% Preventive Maintenance (PM) completion rate was maintained (currently at 98%). All PM records are located in the facility's Engineering Department.

The Engineering Department continues to work with Infection Control on all construction projects to ensure adequate infection control measures are in place. An infection control risk assessment program is in place to minimize the risk of facility-acquired illnesses for patients.

No problems occurred during the past year regarding pathogenic biological agents such as Legionella or airborne contaminants such as Aspergillus. An on-going management program as described in the Utility Systems Management plan is in place to minimize the risk of Legionella and Aspergillus by identifying needs for procedures and controls to minimize the potential for the spread of infections through the utility systems.

Performance monitoring data is tracked using the Osborne Engineering, Inc. Environment of Care Benchmarking database. All Utility Systems performance data results were within control limits (i.e., w/i one standard deviation of the database mean)

The database provides Sierra View Medical Center with comparative data in over eighty areas of performance within the Environment of Care. Fifteen areas of Utility Systems performance are benchmarked.

The Utility Systems Management Program is deemed effective based on the following data and criteria:

- Performance Monitoring and Benchmarking Data Results
- Training and Education Results
- Safety Committee Activity
- Inspection, Testing and Maintenance Results of Utility Systems
- Utility Management Plan revised and adopted
- Utility 96 Hour Disruption Matrix implemented

D. Review of 2023 Goal:

- Work with Engineering to improve the Preventative Maintenance quarterly completion rate to 100% in the Osborne Engineering Benchmarking Database. *This goal was not met and was at 98% in the 4th quarter of 2023, we will continue with this goal.*

F. Goal for 2024:

- Continue working with Engineering to improve the Preventative Maintenance quarterly completion rate to 100% in the Osborne Engineering Benchmarking Database. *Work with Engineering and TMS to better align the due dates of PM's in the report so that it shows an accurate completion percentage.*

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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 **August 27, 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 5:01 p.m.

Directors Present: **REDDY, LOMELI, MARTINEZ**
Directors Absent at Start of Meeting: PANDYA, KASHYAP

Others Present: Donna Hefner, President/Chief Executive Officer, Jeffery Hudson, VPPCS/CNO/DIO, Tracy Canales, VP of Human Resources, Craig McDonald, Chief Financial Officer, Ron Wheaton, VP of Professional Services/Physician Recruitment, Terry Villareal, Executive Assistant and Clerk to the Board, Kim Prior-DeShazo, Director of Marketing, Julie Franer, Director of Revenue Cycle, Staci Bowles, Patient Registration Manager, Christen Rios, Director of Surgical Services, Kathy Shelton, Clinical Manager, Cindy Gomez, Dan Blazar, Patient Experience officer, Mark Nanamura, Mutual Advisors LLC, Patrick Nanamura, Alex Reed-Krase, Legal Counsel, Harpreet Sandhu, Chief of Staff

I. Approval of Agenda:

Chairman REDDY motioned to approve the Agenda. The motion was moved by Director MARTINEZ, seconded by, Vice Chairman LOMELI and carried to approve the agenda. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Absent
KASHYAP	Absent

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:02 p.m. to discuss the following items:

Director Pandya arrived to the meeting at 5:02 p.m., just as Closed Session was about to begin.

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. Compliance Report – Quarter 4

Vice Chairman Lomeli left Closed Session to take phone call at 5:17 p.m., returned to Closed Session at 5:18 p.m.

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

Closed Session Items C and E were deferred to the conclusion of Open Session as there was not enough time for discussion prior to Open Session's scheduled start time.

III. Open Session: Chairman REDDY adjourned Closed Session at 5:35 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.
Information only; no action taken.

B. Pursuant to Evidence Code Section 1156 and 1157.7:

1. Compliance Report – Quarter 4

Following review and discussion, it was moved by Director PANDYA, seconded by Director MARTINEZ, and carried to approve the Compliance Report for Quarter 4 as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Absent

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

IV. Public Comments

Dawn Bennett, Porterville, CA – Expressed concerns with her recent visit to the Emergency Room regarding the admission process and the quality of care that she received while being treated. Dan Blazer, Sierra View Director of Patient Experience, met with her after her comment.

Christen Rios, Director of Surgical Services – Introduced the new RN Clinical Manager, Kathy Shelton, to the Board of Directors.

V. Consent Agenda

The Medical Staff Policies/Procedures/Protocols/Plans and Hospital Policies/Procedures/Protocols/Plans were presented for approval (Consent Agenda attached to the file copy of these Minutes). It was moved by Vice Chairman LOMELI, seconded by, Director MARTINEZ and carried to approve the Consent Agenda as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Absent

VI. Approval of Minutes:

A. Following review and discussion, it was moved by Director MARTINEZ and seconded by Vice Chairman LOMELI to approve the July 23, 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	Absent

B. Following review and discussion, it was moved by Director PANDYA and seconded by Vice Chairman LOMELI to approve the August 10, 2024 Special 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	Absent

VII. Business Items

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

B. July 2024 Financials

Craig McDonald, CFO presented the Financials for July 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 July 2024 Financials as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Absent

C. Capital Budget Report Quarter 4
Deferred to the next Regular Board Meeting scheduled for September 24, 2024

D. Investment Report Quarter 4

Craig McDonald, CFO presented the Investment Report for Quarter 4. 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 Investment Report for Quarter 4 as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Absent

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 – September 24, 2024 at 5:00 p.m.

X. Closed Session: Board adjourned Open Session at 6:21 p.m., reconvening in Closed Session at 6:31 p.m. to discuss the following items.

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.

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).

Chairman Reddy left Closed Session at 7:04 p.m. to take a phone call, returned to Closed Session at 7:05p.m.

XI. Open Session: Chairman REDDY adjourned Closed Session at 7:09 p.m., reconvening in Open Session at 7:09 p.m.

Pursuant to Gov. Code Section 54957.1; Action(s) taken as a result of discussion(s) in Closed Session.

C. Conference with SVLHCD Real Property Negotiator Regarding Westwood Property

Following review and discussion, it was moved by Director PANDYA, seconded by Vice Chairman LOMELI and carried to approve the price and sale terms presented by the negotiators. Disclose of the price and terms will be disclosed pursuant to Cal.Gov. Code § 54957.1(a)(1)(B), if and when the terms have been formally approved in a written agreement signed by the opposing party. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Absent

E. Conference with Legal Counsel
Information Only: No Action Taken

XII. Adjournment

The meeting was adjourned at 7:10 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: tv

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CONFLICT-OF-INTEREST CODE
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The Political Reform Act (Government Code §§ 81000 *et seq.*) requires local government agencies to adopt and promulgate a conflict-of-interest code. This code is designed to ensure that board members and employees of this agency do not engage in government decision-making in which the officer or employee may have a personal financial interest. In addition, board members and decision-making employees designated in the agency's code[1] are required to file periodic public statements disclosing their personal economic interests (Form 700).[2]

The Fair Political Practices Commission ('Commission") has adopted Regulation 18730[3] that contains the terms of a model conflict-of-interest code. The Board for Sierra View Local Health Care District ("Sierra View") hereby adopts the terms of Regulation 18730, and any amendments to it duly adopted by the Commission in the future, along with the attached Appendix B in which officials and employees are designated and disclosure categories are set forth, together all of which are incorporated by reference and constitute the conflict-of-interest code of Sierra View.[4]

Persons serving in designated positions (APPENDIX B) shall file periodic disclosure statements (Form 700) with this agency, as required by law, and pursuant to notice from this agency's filing officer. The disclosure statements shall be retained by the agency for no less than seven years and shall be made available for public inspection and reproduction upon request.

Adopted by Agency: Meeting Date: _____

Approved by Tulare County Board of Supervisors: Meeting Date: _____

[1] Government Code section 82019
[2] Government Code section 87302(b)
[3] Copy of Regulation as of date of adoption of this code attached hereto for convenience.
[4] Agency also has a conflict of interest policy that applies to all employees, a copy of which (as of the date of adoption of this resolution) is attached hereto for convenience.

SIERRA VIEW LOCAL HEALTH CARE DISTRICT
APPENDIX B
LIST OF DESIGNATED POSITIONS

Designated Position	Assigned Disclosure Category
Board Member	1
Chief Executive Officer / President	1
Chief Financial Officer	1
Vice President of Patient Care Services & Chief Nurse Executive (CNE) AND Chief Academic Officer	2
Vice President of Professional Services and Physician Recruitment	1
Vice President of Human Resources	2
Vice President of Quality and Regulatory Affairs	2
Contracts Specialist	4
Admin Director of General Services	2
Director of Information and Technology	4
Director of Materials Management	4
Manager of Environmental Services	4
Manager of Facilities	4
Manager of Pharmacy	4
Director of Food and Nutrition	4
Director of Surgical Services	4
Manager of Labor/Delivery & Obstetrics	4
General Legal Counsel	1
Consultant	1*

*Consultants/New Positions are included in the list of designated positions and shall disclose pursuant to the broadest category in the code, subject to the following limitations:

The Chief Executive Officer or her designee may determine in writing that a particular consultant or new position, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with disclosure requirements in this section. Such written determination shall include a description, a statement of the consultant's or new position's duties and, based upon that description, a statement of the extent of disclosures requirements. The CEO's determination is a public record and shall be retained for public inspection in the same manner and location as this conflict of interest code. (Gov. Code Section 81008.)

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FINANCIAL PACKAGE
August 2024

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
August 2024

Statistic	Aug-24 Actual	Aug-24 Budget	Aug-24 Over/ (Under)	Aug-24 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 24 YTD	Increase/ (Decrease) Aug-23	% Change
Utilization											
SNF Patient Days											
Total	31	56	(25)	-44.9%	62	113	(51)	-44.9%	201	(139)	-69.2%
Medi-Cal	31	56	(25)	-44.6%	62	112	(50)	-44.6%	201	(139)	-69.2%
Sub-Acute Patient Days											
Total	1,019	970	49	5.1%	2,066	1,939	127	6.5%	1,860	206	11.1%
Medi-Cal	526	805	(279)	-34.6%	1,083	1,627	(544)	-33.4%	1,561	(478)	-30.6%
Acute Patient Days	1,626	1,648	(22)	-1.3%	3,185	3,295	(110)	-3.3%	3,467	(282)	-8.1%
Acute Discharges	463	427	36	8.5%	892	854	38	4.5%	891	1	0.1%
Medicare	174	160	14	9.0%	344	319	25	7.8%	333	11	3.3%
Medi-Cal	236	217	19	8.7%	427	427	(0)	0.0%	446	(19)	-4.3%
Contract	51	46	5	10.2%	113	103	10	10.1%	107	6	5.6%
Other	2	4	(2)	-47.1%	8	5	3	68.4%	5	3	60.0%
Average Length of Stay	3.51	3.86	(0.35)	-9.0%	3.57	3.86	(0.29)	-7.5%	3.89	(0.32)	-8.2%
Newborn Patient Days											
Medi-Cal	192	157	35	22.5%	339	313	26	8.2%	335	4	1.2%
Other	47	36	11	32.2%	81	71	10	13.9%	92	(11)	-12.0%
Total	239	192	47	24.3%	420	385	36	9.2%	427	(7)	-1.6%
Total Deliveries	112	99	13	13.1%	204	198	6	3.0%	229	(25)	-10.9%
Medi-Cal %	84.82%	83.43%	1.39%	1.7%	84.31%	83.43%	0.88%	1.1%	80.35%	3.96%	4.9%
Case Mix Index											
Medicare	1.6878	1.6368	0.0510	3.1%	1.6578	1.6368	0.0210	1.3%	1.4370	0.2208	15.4%
Medi-Cal	1.1606	1.1975	(0.0369)	-3.1%	1.1854	1.1975	(0.0121)	-1.0%	1.1380	0.0474	4.2%
Overall	1.3471	1.3724	(0.0253)	-1.8%	1.3777	1.3724	0.0053	0.4%	1.2927	0.0850	6.6%
Ancillary Services											
Inpatient											
Surgery Minutes	8,986	8,224	762	9.3%	15,331	16,448	(1,117)	-6.8%	17,392	(2,061)	-11.9%
Surgery Cases	105	94	11	12.0%	182	188	(6)	-2.9%	195	(13)	-6.7%
Imaging Procedures	1,477	1,404	73	5.2%	2,992	2,809	184	6.5%	2,732	260	9.5%
Outpatient											
Surgery Minutes	15,767	12,775	2,992	23.4%	29,367	25,550	3,817	14.9%	28,637	730	2.5%
Surgery Cases	215	204	11	5.5%	384	408	(24)	-5.8%	417	(33)	-7.9%
Endoscopy Procedures	176	192	(16)	-8.1%	385	383	2	0.5%	410	(25)	-6.1%
Imaging Procedures	4,168	3,886	282	7.3%	7,672	7,772	(99)	-1.3%	7,356	316	4.3%
MRI Procedures	327	302	25	8.4%	595	603	(8)	-1.4%	666	(71)	-10.7%
CT Procedures	1,263	1,237	26	2.1%	2,511	2,474	37	1.5%	2,594	(83)	-3.2%
Ultrasound Procedures	1,359	1,244	115	9.3%	2,720	2,487	233	9.4%	2,584	136	5.3%
Lab Tests	32,034	32,140	(106)	-0.3%	64,957	64,280	677	1.1%	65,832	(875)	-1.3%
Dialysis	4	6	(2)	-36.8%	4	13	(9)	-68.4%	7	(3)	-42.9%

Sierra View Medical Center
Financial Statistics Summary Report
August 2024

	Aug-24				YTD					Increase/	
Statistic	Actual	Budget	Over/ (Under)	% Var.	Actual	Budget	Over/ (Under)	% Var.	Fiscal 24 YTD	(Decrease) Aug-23	% Change
Cancer Treatment Center											
Chemo Treatments	2,157	1,924	233	12.1%	4,576	3,848	729	18.9%	2,961	1,615	54.5%
Radiation Treatments	1,965	1,836	129	7.0%	4,397	3,672	726	19.8%	4,312	85	2.0%
Cardiac Cath Lab											
Cath Lab IP Procedures	7	11	(4)	-37.8%	17	23	(6)	-24.4%	26	(9)	-34.6%
Cath Lab OP Procedures	27	30	(3)	-9.7%	53	60	(7)	-11.4%	68	(15)	-22.1%
Total Cardiac Cath Lab	34	41	(7)	-17.4%	70	82	(12)	-15.0%	94	(24)	-25.5%
Outpatient Visits											
Emergency	3,503	3,415	88	2.6%	6,874	6,829	45	0.7%	6,832	42	0.6%
Total Outpatient	14,228	13,994	234	1.7%	28,072	27,989	84	0.3%	26,993	1,079	4.0%
Staffing											
Paid FTE's	885.37	855.00	30.37	3.6%	883.71	855.00	28.71	3.4%	851.75	31.96	3.8%
Productive FTE's	757.24	734.21	23.03	3.1%	743.86	734.21	9.65	1.3%	742.66	1.20	0.2%
Paid FTE's/AOB	5.31	4.98	0.32	6.5%	5.30	4.98	0.31	6.3%	4.85	0.44	9.2%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	11,307	10,552	755	7.2%	11,209	10,552	657	6.2%	10,257	952	9.3%
Cost/Adj.Patient Day	2,748	2,639	108	4.1%	2,710	2,643	66	2.5%	2,518	192	7.6%
Revenue/Adj. Discharge	52,173	53,065	(892)	-1.7%	53,052	53,065	(14)	0.0%	51,141	1,911	3.7%
Cost/Adj. Discharge	12,678	13,272	(594)	-4.5%	12,825	13,293	(468)	-3.5%	12,555	270	2.2%
Adj. Discharge	1,121	1,057	64	6.0%	2,186	2,115	71	3.3%	2,183	3	0.1%
Net Op. Gain/(Loss) %	-3.14%	-5.13%	1.99%	-38.8%	-3.17%	-5.29%	2.12%	-40.2%	-6.36%	3.20%	-50.3%
Net Op. Gain/(Loss) $	(432,653)	(684,492)	251,839	-36.8%	(860,180)	(1,412,514)	552,334	-39.1%	(1,639,601)	779,421	-47.5%
Gross Days in Accts Rec.	97.82	95.03	2.80	2.9%	97.82	95.03	2.80	2.9%	96.37	1.45	1.5%
Net Days in Accts. Rec.	50.53	57.75	(7.22)	-12.5%	50.53	57.75	(7.22)	-12.5%	62.62	(12.09)	-19.3%

COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

	AUG 2024	JUL 2024
ASSETS		
CURRENT ASSETS:		
CASH & CASH EQUIVALENTS	$ 13,647,993	$ 16,157,101
SHORT-TERM INVESTMENTS	35,633	51,137
ASSETS LIMITED AS TO USE	135,974	65,251
PATIENT ACCOUNTS RECEIVABLE	185,376,544	180,089,543
LESS UNCOLLECTIBLES	(23,305,088)	(26,121,629)
CONTRACTUAL ALLOWANCES	(139,207,024)	(132,200,199)
OTHER RECEIVABLES	22,094,084	20,224,091
INVENTORIES	4,353,301	4,404,652
PREPAID EXPENSES AND DEPOSITS	2,498,830	2,824,426
LEASE RECEIVABLE - CURRENT	314,237	314,237
TOTAL CURRENT ASSETS	65,944,485	65,808,610
ASSETS LIMITED AS TO USE, LESS CURRENT REQUIREMENTS	32,699,209	32,124,334
LONG-TERM INVESTMENTS	133,831,650	132,908,911
PROPERTY, PLANT AND EQUIPMENT, NET	76,296,260	77,017,289
INTANGIBLE RIGHT OF USE ASSETS	399,337	411,329
SBITA RIGHT OF USE ASSETS	2,458,128	2,581,364
LEASE RECEIVABLE - LT	927,459	953,095
OTHER INVESTMENTS	250,000	250,000
PREPAID LOSS ON BONDS	1,468,573	1,489,553
TOTAL ASSETS	$ 314,275,101	$ 313,544,485

COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

	AUG 2024	JUL 2024
LIABILITIES AND FUND BALANCE		
CURRENT LIABILITIES:		
BOND INTEREST PAYABLE	$ 231,175	$ 115,588
CURRENT MATURITIES OF BONDS PAYABLE	4,235,000	4,235,000
CURRENT MATURITIES OF LONG TERM DEBT	1,972,966	2,057,015
ACCOUNTS PAYABLE AND ACCRUED EXPENSES	4,837,933	4,673,741
ACCRUED PAYROLL AND RELATED COSTS	6,982,667	6,942,587
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	3,554,136	3,584,136
LEASE LIABILITY - CURRENT	141,812	141,812
SBITA LIABILITY - CURRENT	1,154,846	1,242,727
TOTAL CURRENT LIABILITIES	23,110,535	22,992,605
SELF-INSURANCE RESERVES	2,192,259	2,154,941
BONDS PAYABLE, LESS CURR REQT	33,275,000	33,275,000
BOND PREMIUM LIABILITY - LT	2,598,147	2,650,104
LEASE LIABILITY - LT	279,470	291,037
SBITA LIABILITY - LT	1,504,580	1,544,858
DEFERRED INFLOW - LEASES	1,171,314	1,197,615
TOTAL LIABILITIES	64,131,304	64,106,160
UNRESTRICTED FUND	248,385,511	248,385,511
PROFIT OR (LOSS)	1,758,287	1,052,815
TOTAL LIABILITIES AND FUND BALANCE	$ 314,275,101	$ 313,544,485

COMBINED INCOME STATEMENT FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

AUG 2024 ACTUAL	AUG 2024 BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE		Y-T-D ACTUAL	Y-T-D BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE
				***** OPERATING REVENUE *****				
5,389,328	5,253,784	(135,544)	3%	INPATIENT - NURSING	10,537,997	10,507,568	(30,429)	0%
18,845,078	17,396,290	(1,448,788)	8%	INPATIENT - ANCILLARY	36,916,813	34,792,582	(2,124,231)	6%
24,234,406	22,650,074	(1,584,332)	7%	TOTAL INPATIENT REVENUE	47,454,810	45,300,150	(2,154,660)	5%
34,252,736	33,463,071	(789,665)	2%	OUTPATIENT - ANCILLARY	68,491,046	66,926,143	(1,564,903)	2%
58,487,142	56,113,145	(2,373,997)	4%	TOTAL PATIENT REVENUE	115,945,856	112,226,293	(3,719,563)	3%
				DEDUCTIONS FROM REVENUE				
(18,630,464)	(18,243,309)	387,155	2%	MEDICARE	(34,325,953)	(36,486,618)	(2,160,665)	(6)%
(16,329,943)	(18,032,202)	(1,702,259)	(9)%	MEDI-CAL	(37,919,025)	(36,064,404)	1,854,621	5%
(12,226,897)	(6,660,852)	5,566,045	84%	OTHER/CHARITY	(15,389,066)	(13,321,704)	2,067,362	16%
(326,687)	(9,556)	317,131	3,319%	DISCOUNTS & ALLOWANCES	(1,663,081)	(19,112)	1,643,969	8,602%
2,348,020	(499,610)	(2,847,630)	(570)%	BAD DEBTS	(562,194)	(999,220)	(437,026)	(44)%
(45,165,971)	(43,445,529)	1,720,442	4%	TOTAL DEDUCTIONS	(89,859,318)	(86,891,058)	2,968,260	3%
13,321,171	12,667,616	(653,555)	5%	NET SERVICE REVENUE	26,086,538	25,335,235	(751,303)	3%
458,269	682,482	224,213	(33)%	OTHER OPERATING REVENUE	1,082,449	1,364,964	282,515	(21)%
13,779,440	13,350,098	(429,342)	3%	TOTAL OPERATING REVENUE	27,168,987	26,700,199	(468,788)	2%
				***** OPERATING EXPENSE *****				
5,772,635	5,554,739	217,896	4%	SALARIES	11,596,088	11,109,752	486,336	4%
683,496	677,817	5,679	1%	S&W PTO	1,245,547	1,354,174	(108,627)	(8)%
1,453,211	1,470,434	(17,224)	(1)%	EMPLOYEE BENEFITS	2,889,441	2,943,661	(54,221)	(2)%
1,629,154	1,424,318	204,836	14%	PROFESSIONAL FEES	2,915,347	2,848,636	66,711	2%
799,668	821,501	(21,833)	(3)%	PURCHASED SERVICES	1,468,021	1,688,273	(220,252)	(13)%
1,931,187	2,034,392	(103,206)	(5)%	SUPPLIES & EXPENSES	3,942,046	4,066,693	(124,647)	(3)%
210,843	279,146	(68,303)	(25)%	MAINTENANCE & REPAIRS	484,342	545,593	(61,251)	(11)%
373,687	277,064	96,623	35%	UTILITIES	617,465	554,128	63,337	11%
26,922	19,605	7,317	37%	RENT/LEASE	66,825	39,210	27,615	70%
120,242	121,228	(987)	(1)%	INSURANCE	268,472	242,456	26,016	11%
977,675	1,031,428	(53,753)	(5)%	DEPRECIATION/AMORTIZATION	1,946,210	2,071,979	(125,769)	(6)%
233,375	322,918	(89,543)	(28)%	OTHER EXPENSE	589,367	648,158	(58,791)	(9)%
0	0	0	0%	IMPAIRED COSTS	0	0	0	0%
14,212,093	14,034,590	177,503	1%	TOTAL OPERATING EXPENSE	28,029,168	28,112,713	(83,545)	0%
(432,654)	(684,492)	(251,839)	(37)%	NET GAIN/(LOSS) FROM OPERATIONS	(860,181)	(1,412,514)	(552,333)	(39)%
138,253	138,253	0	0%	DISTRICT TAXES	276,506	276,506	0	0%
291,905	343,454	51,549	(15)%	INVESTMENTS INCOME	716,911	686,908	(30,003)	4%
48,657	54,011	5,354	(10)%	OTHER NON OPERATING INCOME	98,363	108,021	9,658	(9)%
(78,789)	(80,574)	(1,785)	(2)%	INTEREST EXPENSE	(156,326)	(161,146)	(4,820)	(3)%
(22,580)	(36,953)	(14,373)	(39)%	NON-OPERATING EXPENSE	(79,396)	(73,907)	5,489	7%
377,446	418,191	40,745	(10)%	TOTAL NON-OPERATING INCOME	856,058	836,382	(19,676)	2%
(55,207)	(266,301)	(211,094)	(79)%	GAIN/(LOSS) BEFORE NET INCR/(DECR) FV INVSMT	(4,123)	(576,132)	(572,009)	(99)%
760,679	100,000	(660,679)	661%	NET INCR/(DECR) IN THE FAIR VALUE OF INVSTMT	1,762,410	200,000	(1,562,410)	781%
705,472	(166,301)	(871,773)	(524)%	NET GAIN/(LOSS)	1,758,287	(376,132)	(2,134,419)	(568)%

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
08/31/24

	CURRENT MONTH	YEAR TO DATE
Cash flows from operating activities:		
Operating Income/(Loss)	(432,654)	(860,181)
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation and amortization	977,675	1,946,210
Provision for bad debts	(2,816,541)	(241,187)
Change in assets and liabilities:		
Patient accounts receivable, net	1,719,823	1,191,748
Other receivables	(1,869,993)	(3,843,901)
Inventories	51,351	(62,649)
Prepaid expenses and deposits	325,596	(177,426)
Advance refunding of bonds payable, net	20,980	41,959
Accounts payable and accrued expenses	164,192	(1,485,660)
Deferred inflows - leases	(26,301)	(52,602)
Accrued payroll and related costs	40,080	(1,577,152)
Estimated third-party payor settlements	(30,000)	(102,809)
Self-insurance reserves	37,318	3,259
Total adjustments	(1,405,820)	(4,360,210)
Net cash provided by (used in) operating activities	(1,838,474)	(5,220,391)
Cash flows from noncapital financing activities:		
District tax revenues	138,253	276,506
Noncapital grants and contributions, net of other expenses	12,833	(6,353)
Net cash provided by (used in) noncapital financing activities	151,086	270,153
Cash flows from capital and related financing activities:		
Purchase of capital assets	(244,654)	(403,940)
Proceeds from lease receivable, net	25,636	51,195
Principal payments on debt borrowings	-	(4,055,000)
Interest payments	(1,914)	(787,445)
Net change in notes payable and lease liability	(100,539)	(199,576)
Net changes in assets limited as to use	(645,598)	3,598,960
Net cash provided by (used in) capital and related financing activities	(967,069)	(1,795,806)
Cash flows from investing activities:		
Net (purchase) or sale of investments	(162,060)	(3,333,879)
Investment income	291,905	716,911
Net cash provided by (used in) investing activities	129,845	(2,616,968)
Net increase (decrease) in cash and cash equivalents:	(2,524,612)	(9,363,012)
Cash and cash equivalents at beginning of month/year	16,208,238	23,046,638
Cash and cash equivalents at end of month	13,683,626	13,683,626

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
August 2024

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
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
Aug-24	**10,684,807**	**298,095**	**10,982,902**

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