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

AGENDA
June 25, 2024

OPEN SESSION (5:00 PM)

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

Call to Order

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

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

II. Adjourn Open Session and go into Closed Session

CLOSED SESSION (5:01 PM)

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

III. Closed Session Business

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

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

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

2. Quality Division Update –Quality Report

C. Pursuant to Gov. Code Section 54956.9; Existing Litigation to subdivision (d) (1): Conference with Legal Counsel. Beazley Claim No. BEAZL100005275260

D. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (1 Item). Estimated Date of Disclosure – November 2024

E. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service and Strategic Planning (1 Item). Estimated Date of Disclosure – December 2024

F. Pursuant to Gov. Code Section 54957(b): Discussion Regarding Confidential Personnel Matter. Estimated Date of Disclosure, for non-confidential personnel records – August, 2024

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

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

IV. Adjourn Closed Session and go into Open Session

OPEN SESSION (5:30 PM)

V. Closed Session Action Taken

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

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

B. Quality Review

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

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

C. *Conference with Legal Counsel Beazley Claim No.* BEAZL100005275260
Recommended Action: Approve/Deny Beazley Claim No. BEAZL100005275260

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

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

F. Discussion Regarding Confidential Personnel Matter
Recommended Action: Information Only: No Action Taken

G. 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. **May 28, 2024 Minutes of the Regular Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove May 28, 2024 Minutes of the Regular Meeting of the Board of Directors

B. **June 3, 2024 Minutes of the Special Meeting of the Board of Directors**
Recommended Action: Approve/Disapprove June 3, 2024 Minutes of the Special Meeting of the Board of Directors

IX. Business Items

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

B. **SVLHCD Fiscal Year 2025 Operating Budget**
Recommended Action: Approve/Disapprove SVLHCD FY 2025 Operating Budget

C. **SVLHCD Fiscal Year 2025 Capital Budget**
Recommended Action: Approve/Disapprove SVLHCD FY 2025 Capital Budget

D. **Salary Equity Adjustment**
Recommended Action: Approve/Disapprove Salary Equity Adjustment

X. CEO Report

XI. Announcements:

A. Regular Board of Directors Meeting – July 23, 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.

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MEDICAL EXECUTIVE COMMITTEE	06/05/2024
BOARD OF DIRECTORS APPROVAL	
	06/25/2024
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
June 25, 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
• Discharge Planning and Reporting Requirements for Patients with Suspected or Confirmed TB	1-2	↓
• Disinfectants: Their Selection and Use	3-4	
• Inpatient Pharmacy Downtime Procedure	5-8	
• Influx of Infectious Patients Contingency Plan	9-38	
• IV Preparation and Dispensing	39-53	
• Latex Allergy/Sensitivity Identification & Management	54-61	
• Notification of Exposure of Emergency Responders	62-65	
• Pharmacy Organization	66-67	
• Pyxis Access	68-70	
• Transfer of Patient to Higher Level of Care from Cardiac Cath Lab	71-72	
• Tube Feeding	73-75	
• Tuberculosis Control Plan	76-106	
• Use of Externally Supplied Medications in Clinic Settings	107-108	
• Withholding or Withdrawing Life-Sustaining Treatment	109-115	

SUBJECT:	SECTION:
DISCHARGE PLANNING AND REPORTING REQUIREMENTS FOR PATIENTS WITH SUSPECTED OR CONFIRMED TB	**Page 1 of 2**

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

PURPOSE:

To ensure that reporting requirements for patients with suspected or confirmed tuberculosis (TB) are met.

To ensure that between diagnoses and discharge, there is communication between Sierra View Medical Center (SVMC) and Tulare County Public Health Department, and that written approval is sought from the Public Health Department one (1) working day prior to discharge. This is required by law.

POLICY:

SVMC shall comply with all regulatory requirements for reporting and discharging of TB or suspect TB patients.

AFFECTED AREAS/PERSONNEL:

NURSING STAFF, UTILIZATION REVIEW/DISCHARGE PLANNING, INFECTION PREVENTION, LABORATORY, MEDICAL STAFF

PROCEDURE:

1. Immediately report all suspected or confirmed TB cases to the Infection Prevention Department or designee.

2. The Infection Prevention Manager or designee will submit Tuberculosis Suspect Case Report (see TB Suspect Case Report - Tulare County Department of Health Services) within 24 hours after a patient has been diagnosed with suspected or confirmed TB.

    a. A suspected case of tuberculosis can be defined as any person who, based on clinical or epidemiological evidence, has a reasonable likelihood of having tuberculosis, whether started on anti-tubercular therapy or not.

    b. Examples of suspected cases include:

    - Any person with clinical or laboratory evidence consistent with active TB, even if the diagnostic evaluation is incomplete or culture results are pending.
    - Any person who has been started on anti-tuberculosis therapy for suspicion of active TB.
    - Any person with findings consistent with active TB, unless other clinical evidence makes a diagnosis of TB unlikely.

3. The Infection Prevention Manager or designee, in consultation with the Discharge Planner, will communicate with the Tulare County Public Health Department about possible discharge plans.

   a. One (1) working day prior to discharge or transfer, a written discharge plan (see Tuberculosis Discharge Planning Summary- Tulare County Department of Health Services) will be submitted to the Health Officer or his/her designee.
   By phone: Monday through Thursday 8:00 a.m. – 5:30 p.m., Friday 8:00 a.m. – 12:00 p.m. at (559) 685-5720 -By Fax: (559) 749-9779

   - The patient may not be discharged, transferred, or released without the approval of the Tulare County Public Health Officers in the following situations:

     - Discharge or release from SVMC
     - Transfer to another health care facility unless the transfer is to an acute care hospital when there is an immediate need for a higher level of care.
     - Transfer to a local detention facility.

REFERENCES:

- Communicable Disease and Other Required Reporting (n.d.). Retrieved on March 12, 2024,last update 2024, https://tchhsa.org/eng/public-health/communicable-disease-and-other-required-reporting/

CROSS REFERENCE:

- Communicable Disease Reporting Policy & Procedure

SUBJECT:	SECTION:
DISINFECTANTS: THEIR SELECTION AND USE	***Surveillance, Prevention, Control of Infection (IC)***

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

PURPOSE:

To establish infection control standards for selection, review and approval of changes to established Food and Drug Administration (FDA) approved cleaning products.

POLICY:

Products selected and used at Sierra View Medical Center (SVMC) for cleaning and disinfecting will be FDA-approved products. These products will be reviewed and approved by the Pharmacy and Therapeutics/Infection Prevention Council annually, but no less than every two years.

AFFECTED PERSONNEL/AREAS: *ALL AREAS*

PROCEDURE:

To make the right selection of a product:

A. Study the manufacturer's recommendations carefully, particularly the restrictions.

B. Consult with the microbiologist for assistance in interpreting company claims and laboratory studies.

C. Be sure which products can be used in specific areas and on particular types of equipment.

D. Be sure that personnel will have the necessary personal protective equipment (PPE), such as gloves, and can be properly instructed in the use of the product.

E. Purchase products in sizes appropriate for storage, usage and economy.

The three main categories of disinfectants are: phenolics, quaternary ammonium compounds and iodine solution. Each is generally used for certain purposes only.

A. Phenolic

These are the strongest disinfectants and are used on surfaces that do not have direct contact with patients. Germicidal effectiveness of the phenolic solutions depends on the strength and combination of ingredients in a particular product.

Generally, a phenolic detergent with a phenol coefficient of at least 6 will be effective in destroying or inactivating harmful organisms.

B. Quaternary Ammonium Compounds

These are most commonly used in the food service area because they destroy or inhibit the organisms most commonly found in these areas. They are less caustic than the phenolics and do not have the pungent odors of the phenolics.

C. Iodine Solutions

These have come into wide usage in recent years and are most often recommended for equipment that comes in direct contact with the patient. It is not recommended for cleaning heavily soiled surfaces since its detergent actions are not as effective as that of the phenolics and ammoniums.

NOTE: Hospitals must attempt to keep down the number of different products stocked for disinfection uses. Thus, proper selection is extremely important. The products chosen should be effective for the job to be done, and personnel should be fully instructed in proper usage. New products should be given a ***controlled trial period.***

Future research should examine new emerging strategies, such as, but not limited to, peracetic acid, and hydrogen peroxide wipes as cleaning strategies, and adenosine triphosphate and ultraviolet light technologies as monitoring strategies.

REFERENCES:

- Rutala WA, Weber DJ and the Healthcare Infection Control Practices Advisory Committee (HICPAC). Guidelines for Disinfection and Sterilization in Healthcare Facilities, 2008. CDC Update May 2019. Accessed Jan. 29, 2024 from: https://www.cdc.gov/infectioncontrol/guidelines/disinfection/

- Leas BF, Sullivan N, Han JH, Pegues DA, Kaczmarek JL, Umscheid CA. Environmental Cleaning for the Prevention of Healthcare-Associated Infections. Technical Brief No. 22 (Prepared by the ECRI Institute – Penn Medicine Evidence-based Practice Center under Contract No. 290-2012-00011-I.) AHRQ Publication No. 15-EHC020-EF. Rockville, MD: Agency for Healthcare Research and Quality; August 2015. https://www.ncbi.nlm.nih.gov/books/NBK311016/

- The Joint Commission (retrieved February 21, 2022). Infection Prevention and Control - Disinfection and Sterilization. Retrieved on February 21. 2022 from https://www.jointcommission.org/resources/patient-safety-topics/infection-prevention-and-control/disinfection-and-sterilization/

SUBJECT: **INPATIENT PHARMACY DOWNTIME PROCEDURE**	SECTION: **Page 1 of 4**

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

PURPOSE:

To provide guidelines for pharmacy personnel in the management and delivery of pharmaceutical care in the event of computer system(s) downtime.

DEFINITIONS:

1. EMR-Electronic Medical Record.

2. MAR-Medication Administration Record.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) Department of Pharmacy to provide pharmaceutical care while computer systems are nonoperational.

AFFECTED PERSONNEL/AREAS: *NURSING; PHARMACY*

EQUIPMENT:

- Meditech computer operating system
- Pyxis automated dispensing cabinets
- Medication refrigerators
- Wholesaler ordering software.

PROCEDURE:

A. Pharmacy Medi-Tech System Downtime

1. Upon notification from nursing staff office or an established command center or other senior leadership, the inpatient pharmacy will initiate downtime procedures as follows:

   a. The last available patient medication profiles will be printed and available for pharmacist review. A second copy will be printed for nursing staff if they are unable to print their own.

   b. The MAR will be stored in a pharmacy downtime binder that is filed according to patient location.

   c. Orders for medications will be faxed to inpatient fax number or hand delivered to the pharmacy for processing.

   d. Orders will be screened for allergies, route, strength, interactions manually.

e. Orders verified will be processed with two identical labels. One label will be affixed to the patient's printed paper MAR and the other label will be affixed to medication that is to be dispensed.

i. Labels should have the following information at minimum

SVMC 465 W Putman Ave Porterville, CA 93257
PATIENT_____
ACCOUNT#_____
ROOM#_____RX#_____DOB_____
DRUG_____
SIG_____
TOTAL VOLUME RATE ML/HR

Expiration's for IV's will be on the Beyond use date label affixed to the individual product dispensed.

f. The orders will then be stored with the rest of the patient's MAR in the downtime binder.

2. During hours where pharmacy is not on sight the following downtime procedure will be initiated as follows:

a. Pyxis will be placed on override to allow access to medications while the pharmacy is closed.

b. Orders written at night will be collected and brought to the pharmacy for verification and to update the paper MAR patient profile as soon as pharmacy resumes operations on sight.

c. Providers will be instructed to phone in all discharge medications to outside pharmacies during this time. If a Scheduled II medication is to be part of discharge medications it will require security paper.

i. Security paper

a) Providers needing security paper to write orders for schedule II narcotics may call pharmacy for a single sheet of security paper, while they are on site. The pharmacist will log the information required on the "security paper log" (see Addendum A). The paper will be delivered directly to the prescriber.

b) When Pharmacy staff are not on sight it is expected that discharges will only come from the Emergency Department that may require Schedule II's. The Medical Director of the Emergency Department will be provided a batch of their security paper & a paper log to allow the providers of that unit access to complete their discharge prescriptions.

B. Pyxis Downtime

1. A call to Pyxis customer service will be placed to notify downtime trouble shoot with expert instruction if necessary.

2. Pyxis will be placed on a critical override to allow access to medications in the event of a computer system failure. If Pyxis is unable to execute critical override, then medications will be dispensed from the inpatient pharmacy.

3. Medications withdrawn will be reviewed on the Pyxis override report when systems become operational.

C. Medication Refrigerators and Freezers

1. Medications may be relocated to the main pharmacy refrigerator or freezer as they are connected to the hospital's backup power generator, until the problem is corrected. The pharmacist in charge will be consulted to ensure the proper relocation of medications.

D. Drug Wholesaler Computer System

1. Any downtime with ordering software will be managed by calling the distributor and placing orders verbally over the phone.

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **INPATIENT PHARMACY DOWNTIME PROCEDURE**	SECTION: **Page 4 of 4**

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Addendum A

Batch #	Beginning No. Ending No.	Date Sign Out	Department Dispense To	RX Signature	Dept. Signature

SUBJECT: **INFLUX OF INFECTIOUS PATIENTS CONTINGENCY PLAN**	SECTION: **Page 1 of 31**

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

INTRODUCTION

Natural disaster, man-made disasters, bioterrorism events, influenza and other infectious pandemics have the potential to introduce microorganisms that threaten health into the environment. The illnesses and conditions caused by these microorganisms can disrupt patient care activities and the healthcare environment. Ensuring the safety of healthcare providers, patients, and visitors is a high priority. Infection prevention and control measures must be an integral part of the emergency management plan for any institution.

This plan has been developed to address infection control issues that will arise during pandemics, bioterrorism events, and disasters. This plan is an essential component of the hospital's existing emergency management plan. As information related to recognizing, diagnosing, treating, and prevention infectious disease events is updated at the federal, state and local levels, this response plan will be modified accordingly.

PURPOSE:

- To authorize the Infection Prevention Manager, or designee, to rapidly implement prevention and control measures in response to a suspected outbreak.
- To outline appropriate measures and actions regarding management of infections as a result of pandemics, disasters, or bioterrorism events.
- To describe processes to ensure the safety of patients, visitors, volunteers, and healthcare personnel in the event of an unusual increase in patients presenting with infectious conditions.

POLICY:

The hospital keeps abreast of infectious diseases that are occurring locally, nationally, or worldwide that could potentially affect our local community and result in an influx of patients with infectious conditions.

AFFECTED PERSONNEL/AREAS: *ALL HEALTH CARE WORKERS*

PREPARATION & IDENTIFICATION

Triggers that identify a potential influx include:

- A local or state health department alert of a potential increase in admissions of infectious patients requiring isolation.
- A rapidly increasing disease incidence within hours or days in a normally healthy population.
- Emergency Department (ED) report of an increase in patients with potentially infectious symptoms/conditions.

- Infection Control, Nursing Supervisors, Emergency Department, or Urgent Care personnel note an unusual increase in the number of people seeking care, especially with fever, respiratory, or gastrointestinal complaints.
- Clusters of patients arriving from a single location.
- Any patient presenting with a disease that is relatively uncommon and has bioterrorism potential.
- Lower attack rates among people who have been indoors, especially in areas with filtered air or closed ventilation systems, compared with people who had been outside.
- Large numbers of rapidly fatal cases.

COMMUNICATION

If the potential for an influx of infectious patients is identified:

- The VP of Patient Care Services, the Chief of Staff, the Safety Officer, Infection Prevention Manager/Nurse, the Hospital Supervisor and other appropriate individuals will review the available information and determine whether additional action is needed.
- Current resource availability will be assessed using the Surge Capacity Management Plan.
- The VP of Patient Care Services, Chief of Staff, or other designee, will determine if the facility's Hospital Incident Command Center (HICS) Plan needs to be activated, and if so, will notify the Safety Officer and other appropriate individuals.

Ongoing communication considerations will include the needs for:

- Frequent updates for managers, physicians, and other hospital personnel.
- Infection Prevention Nurse visits to units to assess their situation and offer assistance regarding infection prevention and control issues.
- Initial notification and communication with local Public Health Services.
- Requests for assistance from the local or state health departments and/or other support agencies.

EVALUATION

The VP of Patient Care Services, Chief of Staff, Safety Officer, Infection Prevention Nurse, Chair of Infection Prevention/Control Committee and other appropriate individuals will evaluate the situation on an ongoing basis to determine:

- If other patient admissions need to be suspended.
- If elective procedures, including surgery, need to be cancelled.
- If the facility's visiting policy needs to be temporarily revised, or suspended.
- Appropriate patient placement, including alternative sites for patient holding, triage, treatment and morgue facilities, as needed.
- When the Influx Contingency Plan is no longer needed.

PATIENT MANAGEMENT

A. **Initial Management of Persons with Infectious Conditions**

To aid in the detection of persons entering the facility who may have an infectious condition, the following interventions will be implemented:

1. Visual alerts, in appropriate languages, will be posted at all appropriate entrances to the facility instructing all persons with signs/symptoms of infectious disease, especially respiratory, to:

   a. Inform reception and healthcare personnel when they first register for care that they may be infectious.

   b. Practice respiratory hygiene/cough etiquette.

2. Patients calling Sierra View Medical Center (SVMC) for advice will be discouraged from making unnecessary visits to the hospital.

3. As the number of infectious patients increases, measures will be implemented to reduce the spread of infection within the facility:

   a. A triage officer will be assigned responsibility for managing patient flow, including deferral of patients who do not need emergency care.

   b. The waiting area will be set up to enable patients with respiratory symptoms to sit at least 3 feet away from other patients and visitors. The patient will be required to wear an approved surgical mask, or placed in a single patient room.

4. Signs that promote respiratory hygiene/cough etiquette will be placed in areas such as Emergency Room, entrances to the Main Hospital, and Medical Office Building (MOB) waiting areas, where they can serve as reminders to all persons in the facility. The signs will instruct persons to:

a. Cover the nose/mouth when coughing or sneezing.

b. Use tissues to contain respiratory secretions.

c. Dispose of tissues in the nearest waste receptacle immediately after use.

d. Patients will be given masks upon entry to the facility with instructions to wear them until they have been evaluated and admitted or discharged, if the symptoms/syndrome suggest that airborne transmission is a possibility.

e. Perform hand hygiene after contact with respiratory secretions.

5. Sierra View Medical Center (SVMC) will facilitate adherence to respiratory hygiene/cough etiquette by ensuring the availability of appropriate materials in waiting areas for patient and visitors:

a. Tissues and no touch waste receptacles for used tissue disposal.

b. Conveniently located dispensers of alcohol hand sanitizers.

c. Soap and disposable towels for hand washing where sinks are available.

6. Visitors will be screened for signs/symptoms of infectious disease before entry into the facility:

a. Symptomatic visitors will be excluded from the facility.

b. Family members who accompany patients with infectious illness to the hospital will be assumed to have been exposed to the infectious condition and will be asked to don masks if the condition is respiratory in nature.

c. Visitors will be limited to persons who are necessary for the patient's emotional well-being and care.

d. Visitors will be required to wear appropriate Personal Protective Equipment (PPE) while visiting an infected patient.

e. Visitors will be instructed on hand hygiene practices.

B. **Isolation Precautions and PPE**

In the early stages of an influx of patients, it may not be clear that patients have been exposed to an infectious condition. Therefore, precautions consistent with all possible etiologies must be implemented. Standard precautions, combined with contact, droplet and/or airborne precautions will be implemented until a diagnosis is established.

Staff will be instructed to carefully don PPE before patient contact to avoid the need to make PPE adjustments and risk self-contamination during use. Careful removal of PPE will also be stressed.

1. GLOVES

   a. Wear disposable gloves when contact with visible blood and body fluids is anticipated. Gloves should also be worn when touching environmental surfaces and patient care articles visibly soiled with blood or body fluids.

   b. Gloves should be put on just prior to performing a patient care task that involves contact with blood or body fluids and removed immediately, without touching non-contaminated surfaces, when the task is complete.

   c. When performing multiple procedures on the same patient, gloves should be changed after contact with blood and body fluids that contain high concentrations of microorganisms (e.g., feces, wound drainage or oropharyngeal secretions) and before contact with a clean body site such as non-intact skin and vascular access sites.

   d. Remove and dispose of gloves after use on a patient.

   e. Staff will be reminded to avoid touching their eyes, nose or mouth with contaminated hands, gloved or ungloved.

2. FACIAL PROTECTION

   a. If an airborne pathogen is suspected of causing the infectious condition, staff will be required to wear either an N-95 respirator or a mask when entering a patient's room. The facility's Infection Preventionist (IP) will decide which is most appropriate.

      - Masks/respirators will be worn once and then discarded.

      - Masks/respirators will be changed when they become moist or soiled.
      - Personnel will not be allowed to leave masks/respirators dangling around their neck.

      - Hand hygiene must be performed upon touching or discarding a used mask.

   b. Wear disposable, fluid-resistant masks and eye shields (goggles with side-shields) or a face shield if the patient is coughing or when performing patient care tasks likely to generate splashing or spraying of blood and body fluids onto the mucous membranes of the face.

3. GOWNS

   a. Don a disposable, fluid-repelling gowns to protect skin and clothing when performing procedures likely to generate splashing or spraying of blood and body fluids.

   b. Plastic aprons may be worn for procedures likely to soil clothing but are unlikely to generate splashing or spraying of blood or body fluids (e.g., cleaning incontinent patients).

   c. Remove soiled gowns after patient contact (Use appropriate doffing technique).

   d. Reusable cloth gowns may be used for patient contacts, if splashing or spraying of blood and body fluids is unlikely. If soiled, then only wear once and place in holding receptacles for laundering.

   e. Disposable gowns should only be worn once and then discarded.

4. PPE FOR SPECIAL CIRCUMSTANCES

   a. During aerosol generating procedures (e.g. endotracheal intubation, nebulizer treatment, bronchoscopy, suctioning, etc.) personnel will wear gloves, gown, face/eye protections and an N-95 respirator.

   b. If feasible, all aerosol generating procedures will be conducted in an airborne isolation room (negative pressure room or use a private room with an appropriately placed High Efficiency Particulate Air,(HEPA) filter).

5. HANDWASHING

   a. Wash hands with soap and water after protected (gloves) and unprotected (ungloved) contact with visible blood, body fluids (secretions and/or excretions such as urine and feces), wound drainage or when skin is visibly soiled.

   b. Wash hands before leaving the immediate vicinity of patient contact (patient room, cubicle, or bathroom).

   c. After hand washing, avoid touching the patient and surfaces or items in the immediate vicinity of the patient (bedpans, bed rails, and bedside tables).

   d. Hand hygiene options must be available even if domestic water supplies are not disrupted.

- **Alcohol based hand sanitizer** (ABHS) is an acceptable alternative with supplies readily available. To calculate volume needed - conservatively estimate 4 hand washes per employee per hour. Each hand wash will use about 1 ml of rinse. The sanitizer is purchased in 1000 ml containers with 8 containers per case. With an average of 400 employees scheduled each day, adequate quantity for no less than 96 hours or 4 days will be stored on site. Environmental Services Department will inventory no less than 20 cases on site. *(547 employees x 4 ml x 24 hours x 4 days = 210,048 ml / 800 ml = 26.3 cases).*

- A hand washing station can be improvised with a coffee urn at the edge of a table with a bucket underneath. The water must be clean.

- Hand washing towelettes are acceptable.

e. Methods of hand hygiene that involve standing water are not acceptable.

C. **Transporting Patients**

1. Limit patient movement and transport outside the isolation area to medically necessary purposes.

2. Use portable x-ray equipment when possible

3. Transport patients to diagnostic services according to hospital procedure.

   a. The patient must wear a mask if respiratory illness is suspected.

   b. If the patient cannot tolerate a mask, apply the most practical measures available to contain respiratory secretions, for instance, a face shield, etc.

   c. Instruct the patient to perform hand hygiene before leaving the room.

D. **Laboratory Specimens**

1. Transport specimens to the laboratory according to normal hospital procedures.

2. Laboratory personnel will adhere to chain of custody protocols developed by CDPH and/or the FBI, if applicable.

E. **Dietary Trays**

1. Wash reusable dishes and utensils according to normal hospital procedures.
2. Disposable dishes and utensils can be discarded as regular waste.

3. Personnel will wear gloves when handling patient trays, dishes, and utensils.

4. Trays, dishes and utensils can be transported to the kitchen in the usual manner.

5. The use of disposable dishes is not necessary unless water service is disrupted.

F. **Patient Care Equipment**

Follow standard practices for handling and reprocessing used patient care equipment, including medical devices.

1. Wear gloves when handling and transporting used patient care equipment.

2. Wipe external surfaces of portable equipment in the patient's room with an EPA-approved hospital disinfectant upon removal from the patient's room.

3. Equipment such as bedpans, urinals, and emesis basins should be cleaned in a manner that prevents splashing and spraying of blood and body fluids onto the healthcare worker's clothing.

4. Reusable equipment that requires cleaning and disinfection or sterilization should be sent to the Central Processing Department (CPD) in covered containers for reprocessing. Follow current policy for cleaning, disinfection and sterilization of re-usable patient care equipment.

5. Disposable equipment not intended for reuse should be discarded.

G. **Environmental Services (EVS)**

1. EVS personnel will wear appropriate PPE as required by the situation.

2. The area around the patient will be kept free of unnecessary supplies and equipment to facilitate cleaning.

3. Follow current policies for regular cleaning of patient occupied rooms:

   a. Staff will give special attention to frequently touched surfaces, such as bedrails, bedside and over-bed tables, TV controls, call buttons, telephones, and lavatory surfaces.

   b. Clean floors and other *horizontal* surfaces daily.

   c. Clean and disinfect blood and body fluids, and after the patient is discharged from the room, with an EPA registered disinfectant.

4. Follow current policies for cleaning and disinfection after patient discharge or transfer:

   a. Clean and disinfect all surfaces that were in contact with the patient or might have become contaminated during patient care.

   b. No special treatment is necessary for window curtains, ceilings, and walls unless there is evidence of visible soiling.

5. Do not spray or fog occupied or unoccupied rooms with disinfectant.

H. Laundry and Linen

1. Patient linen will be handled in accordance with Standard Precautions.
2. Place soiled linen directly into a leak-proof bag in the patient's room.
3. Contain linen in a manner that prevents the linen bag from opening or bursting during transport and while in the soiled linen holding area.
4. Wear gloves and gown when directly handling soiled linen and laundry such as bedding, towels, and personal clothing.
5. Do not shake or otherwise handle soiled linen and laundry in a manner that might create an opportunity for disease transmission or contamination of the environment.
6. Wear gloves for transporting bagged linen and laundry.
7. Perform hand hygiene after removing gloves that have been in contact with soiled laundry and linen.
8. Transport linen according to current policies.

I. Patient's Clothing

1. Bag patient's clothing if visibly soiled with blood or body fluids and send home with a family member with instructions to use warm water and a commercial laundry product.

J. Waste Disposal

Standard Precautions will be implemented for disposal of solid waste, both medical and non-medical, that might be contaminated with an infectious agent.

1. Contain and dispose of contaminated medical waste in accordance with current facility policies and local/state regulations.

2. Discard as routine waste, used patient care supplies that are not likely to be contaminated.

3. Wear disposable gloves when handling waste and perform hand hygiene after removal of gloves.

K. **Deceased Patient**

1. Use Standard Precautions for handling deceased patients.

2. Follow current hospital policy for transferring deceased patients to the mortuary.

L. **Patient Placement**

In small-scale events, routine facility patient placement and infection prevention and control practices will be followed. However, when the number of patients presenting to the facility is too large to allow routine triage and isolation strategies, other alternatives will be considered. These may include cohorting patients who present with similar syndromes. Designated cohorting groupings or sites will be determined by the IP Committee in consultation with facility engineering staff, based on patterns of airflow and ventilation, availability of adequate plumbing and waste disposal, and capacity to safely hold potentially large numbers of patients.

To the extent possible, limit contact between infectious and non-infectious persons.

1. Isolate infected persons.

2. Limit contact between nonessential personnel and other persons and patients who are ill.

3. If the infectious condition is respiratory in nature, promote spatial separation in common areas (at least 3 feet) to limit contact between symptomatic and non-symptomatic persons.

4. Limit admissions of infected patients to those with severe symptoms or complications and those who cannot be cared for outside the hospital setting.

5. Patients will be admitted to either a single patient room or to an area designated for cohorting.

6. Infection Prevention, Administrative and Maintenance staff will designate a unit or area of the facility that will be used for cohorting. Because of the high patient volumes anticipated during an influx, cohorting will be implemented early in the course of an outbreak.

a. Clinical and non-clinical personnel assigned to cohorted patient care units will not float or otherwise be assigned to other patient care areas.

b. The number of personnel entering the cohorting area will be limited to those necessary for patient care and support.

c. Personnel assigned to cohorted patient care units must be made aware that patients may be concurrently infected or colonized with other pathogenic organisms and must adhere to standard precautions to prevent cross contamination.

K. Negative Pressure Surge Capacity

Negative pressure surge capacity is defined as a portion of a building or individual rooms where inpatient rooms can be used to temporarily isolate patients with airborne transmitted infections in an emergency situation.

1. The following rooms are permanent negative pressure isolation rooms:

   a. 260 – Telemetry

   b. 360 – Med/Surg

2. If no negative pressure room is available, the patient will be placed in a private room. The room will be equipped with a HEPA filtration unit if available. The windows and doors will remain closed and the patient will remain in the room.

3. As the need for airborne isolation increases, a wing of a nursing unit or an entire nursing unit will be designated the infectious disease unit. Infectious patients will be geographically isolated from non-infectious patients and the public.

4. Engineering controls and other methods may be used to establish temporary isolation rooms for patients with airborne transmitted infections.

5. Maintenance Department and Infection Control personnel will determine the best location within the facility to convert additional rooms to negative pressure through the use of engineering controls (shutting off the air supply and running the exhaust fans.)

L. Water

Both natural disasters and power disruptions may affect the supply and/or purity of water.; drinking water supplies will be stored and monitored on site by Dietary & Engineering Departments. An estimated 200 patients (163 licensed beds; 37 unlicensed beds -- ED, Flexcare & PACU] and 400 staff / physicians with a minimum of ½ gallon per person per day for drinking and one gallon per person per day for hand washing, bathing, sterilizing, dialysis, processing of

scopes, flushing toilets, etc. for the duration of 96 hours or 4 days. A minimum of 2,600 gallons stored as bottled water in addition to a minimum of 1,030 gallons of water stored in domestic hot water tanks on site.

[600 (patients + staff) x 1.5 gallons x 4 days = 3,600 gallons].

If water quality is uncertain, it may be purified by:

1. Boiling for 5 – 10 minutes.

2. Adding 10 drops of bleach per gallon. Mix thoroughly and allow to stand for 30 minutes before using (Can be used for 24-hours).

Assess all domestic water initially and periodically, as needed, to ensure it is safe to use. Communicate the findings of the assessment quickly to the Facilities and Safety Officer.

Following the event, determine the degree of water system purification necessary before using domestic water systems.

M. **Food**

Food must be provided for all individuals who will remain on the premises. Balanced meals are necessary for physical health. Monitor food services practices for basic sanitation. Monitor holding temperatures and the length of time food is held in the danger zone (41°F - 140°F). Food that has been in the danger zone for more than 4 hours must be discarded

N. **Toilet Facilities**

If sewer lines are disrupted or broken, toilets cannot be flushed. However, toilet facilities must be available. Temporary toilet facilities may include the following:

1. Place chemical toilets at various locations outside the facility.

2. Place three plastic bags in a bucket or toilet – Tie each bag separately, and store used bags in a leak-proof container, such as a garbage can, until the chemical toilet company can collect them.

3. One bag for one use only – Tie the bag off after use, and store in leak-proof container.

4. Use toilets without flushing until better arrangements can be made.

5. If sewer lines are intact, toilets may be flushed by pouring a bucket of water down them and the water need not be clean.

O. **Supplies**

Supplies may not be available in the usual quantities. The Infection Prevention Department will make decisions regarding curtailing of routine changes of tubing. The department will also determine when and/or if high level disinfection is an acceptable alternative to sterilization if reusable equipment is in short supply and sterilization is not an option.

Materials Management staff will be responsible for identifying facility resources for supplies and equipment.

P. **Surveillance**

Surveillance for infection control problems will be maintained to the extent feasible, even though infection prevention personnel will likely be assigned to disaster related duties. Problems existing before the event will continue to be monitored and problems specific to the event will be detected, assessed and acted upon in a timely manner. Heightened attention will be given to such things as waterborne illness, illness from improper food preparation/handling/storage, post-trauma wound infections, crush injuries, dehydration, heat stroke/exposure, and loss of HVAC in controlled environments.

Q. **Communicable Diseases**

The most realistic danger is the spread of locally endemic diseases as a result of crowding, compromised sanitary conditions, and increased susceptibility caused by stress.

Tuberculosis precautions for inpatients must be maintained. Outbreaks of communicable diseases must continue to be reported to local public health authorities.

ATTACHMENTS:

- Attachment A: Surge Capacity Management Plan
- Attachment B: Pandemic Influenza Management
- Attachment C: Key Facts about Avian Influenza and Avian Influenza A Virus

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ATTACHMENT A

SURGE CAPACITY MANAGMENT PLAN

PART I – CRITERIA

STATUS:	GREEN	YELLOW	ORANGE	(DISASTER PLAN)
Definition:	Staffing, resources and bed availability match patient needs and there is smooth collaboration between all departments.	Early triggers identify a need to initiate prompt interventions to avoid escalation and meet patient demand.	Escalating demand without available capacity and/or resources. Aggressive action is required to avoid declaring internal disaster.	Deployment of internal disaster plan is required. Will take many hours of intervention, perhaps days, to return to equilibrium.
	CRITERIA	**CRITERIA**	**CRITERIA**	**CRITERIA**
Census/Beds (census, number of available beds, number of scheduled procedures/visits, other volume indicators)	• Inpatient beds available = ≥6 • ≥ 2 ICU beds available • Discharges identified • Post-ops have tentative bed assignments • ED at Alert 1	• Empty inpatient beds = <6 • 1 ICU bed • Surgeries may be on hold • All post-ops do not have bed assigned • Homecare/SNF full/ unable to take patients	• 100% occupancy with temporary use of unlicensed space. • Few identified discharges • Surgeries rescheduled. • Diminished ED capacity due to holding of multiple admits.	• >100% occupancy with use of unlicensed space • Few or no discharges identified • ED ready to implement Internal Disaster Plan • Surgeries cancelled
Acuity (special patient needs, STATs, special circumstances)	• Manageable number of special needs patients (see "yellow"), allowing needs to be	• Multiple special needs patients such as: - mental/beha	• Multiple special needs patients in multiple units • Emergency surgeries • ICU admits held in ED	• Multiple ICU admits and/or special needs patients held in ED • Emergency surgeries

	met without stretching resources.	vioral health - isolation precautions - dialysis, chemo, trauma - several that require private room		
Resources (Equipment, Supplies, Information Technology systems)	• Equipment & supplies are available & in stock on units • IT services running and support is available • All utilities functioning (phones, elevator, power, water, gases, answering service, etc.)	• Equipment & supplies limited &/or not accessible on unit within acceptable time frames. • Prolonged unscheduled IT downtime affecting workload and/or communication. • Imaging/diagnostic equipment down • Failure of one or more utilities, although adequate back up in place	• Significant and prolonged equipment and/or supply shortages or prolonged delays • Severe pharmaceutical/blood shortage • Imaging/diagnostic/critical patient care equipment down/unavailable – back up system is stretched • One or more utilities failed • Prolonged unscheduled IT downtime affecting workload and interdepartmental communication	• Key equipment & supplies unavailable. • Full IT downtime >24 hrs impacting communication and workload without availability of adequate support • Multiple utility/power failures
Employees/Staffing (Number of personnel required vs. actual,	• Most departments meet staffing standards	• Acute units staffed per staffing plan/PCS/rat	• Multiple departments staffed below staffing	• Multiple departments staffed critically below staffing plan/PCS/ratios. • No additional staffing

department vs. float/temporary staff)	• All acute units have sufficient licensed staff per staffing plan • May be "short" in support staff positions. • Staff may be available for overtime, call in	ios • No staff available for overtime, call in • Multiple registry and/or float staff scheduled • Some ancillary departments not meeting staffing standards	plan/ratios • No additional staffing resources available (registry, other depts.) • Most managers on units; some not available	resources available (registry, other depts.) • Financial incentives not effective. • All management/non-direct care staff reassigned to patient care/ clinical areas with some not available.

PART II – INTERVENTIONS
For every criteria there must be an intervention. These are the required responses to achieve success in reducing the status to next lower level.

Status:	**GREEN**	**YELLOW**	**ORANGE**	**(DISASTER PLAN)**
Definition:	Staffing, resources and bed availability match patient needs and there is easy collaboration between all departments.	A state of early triggers identifying a need to initiate early interventions to avoid escalation and meet patient demand.	Escalating demand without readily available capacity and/or resources. Aggressive action is required to avoid system overload and gridlock.	Deployment of organization disaster plan required. Will take many hours of intervention, perhaps days, to return to equilibrium.
	INTERVENTIONS	**INTERVENTIONS**	**INTERVENTIONS**	**INTERVENTIONS**
Census/Beds (census, number of available beds, number of scheduled visits/procedures, other volume indicators)	• Beds cleaned within 30 minutes or less • Identify surgeries that may be placed "on hold" if status progresses • Cohort patients together in double rooms, to the extent possible	• Assign specific post-op beds just prior to/during procedure • Surgical and other appropriate female patients placed in OB beds • Identify inpatient and outpatient surgeries for	• Consider accommodating inpatients in unlicensed space (corridors, etc.) • Consider rescheduling non-emergent surgeries, procedures, and treatments • Consider using	• Consider use of non-hospital areas for acute care inpatients (off-site clinics and offices) • Cancel elective surgeries

		potential "hold" • Ensure that all outpatients are treated in outpatient treatment areas (and not occupying inpatient beds)	alternative area for discharge activities • Activate Corporate Communication staff for Service Recovery efforts	
Acuity (special patient needs, STATs, special circumstances)	• STATs ordered appropriately	• Surgical and other appropriate female patients placed in OB beds • Mobilize Social Workers to assist with potential for alternative placement of special needs patients	• Consider expanded use of safety attendants to free up clinical staff • Consider runners for labs, etc.	
Resources (Equipment, Supplies, Information Technology systems)	• Evaluate availability of IV pumps, ventilators and other patient care equipment in relationship to potentially climbing census • Evaluate linen, dietary supplies, etc. in relationship to potentially climbing census	• Gather spare equipment (IV Poles, pumps, etc.) and send to Central Processing • MM rents additional equipment • Additional PAR stock obtained by MM • Restock linen • Send spare gurneys to area of need • Increase number of trash runs • ED notifies Food & Nutrition services if patients need trays	• MM makes immediate purchase of needed supplies through established vendors, alternative vendors, or local shopping • Ensure presence of IT, Materials Management and Maintenance personnel throughout all shifts	• Implement Utilities Failure plan
Employees/Staffing (Number of personnel required vs.	• Intensive Units and ED are adequately staffed and additional staff is available if census	• Send float staff to areas of greatest need • Determine availability of staff	• Identify clinical staff who typically work in other roles for potential reassignment to	• Consider mandatory overtime. **Other interventions**

actual, department vs. temp/float staff)	increases	who are not currently on duty • Request staff from all sites/ departments to perform needed duties: o Couriers o Runners o Locate and send/deliver equipment/supplies o Trash emptying o Linen restocking o Calls to families to pick up patients o Answer patient call lights and provide information to patients and families o Answer phones, distribute faxes, obtain lab results, and perform other miscellaneous functions o Consider need for additional PBX operators	areas of need (PI, Risk Management, Education, etc.) • Managers called back from days off • Utilize "personnel pool" • IT and Maintenance available on-site • Bio-med available on-site • Communicate to patients that there will be delays	**as determined per disaster plan**

ATTACHMENT B

PANDEMIC INFLUENZA MANAGEMENT

Infection Prevention

PURPOSE:

- To provide guidelines for management of pandemic influenza.
- To provide planning and decision-making structures for responding to pandemic influenza.

POLICY:

A. Enhanced surveillance will be conducted when directed by the Tulare County Health and Human Services Agency (TCHHSA).

B. The following patients should be evaluated for possible infection with influenza A (H3N2, H1N1, H5N1) and/or Influenza B :

1. Hospitalized patients with:

   - Radiographically confirmed pneumonia, acute respiratory distress syndrome (ARDS), or other severe respiratory illness for which an alternate diagnosis has not been established, **AND**

   - History of travel within 10 days of symptoms onset to a country with documented high influenza rate in poultry and/or humans, **OR**

2. Hospitalized or ambulatory patients with:

   - Documented temperature of >38° C (>100.4°F), **AND**

   - One or more of the following: cough, sore throat, shortness of breath, **AND**

   - History of contact with poultry (e.g., visited a poultry farm, a household raising poultry, or a bird market) or a known or suspected human case of influenza A (H3N2, H1N1, H5N1.) in an -affected country within 10 days of onset.

3. When both clinical and epidemiologic criteria for suspected influenza A infection have been met, the hospital will immediately proceed with the following actions:

   - Implement infection control precautions;

- Infection Prevention Office will report the case to the TCHHSA;
- Obtain clinical specimens for novel Influenza A infection and submit them to Tulare County Public Health laboratory, NOT to the State Health Department or hospital laboratory;
- Initiate antiviral treatment, if available;
- Triage to the appropriate level of care;
- Evaluate alternative diagnoses;
- Provide necessary clinical evaluation and management services, including monitoring the patient appropriately for complications; and
- Assist the TCHSSA with the identification of potentially exposed contacts including healthcare workers, as requested.

C. Prepare to activate Hospital Pandemic Influenza Plan as necessary.

D. Identify and isolate all potential patients with pandemic influenza.

E. All health care workers, volunteers, and Licensed Independent Providers will be offered vaccination against influenza annually as the vaccination becomes available in September. All appropriate patients will be given vaccination against influenza.

F. Antiviral drugs for influenza are an adjunct to influenza vaccine for controlling and preventing influenza and will be given as available.

G. In the event of pandemic influenza, the administrator will discuss with local health department whether how, and when an "Altered Standards of Care in Mass Casualty Events" will be invoked.

H. Hospital Emergency Incident Command System (HEICS) may be activated by volume of flu like symptoms, increase in in-patient census and/or staff shortages.

I. If necessary, cohort pandemic influenza patients.

J. Infection Prevention education will be provided on a regular basis.

K. Enhanced assessment of drugs, supplies and equipment inventory will be conducted.

DEFINITIONS

A. INFLUENZA: commonly called "The Flu," is caused by the influenza virus, which infects the respiratory tract (nose, throat, lungs). Unlike many other viral respiratory infections, such as the common cold, the flu causes severe illness and life-threatening complications in many people. Symptoms of the flu include fever, headache, extreme tiredness, dry cough, sore throat, runny or stuffy nose, and muscle aches.

B. AVIAN INFLUENZA: is an infection caused by avian (bird) influenza viruses. These flu viruses occur naturally among birds. Wild birds worldwide carry the viruses in their intestines, but usually do not get sick from them. However, avian influenza is very contagious among birds and can make some domesticated birds, including chickens, ducks and turkeys very sick and kill them. Bird flu viruses do not usually infect humans, but more than 100 confirmed cases in human infection with bird flu viruses have occurred since 1997. Most cases of avian influenza infection in humans have resulted from direct or close contact with infected poultry or surfaces contaminated with secretions and excretions from infected birds. Last outbreak of H5N1 was in 2014-2015 season.

C. STAGES OF A PANDEMIC:

Inter Pandemic Period:

- Phase 1: No new influenza virus subtypes have been detected in humans. An influenza virus subtype that has caused human infection may be present in animals. If present in animals, the risk of human infection or disease is considered to be low.

- Phase 2: No new influenza virus subtypes have been detected in humans. However, a circulating animal influenza virus subtype poses a substantial risk of human disease.

Pandemic Alert Period:

- Phase 3: Human infection(s) with a new subtype, but no human-to-human spread, or at most rare instances of spread to a close contact.

- Phase 4: Small cluster(s) with limited human-to-human transmission but spread is highly localized, suggesting that the virus is not well adapted to humans.

- Phase 5: Larger cluster(s) but human-to-human spread still localized, suggesting that the virus is becoming increasingly better adapted to humans but may not yet be fully transmissible (substantial pandemic risk).

  NOTE: During the pandemic alert period, patients with confirmed infection with a novel influenza strain should be isolated from patients with seasonal influenza, in order to decrease the risk of co-infection and viral genetic re-assortment.

Pandemic Period:

- Phase 6: Pandemic; increased and sustained transmission in general population.

D. ALTERED STANDARDS OF CARE IN MASS CASUALTY EVENTS – when to consider:

1. Volume of flu-like symptoms to the Medical Center.
2. Increase in in-patient census.
3. Staff shortages.

PROCEDURE:

A. A multidisciplinary planning committee with responsibility for pandemic influenza preparedness and response will include the following individuals:

- Safety Officer
- Administrator(s)
- Infection Prevention
- Emergency Department
- Materials Management
- Clinical Education
- Marketing
- Facilities/Plant Operations
- Laboratory
- EHS
- Pharmacy
- Pharmacy Care Departments Representatives

B. If pandemic influenza is noted in local area:

- Infection Prevention will establish contact with TCHHSA.

- Conduct hospital surveillance for influenza.
- Monitor healthcare personnel who might be infected with a pandemic strain of influenza. Department director/manager will monitor all employee sick calls.
- Reinforce infection prevention procedures.
- Accelerate staff education
- Implement activities to increase capacity:
  - Consider revising admissions criteria and working with home care agencies.
  - Plan to shift some patients to other facilities or identify space that could be vacated for use as a supplemental hospital
  - Plan for isolation zones to prevent further spread of the disease.
  - Consider how to handle, treat, and isolate patients with no influenza illness.
  - Consider how decisions will be made about patient priorities for admission.
- Emergency department will segregate waiting areas for persons with symptoms of influenza.
- Limit number of visitors to those essential for patient support.
- Defer elective admissions and procedures until local epidemic wanes.
- Discharge patients as soon as possible.
- Cohort patients admitted with influenza.
- Monitor for hospital acquired infection transmission.
- Consider furlough or reassignment of pregnant staff and other staff at high risk for complications of influenza.
- Consider reassigning non-essential staff to support critical hospital services or placing them on administrative leave.
- Consider assigning staff recovering from influenza to care for influenza patients.
- Screen staff reporting for duty.

- Provide staff with antiviral prophylaxis. According to HHS recommendations.
- If widespread transmission in community and hospital:
  - Redirect personnel resources to support patient care.
  - Recruit community volunteers.
  - Consider placing on administrative leave all non-essential personnel who cannot be reassigned to support critical hospital services.
  - Consider cross-training programs.
  - Explore options for alternative healthcare workers (e.g., retirees, trainees, family members, or others) as supplemental staff.
  - Prepare for just-in-time training of non-clinical staff.
  - Consider that you might need to replace high-risk personnel, including pregnant women and immune-compromised workers, during an outbreak.

C. Infection Prevention General Guidelines

- Refer to SVMC's Policy Library for specific policies and details on infection prevention measures.
- Standard Precautions and Hand Hygiene policies are indicated.
- Soiled linen/laundry, environmental cleaning and solid waste disposal are performed in the usual manner as defined by policy.
- Special dietary trays and handling is not necessary.
- Respiratory hygiene/cough etiquette:
  - Signage will be posted in hallways, entrances, waiting rooms and other areas that patients visit to point out the urgency of good hygiene in preventing a pandemic.
  - Guidelines include the following:
    - Cover your cough.
    - Wear a mask.

- Perform thorough hand hygiene using soap and water if available, if not, use alcohol-based hand sanitizer. Keep patients with coughs at least 3 feet from others in waiting rooms.

- Droplet Precautions: place patients with influenza in a private room or cohort with other patients with influenza. Keep door closed. During the early stages of a pandemic, infection with influenza should be laboratory confirmed, if possible. Wear a surgical mask for entry into patient room.

- Patient Transport: limit patient movement outside of room to medically necessary purpose; have patient wear a surgical mask when outside the room.

- Aerosol-generating procedures: during procedures that may generate small particles of respiratory secretions, health care workers should wear gloves, gown, face/eye protection and a mask with attached shield, or a mask and goggles.

D. Post Emergency Event Actions:

- Recover normal facility, personnel and patient operations.

- Dissolve the Emergency Operations Center.

- Resume usual use of space and clinical areas.

- Resume normal practice for supplies, medications and equipment.

- Resume usual staffing patterns.

- Conduct post-evaluation and review of performance and operations.

- Debriefing.

E. Laboratory Procedures:

- Collect and handle all clinical specimens from suspect novel Influenza A patients while wearing gloves, face and eye protection and a laboratory coat.

- Collect a nasal and throat swab and place each swab into a separate vial of transport media.

- Label each specimen with the following information: PATIENT'S NAME; DATE COLLECTED, and TYPE OF SPECIMEN. PLEASE NOTE: "SUSPECT CASE OF INFLUENZA A " ON THE FORMS AND SPECIMENS.

- Complete the Specimen Submittal Form for Suspect Influenza A for each patient with the following information: patient's name, age, date of illness onset, type of specimen(s), date collected and clinical symptoms.

- Contact: Tulare County Public Health Lab for specimen transport instructions.

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CROSS REFERENCES:

- SVMC Laboratory Policy & Procedure Manual: FLU A + B

- SVMC Policy and Procedure: Emergency Management Plan

ATTACHMENT C

KEY FACTS
Information about Avian Influenza (Bird Flu) and Avian Influenza A (H5N1) Virus

This fact sheet provides general information about bird flu and information about one type of bird flu, called avian influenza A (H5N1) that is infecting birds in Asia and has infected some humans.

What is avian influenza (bird flu)?
Bird flu is an infection caused by avian (bird) influenza (flu) viruses. These flu viruses occur naturally among birds. Wild birds worldwide carry the viruses in their intestines, but usually do not get sick from them. However, bird flu is very contagious among birds and can make some domesticated birds, including chickens, ducks, and turkeys, very sick and kill them.

Do bird flu viruses infect humans?
Bird flu viruses do not usually infect humans, but several cases of human infection with bird flu viruses have occurred since 1997.

How are bird flu viruses different from human flu viruses?
There are many different subtypes of type A flu viruses. These subtypes differ because of certain proteins on the surface of the flu A virus (hemagglutinin [HA] and neuraminidase [NA] proteins). There are 16 different HA subtypes and 9 different NA subtypes of Flu A viruses. Many different combinations of HA and NA proteins are possible. Each combination is a different subtype. All subtypes of Flu A viruses can be found in birds. However, when we talk about "bird flu" viruses, we are referring to those flu A subtypes that continue to occur mainly in birds. They do not usually infect humans, even though we know they can do so. When we talk about "human flu viruses" we are referring to those subtypes that occur widely in humans. There are only three known subtypes of human flu viruses (H1N1, H1N2, and H3N2); it is likely that some genetic parts of current human flu A viruses came from birds originally. Flu A viruses are constantly changing, and they might adapt over time to infect and spread among humans.

What are the symptoms of bird flu in humans?
Symptoms of bird flu in humans have ranged from typical flu-like symptoms (fever, cough, sore throat and muscle aches) to eye infections, pneumonia, severe respiratory diseases (such as acute respiratory distress), and other severe and life-threatening complications. The symptoms of bird flu may depend on which virus caused the infection.

How does bird flu spread?
Infected birds shed flu virus in their saliva, nasal secretions, and feces. Susceptible birds become infected when they have contact with contaminated excretions or surfaces that are contaminated with excretions. It is believed that most cases of bird flu infection in humans have resulted from contact with infected poultry or contaminated surfaces.

How is bird flu in humans treated?
Studies suggest that the prescription medicines approved for human flu viruses would work in preventing bird flu infection in humans. However, flu viruses can become resistant to these drugs, so these medications may not always work.

What is the risk to humans from bird flu?
The risk from bird flu is generally low to most people because the viruses occur mainly among birds and do not usually infect humans. However, during an outbreak of bird flu among poultry (domesticated chicken, ducks, turkeys), there is a possible risk to people who have contact with infected birds or surfaces that have been contaminated with excretions from infected birds. The current outbreak of avian influenza A (H5N1) among poultry in Asia (see below) is an example of a bird flu outbreak that has caused human infections and deaths. In such situations, people should avoid contact with infected birds or contaminated surfaces, and should be careful when handling and cooking poultry. For more information about avian influenza and food safety issues, visit the World Health Organization website at www.who.int/foodsafety/micro/avian/en.

What is an avian influenza A (H5N1) virus?
Influenza A (H5N1) virus – also called "H5N1 virus" – is an influenza A virus subtype that occurs mainly in birds. It was first isolated from birds (terns) in South Africa in 1961. Like all bird flu viruses, H5N1 virus circulates among birds worldwide, is very contagious among birds, and can be deadly.

What is the H5N1 bird flu that has recently been reported in Asia?
Outbreaks of influenza H5N1 occurred among poultry in eight countries in Asia (Cambodia, China, Indonesia, Japan, Laos, South Korea, Thailand, and Vietnam) during late 2003 and early 2004. At that time, more than 100 million birds in the affected countries either died from the disease or were killed in order to try to control the outbreak. By March 2004, the outbreak was reported to be under control. Beginning in late June 2004, however, new deadly outbreaks of influenza H5N1 among poultry were reported by several countries in Asia (Cambodia, China, Indonesia, Malaysia [first-time reports], Thailand, and Vietnam). It is believed that these outbreaks are ongoing. Human infections of influenza A (H5N1) have been reported in Thailand, Vietnam and Cambodia.

What is the risk to humans from the H5N1 virus in Asia?
The H5N1 virus does not usually infect humans. In 1997, however, the first case of spread from a bird to a human was seen during an outbreak of bird flu in poultry in Hong Kong. The virus caused severe respiratory illness in 18 people, 6 of whom died. Since that time, there have been other cases of H5N1 infection among humans. Most recently, human cases of H5N1 infection have occurred in Thailand, Vietnam and Cambodia during large H5N1 outbreaks in poultry. The death rate for these reported cases has been about 50 percent. Most of these cases occurred from contact with infected poultry or contaminated surfaces; however, it is thought that a few cases of human-to-human spread of H5N1 have occurred.

So far, spread of H5N1 virus from person to person has been rare and spread has not continued beyond one person. However, because all influenza viruses have the ability to change, scientists are concerned that the H5N1 virus could one day be able to infect humans and spread easily from one person to another.

Because these viruses do not commonly infect humans, there is little or no immune protection against them in the human population. If the H5N1 virus were able to infect people and spread easily from person to person, an "influenza pandemic" (worldwide outbreak of disease, see www.cdc.gov/flu/avian/gen-info/pandemics.htm) could begin. No one can predict when a pandemic might occur. However, experts from around the world are watching the H5N1 situation in Asia very closely and are preparing for the possibility that the virus may begin to spread more easily and widely from person to person.

How is infection with H5N1 virus in humans treated?
The H5N1 virus currently infecting birds in Asia that has caused human illness and death is resistant to amantadine and rimantadine, two antiviral medications commonly used for influenza. Two other antiviral medications, oseltamavir and zanamavir, would probably work to treat flu caused by the H5N1 virus, though studies still need to be done to prove that they work.

Is there a vaccine to protect humans from H5N1 virus?
There currently is no vaccine to protect humans against the H5N1 virus that is being seen in Asia. However, vaccine development efforts are under way. Research studies to test a vaccine to protect humans against H5N1 virus began in April 2005. (Researchers are also working on a vaccine against H9N2, another bird flu virus subtype.) For more information about the H5N1 vaccine development process, visit the National Institutes of Health website at http://www2.niaid.nih.gov/Newsroom/Releases/flucontracts.htm.

What is the risk to people in the United States from the H5N1 bird flu outbreak in Asia?
The current risk to Americans from the H5N1 bird flu outbreak in Asia is low. The strain of H5N1 virus found in Asia has not been found in the United States. There have been no human cases of H5N1 flu in the United States. It is possible that travelers returning from affected countries in Asia could be infected. Since February 2004, medical and public health personnel have been watching closely to find any such cases.

What does CDC recommend regarding the H5N1 bird flu outbreak in Asia?
In February 2004, CDC provided U.S. health departments with recommendations for enhanced surveillance ("detection") in the U.S. of avian influenza A (H5N1). Follow-up messages (Health Alert Network) were sent to the health departments on August 12, 2004, and February 4, 2005, both reminding health departments about how to detect (domestic surveillance), diagnose, and prevent the spread of avian influenza A (H5N1). It also recommended measures for laboratory testing for H5N1 virus. CDC currently advises that travelers to countries in Asia with known outbreaks of influenza A (H5N1) avoid poultry farms, contact with animals in live food markets, and any surfaces that appear to be contaminated with feces from poultry or other animals.

SUBJECT: **IV PREPARATION AND DISPENSING**	SECTION: *Pharmaceutical Services* **Page 1 of 15**

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

PURPOSE:

To provide guidelines to ensure quality sterile compound products are produced by using consistent validated methods and outline guidelines for the dispensing of medications and maintenance of records in accordance with law and regulation, licensure, and professional standards of practice.

DEFINITION:

Designated Persons- The pharmacist in charge (PIC) will serve as the designated person who is assigned to be accountable and responsible for the operation and performance of the compounding facility and personnel.

PEC-Primary Engineering Control- A device that provides an International Organization for Standardization (ISO) Class 5 or better environment through the use of non-turbulent, unidirectional high efficiency particulate air (HEPA)-filtered first air for compounding sterile preparations.

Segregated Compounding Area (SCA)- A designated space for sterile-to-sterile compounding where a PEC is located.

Aseptic Processing/Preparation- The technique involving procedures designed to preclude contamination (of drugs, packaging, equipment, or supplies) by microorganisms during processing.

ISO Class 5 Environment- One that contains no more than 3,520 particles per cubic meter that are 0.5 microns or larger in size.

Vertical Laminar Airflow Hoods- A device used to achieve the ISO Class 5 environment that sweeps filtered air from top to bottom.

CAI- Compounding Aseptic Isolator- A unidirectional HEPA-filtered airflow isolator that creates a positive pressure controlled environment. It is designed to provide worker protection from exposure to undesirable levels of airborne drug and to provide an aseptic environment for compounding sterile preparations.

CACI- Compounding Aseptic Containment Isolator- A unidirectional HEPA-filtered airflow isolator that creates a negative pressure controlled environment. It is designed to provide worker protection from exposure to undesirable levels of airborne drug and to provide an aseptic environment for compounding sterile preparations.

High-Efficiency Particulate Air (HEPA) filter - A filter composed of pleats of filter medium separated by rigid sheets of corrugated paper or aluminum foil that direct parallel flow that removes air particles 0.3 micrometers or larger.

CSP- Compounded sterile preparation

Critical Site – Any direct pathway through which contaminants may enter a sterile product (e.g. the point at which a needle pierces a vial stopper).

First Air – First air is the uninterrupted flow of air from the HEPA filter.

Beyond use date (BUD) – Beyond Use Date is the date and hour after which a CSP must not be used.

In-Use Time –The time before which a conventionally manufactured product or a CSP must be used after it has been opened or needle punctured (e.g. after a container closure of a vial has been penetrated). It cannot exceed the BUD or the manufacturer's expiration date.

Category 1 Compounded Sterile Product (CSP)- Category 1 is a risk-based approach defined in USP 797 that establishes a specific BUD for products, personnel qualifications, environmental monitoring, release testing required for sterile compounding. It assigns a BUD of 12 hours at room temperature and 24 hours refrigerated. SVMC BUD for products made in the main hospital pharmacy will not exceed 12 hours.

Category 2 Compounded Sterile Product (CSP)- Category 2 is a risk-based approach defined in USP 797 that establishes a specific BUD for products, personnel qualifications, environmental monitoring, release testing required for sterile compounding. It assigns a BUD of greater than 12 hours at room temperature or greater than 24 hours when refrigerated.

POLICY STATEMENT:

It is the policy of Sierra View Medical Center (SVMC) that sterile pharmaceutical products will be prepared using accepted standards of practice. Medications prepared & administered are in accordance with orders of a licensed practitioner who is responsible for the patient's care & in accordance with hospital policies.

PROCEDURE:

A. Sterile compounded products must be made in pharmacy in an ISO Class 5 PEC environment. The area used is to be maintained in a clean, uncluttered, and functionally separate area.

   a. Sterile compounded products may be made outside of an ISO Class 5 environment only in the case of an emergency where waiting could result in harm to a patient.

      i. These preparations shall be labeled "for immediate use only" and administration shall begin no later than four hours following the start of the compounding process.

ii. Unless the immediate use preparation is immediately and completely administered by the person who prepares it or is witnessed by the preparer, then the preparation shall bear a label with the following information:

1. Patient identification unless preparation is done at patient's bedside
2. Names and amounts of all ingredients, may not exceed three ingredients.
3. Name or initials of person preparing it
4. Exact four (4) hour beyond use date and time
5. If administration has not begun within the four (4) hours, then the preparation will be discarded.
6. Any unused source containers with residual drug shall be properly discarded.

iii. The segregated compounding area in the main hospital pharmacy provides ONLY category 1 sterile-to-sterile preparations.

b. All active and inactive ingredients used in sterile compounding at SVMC shall be procured from a supplier registered with the Food and Drug Administration (FDA).

c. Category 1 or 2 CSP's may be prepared at SVMC's Cancer Treatment Center's Suite B nonhazardous sterile product IV room.

B. Master Formulation Records must be present before the pharmacy can compound any sterile preparations. They must contain the following elements:

a. Name, strength, dosage form

b. Quantity prepared

c. Active ingredients and amounts

d. Inactive ingredients and amounts

e. Equipment to be used

f. The maximum allowable beyond use date for the preparation and the rationale or reference source justifying its determination.

g. Sierra View Medical Center's main pharmacy has a maximum BUD per USP 797's Category 1 specifications.

h. Sierra View's Cancer Treatment Suite B is a nonhazardous product room is a Category 2 facility. The maximum BUD will not exceed 10 days for refrigerated items.

i. Specific and essential compounding steps used to prepare the drug.

j. Quality reviews required at each step in the preparation of the drug.

k. Post-compounding process and any required post-compounding process and procedures, qualitative checks, including visual check and pharmacist initials that signify final product check.

l. Instructions for storage and handling of the compounded drug preparation.

m. Physical description of final preparation and final container to be used.

n. Where the pharmacy does not routinely compound a preparation, then the record may be documented on the prescription itself.

o. Any other information that may be needed to describe the operation and ensure its reproducibility.

p. Professional reference to cite where the compounding information can be found.

C. The methodology for determining the formulation of the sterile product shall be:

a. Consulting appropriate professional references

i. USP 797
ii. American Society of Health System Pharmacist
iii. Trissel's Drug Compatibility
iv. Lexi Comp Drug Information
v. Drug manufacturer package insert

D. A Compounding Record will be present and contain all of the following elements:

a. Name, strength, and dosage form of the compounded sterile preparation

b. Date and time that the preparation was compounded

c. Identity of pharmacy technician and pharmacist who performed the PRE check and POST compounding check.

d. Name and amount of each component

e. Manufacturer, expiration date, and lot number of each component

f. A pharmacy assigned unique reference or lot number

g. BUD: SVMC main pharmacy (Category 1) and CTC Suite B (Category 2)

h. The final quantity or amount of drug preparation compounded for dispensing

i. Visual check of final product. Review for particulates, discoloration, or other loss of integrity.

j. Master formula recorded as reference.

k. The log will be separated alphabetically by active ingredient. All logs will be kept for three years and will be filed alphabetically by the active ingredient's generic name. The last year's compounded drugs will be kept in the pharmacy. Any previous years will be kept at a designated pharmacy storage site as per approved Board of Pharmacy waiver to store records off site.

E. The most common source of contamination of sterile products is from personnel. The two most common causes of these contaminations are via particle shedding from personnel and improper manipulation of equipment.

a. Contamination from personnel due to shedding can be reduced by proper hand hygiene, gowning and gloving.

i. Personnel who are experiencing rashes, sunburn, weeping sores, conjunctivitis, or active respiratory infections shall not compound sterile products.

F. Compounding personnel shall not wear cosmetics, hand, wrist, or other visible jewelry, artificial nails, or extenders. Natural nails shall be kept neat and trimmed. Do not wear earbuds or headphones. Do not bring unnecessary electronic devices into the compounding area. Wipe eyeglasses, if worn.

G. Hand hygiene and donning of personal protective equipment (PPE) will take place in the anteroom:

a. Shoe covers.

b. Hair/beard cover should contain all hair.

c. Mask should be worn to cover from bridge of nose to chin.

d. Hands and forearms will be vigorously washed with soap (and water for at least 30 seconds.

- Remove debris from under fingernails, if present, using a nail cleaner (pick) under warm water.
- Hands and forearms shall be washed vigorously with soap and water for at least 30 seconds.
- Dry hands and forearms up to the elbows with low-lint disposable towels.
- Gown is to be donned next.
  - For a Category 1 & 2: Low-lint (non-shedding) garment with sleeves that fit snugly around the wrists and an enclosed neck (e.g., gown or coverall)
  - 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).
  - 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.
- Prior to donning sterile gloves, use Sterillium© and allow hands to dry thoroughly.
- Put on appropriate sized sterile gloves and apply sterile 70% alcohol and allow to dry.

e. Gloves should be disinfected immediately before compounding begins, before inserting hands into CAI, and before entering or re-entering the PEC and after contact with non-sterile objects.

f. Gloves that become contaminated by contact with non-sterile surfaces should be disinfected with sterile 70% isopropyl.

g. Gloves should be changed whenever contaminated (spills, etc.), torn or every 30 minutes.

h. The CAI fixed glove assembly shall don sterile gloves OVER the CAI isolator gloves immediately before non-hazardous compounding. These sterile gloves must be changed by each individual whenever continuous compounding is ceased and before compounding starts again or when a rip or tear is visible.

H. Personnel will not prepare compounded sterile products until training is complete and competency validated as per SVMC policy STERILE PRODUCTS:EDUCATION AND COMPETENCY.

a. Personnel will be validated every 6 months for garbing competency (including GFT) and media fill with post-GFT and surface sampling. Furthermore, they will be validated every 12 months for training and competency in sterile compounding principles and practices. There will be dates and signatures reflecting all annual reviews of the policies and procedures by the pharmacist-in-charge.

b. Periodic quality checks will be performed per policy. Failure of any quality test will result in the employee being unable to compound sterile products until retrained and competency validated.

I. Proper conduct in the sterile processing area also protects from contamination.

a. Food and drink are prohibited in all areas of the SCA or cleanroom.

b. Actions such as talking and coughing should be directed away from the work area.

c. Any unnecessary motion within the hood should be avoided to minimize the turbulence of air flow.

d. Activities in the sterile products room should only be related to the procedures for parenteral preparations.

e. No cardboard boxes may be in the ante-room or segregated compounding area. Supplies shall be wiped down with sterile alcohol before placing them in the anteroom and buffer room.

J. Proper technique in the ISO Class 5 environment is required to prevent contamination.

a. The critical principle in using laminar airflow hoods is that nothing should interrupt the flow of air between the HEPA filter and the critical site.

b. To maintain sterility, nothing should pass behind a sterile object in a vertical flow hood. Materials placed within the laminar flow hood disturb the patterned flow of air blowing from the HEPA filter. When laminar air flow is moving on all sides of an object, the zone of turbulence is created that may extend six times the diameter of the object. For these reasons, it is advisable to work with objects at least six inches from the sides and front of the hood without blocking air vents, so that unobstructed airflow is maintained between the HEPA filter and sterile objects.

c. Overcrowding of the critical work area may interfere with airflow and increase the potential for compounding errors. Only one individual may work in a hood at one time.

d. Items introduced into the CAI/Hood and their critical sites (vial stopper, IV bag septum) or hood shall be disinfected with 70% sterile alcohol and allowed to dry before aseptic manipulations begin.

K. Although the laminar air flow hood provides an aseptic environment that is safe for the manipulation of sterile products, it is essential that strict aseptic technique be used in conjunction with proper hood preparation.

L. All equipment (syringes, needles, bags, devices) will be used according to standard references to ensure quality, stability and compatibility. Up-to-date references are available in the pharmacy.

M. Ampule Use

a. Before an ampule is opened, any solution visible in the top portion (head) should be moved to the bottom (body) by swirling the ampule in an upright position.

b. To make an ampule break properly, the ampule neck is cleansed with an alcohol swab and the swab should be left in place. Pressure should be exerted on both thumbs, pushing away from oneself in a quick motion to snap open the ampule.

c. Ampules should not be opened toward the HEPA filter of the laminar flow hood or toward other sterile products within the hood.

d. To withdraw medication from an ampule, the ampule should be tilted and the bevel of the needle placed in the corner space (or shoulder) near the opening. As fluid is withdrawn, increase the angle of tilt so that more of the ampule contents flows into the shoulder.

e. Use a filter needle or filter straw to withdraw the ampule contents, and then switch to a regular needle before expelling the solution from the syringe. Alternatively, a regular needle may be used to draw the solution from the ampule, but a filter needle must be used when expelling the solution from the syringe.

f. All ampules are to be immediately discarded and are not to be stored for any length of time.

N. Vial Use

a. Vials with drugs in solution can be multi dose or single dose.

b. Multi dose vials contain a small amount of preservative agent. The presence of these substances does not make the solution self-sterilizing and the use of strict aseptic

technique is still required. Common substances used as preservatives include benzyl alcohol, parabens, phenol and benzalkonium chloride. Due to their toxicity, solutions with preservatives should not be used in preparations for pediatric or neonatal patients or for epidural or intrathecal dosage forms.

c. Unless otherwise specified by the manufacturer, a multi-dose container stored according to the manufacturer's specifications is used in its entirety or its remaining contents are labeled with a BUD and discarded within 28 days from initial opening or puncture. Any multidose container not stored properly or not labeled with a BUD or if BUD is incorrect, the container and drug must be immediately discarded.

d. Single-dose vials do not contain preservative.

i. Most protective covers do not guarantee sterility of the rubber stopper. Before the stopper is penetrated, it must be swabbed with 70% isopropyl alcohol and allowed to dry.

ii. Needle entry into vials with rubber stoppers should be done cautiously to avoid the creation of rubber core particles.

d. Single-dose containers of a compounded sterile drug preparation, other than an ampule, such as a bag, bottle, syringe, or vial, are used in their entirety or their remaining contents are to be labeled with a BUD and discarded within the following time limit, depending on the environment:

i. When needle-punctured in an environment with air quality worse than ISO Class 5,will be discarded after four hours.
ii. When needle-punctured in an environment with ISO Class 5 or better air quality, within twelve hours, unless otherwise specified by the manufacturer.

O. The Role of the Pharmacist

a. As physician's orders are received, the pharmacist will enter the order into the computer, preferably selecting premixed preparations.

b. Medications not available in premixed form will be entered in the computer as part of a multiple item compound that includes the appropriate volume of a compatible base solution.

c. A label will be generated from the computer system.

d. The pharmacist will check ALL ingredients (and calculations) prior to a pharmacy technician commencing any compounding. This PRE check will be documented on the compounding log.

e. Upon completion of the compounding, the pharmacist will visually inspect the product for visible turbidity, cloudiness, i.e., qualitative inspection of the final product and document this on the compounding log, a POST Check.

P. The Role of the Pharmacy Technician

a. Disposal of Supplies Upon Completion of Sterile Compounding

i. Needles will be discarded in puncture-resistant, sealable containers, often called "sharp" containers.
ii. Do NOT recap needles before discarding them into the "sharps" container.
iii. Syringes and containers that do not have medication in them that is not considered to be Resource Conservation and Recovery Act (RCRA) waste shall be disposed of in appropriate pharmaceutical waste bins.
iv. Nonhazardous, empty vials may be discarded in the regular trash.

b. Intravenous Piggyback Set-Up Procedures

i. An intravenous admixture ward list will be printed once a day by pharmacy technicians. This list will create intravenous admixture labels that will need to be affixed to either premixed (from the manufacturer) admixtures. If there are no premixed solutions available, then the admixture will be compounded in the compounding aseptic isolator.
ii. Any frozen solutions shall be thawed from the Pharmacy service freezer.
iii. Using the oldest frozen preparation that will not expire within the 24-hour dispensing period, the technician will label each solution specifically for the patient, drug, and dose.
iv. Expiration dates on the frozen solutions will be checked to assure the oldest acceptable date.
v. Docking of proprietary bag to vial systems for future activation must be done in accordance with USP 797.

c. Pediatric Syringe Preparation Procedure

i. The intravenous admixture ward list will be printed once a day.
ii. Patients with doses due before the next list is printed will have those labels segregated from the worklist.
iii. The amount of drug needed for compounding based on total patient requirements shall be determined.
iv. Materials required for aseptic medication transfer should be gathered and placed in the CAI antechamber and wiped with sterile alcohol.

v. The supplies and drug shall be transferred into the CAI mixing chamber and allowed to sit undisturbed for at least three minutes to allow for the CAI to purge any airborne particles.

vi. The technician will call the pharmacist into the IV room for a PRE check on the materials and calculations for the preparation to be compounded. The identity and quantity of each component will be validated by the pharmacist BEFORE the addition is performed.

vii. After the pharmacist signs off on the PRE check on the compounding log, the appropriate amount of medication for syringe preparation shall be diluted (in the CAI) by the technician.

viii. The calculated amount of drug shall be drawn into the syringe.

ix. Aseptically, the technician will inject the syringe contents into the predetermined base solution and affix the patient-specific label.

x. The patient-specific label is immediately applied and the product is removed from the CAI and made available for the pharmacist to do a final quality check.

xi. The remaining drug in the source container shall be discarded.

d. Large volume parenteral preparation procedure:

i. Solution fill list and labels are obtained as described in the pediatric syringe preparation.

ii. Labels are assembled according to additive type.

iii. The outer wraps of solutions are removed upon reintroduction into the PEC. The large volume bags are wiped with sterile alcohol in the CAI antechamber.

iv. The materials for compounding (drugs and syringes, etc.) are placed in the mixing chamber in the CAI and allowed to sit for a minimum of three (3) minutes to allow for the particulate to return to an ISO class 5 state.

v. The pharmacist is called into the IV room, and the identity, quantity, and calculations are reviewed with the technician prior to the pharmacist signing the compounding log and prior to the technician compounding the sterile product.

vi. The patient specific label is immediately applied and the product is removed from the CAI and made available for the pharmacist to do a final quality check.

Q. Sterile product preparation and verification PRE procedure to be done by the technician BEFORE and during the pharmacist's PRE compounding check:

a. Drugs and equipment and patient specific label (needles/syringes/alcohol wipes/etc.) necessary to prepare and mixture will be assembled for the pharmacist to review with the technician.

b. Ingredients will be carefully checked for accuracy using the master formulation record and label. All products selected for use in compounding shall be verified by the pharmacist prior to any compounding activity. In addition, calculations will be verified with the pharmacist during the PRE CHECK phase of compounding.

c. The pharmacist will then sign and date the compounding log acknowledging the technician has assembled all proper materials, drugs, equipment and has reviewed any and all pertinent calculations.

R. Procedure for transferring necessary ingredients and equipment into the PEC. All items will be carefully wiped down with sterile alcohol and allowed to dry before being placed in the PEC.

a. Only ingredients to make one admixture should be in the PEC.

b. Items will be arranged in a manner that does not block or disrupt airflow.

c. After the compounding materials are in the PEC, a purge time of three (3) minutes will pass before beginning any compounding activities.

d. Gloves will be disinfected with sterile alcohol and allowed to dry.

e. A pharmacist will check ingredients and calculations prior to compounding.

f. Admixture will be prepared using aseptic technique.

g. Trash will be managed in a way that does not obstruct airflow.

h. Admixture will be removed from the PEC and labeled.

i. Label will be signed by the employee and the beyond use date will be written on the label.

j. Employee preparing and pharmacist checking the IV will inspect the IV for leakage, foreign matter, precipitate, or cloudiness.

k. All ingredients and supplies will be removed from PEC and kept together for verification by a pharmacist.

S. Sterile product labels must contain the following elements:

a. The generic names of the drugs

b. The quantity or volume and strength of the active ingredient(s)

c. The name of the patient

d. The direction for use

e. The date of dispensing

f. The name and address of the compounding pharmacy and dispensing pharmacy if different.

g. An order number to identify the prescription, e.g., lot number or pharmacy reference number (prescription number).

h. The name of the prescriber

i. Beyond Use Date (BUD)

j. Date compounded

k. Route of administration

l. Rate of administration for IV admixtures

m. Instructions for storage & handling or warning labels if needed

n. All hazardous drugs shall bear a label which states, "Chemotherapy-Dispose of Properly" or "Hazardous-Dispose of Properly"

T. Statement the "Drug was compounded in pharmacy" if preparation was not outsourced.

U. Beyond Use Dating (BUD) will be assigned to all drug products based on manufacturer's chemical stability recommendations or in accordance with the standards for sterility testing found in USP 797, whichever is shorter.

a. SVMC's main pharmacy exclusively prepares sterile-to-sterile transfers in an ISO class 5 PEC that is located in a segregated compounding area, i.e., Category 1 classification.

b. The Cancer Treatment Center (CTC) suite B prepares hazardous and non-hazardous compounded sterile products by using sterile to sterile transfers in a negative pressure hood and room and a positive pressure room and hood, respectively. The products produced at this location will qualify for Category 2 and MAY have a BUD of not greater than 4 days at room temperature and 10 days refrigerated.

U. Single-dose and multi-dose container dating

a. A single-dose container (not an ampule) must be used entirely or discarded:

i. Within twelve hours, if needle-punctured or opened in an ISO Class 5 environment. If a puncture time is not noted on the container, the container must be immediately discarded.

ii. Within four hours, if needle-punctured or opened in a worse than ISO Class 5 environment.

b. An ampule is a single-dose container that must be used immediately and not stored for any timeframe.

c. A multi-dose container must be used or discarded within 28 days (or shorter if specified by manufacturer).

V. Documentation Retention

a. All records of compounding and materials used to compound sterile preparations shall be maintained in a readily retrievable form for three (3) years from the date the record was last in effect. They will be maintained in a manner to provide an audit trail for revisions and updates of each record document.

b. The pharmacy will maintain records of the acquisition, storage, and destruction of any component used in compounding.

W. Whenever a change in a policy or procedure occurs, the pharmacist in charge will notify the staff via a meeting or email. Staff shall sign off on changes acknowledging changes and intent to comply. Any material failure to follow the pharmacy's written policies and procedures shall constitute a basis for disciplinary action by the Board of Pharmacy.

X. This policy and all policies related to sterile compounding will be reviewed annually by the pharmacist-in-charge, and recordation of the annual review shall be present on each policy and be readily retrievable upon request by the Board of Pharmacy.

Y. All pharmacy staff who compound sterile products or who are responsible for training staff who work in the sterile product environment shall review all policies related to sterile products annually. Documentation of the annual staff review shall be readily retrievable for the State Board of Pharmacy.

Z. In the event of a drug recall, the written plan found in DRUG RECALL PROCEDURE shall be followed.

AA. The Department of Pharmacy will not handle or compound any infectious materials in the sterile compounding area.

BB. Pharmacy will run a "batch" for all IV compounds needed to compound within the next 24hrs once daily in the morning. Dispensing of the IV's are done in a manner to ensure the BUD date is not before their due time.

CC. All medications that are retrievable from Pyxis are immediately available for "dispense" after pharmacy verification. Any medication that does not require compounding and not dispensed via Pyxis will be dispensed prior to first dose upon pharmacy notification. 3 days' supply of medications are sent for medications not in Pyxis and are to be delivered as soon as possible and before the next due time.

EDUCATION:

SVMC Staff: All pharmacist and pharmacy technicians will receive education regarding sterile product preparation and aseptic technique.

REFERENCES:

- The Joint Commission (2024). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
  - MM.05.01.07
    - EP1
    - EP2
    - EP3
    - EP4
    - EP5
  - MM.05.01.11
    - EP3
- Pharmacy Law: California Edition (2024) San Clemente, California: Law Tech Publishing Group.
- USP 797. (n.d.). Retrieved March 4th 2024 from http://www.usp.org/compounding/general-chapter-797.

SUBJECT: **LATEX ALLERGY/SENSITIVITY IDENTIFICATION & MANAGEMENT**	SECTION: **Page 1 of 8**

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

PURPOSE:

To establish a standardized protocol for the identification and management of latex-sensitive/allergic patients and personnel.

POLICY:

Sierra View Medical Center will provide a safe environment for patients and personnel with known sensitivities/allergies to Latex and Latex products.

DEFINITIONS:

A latex-sensitive individual is one who has symptoms of allergic sensitivity after exposure to products containing natural rubber latex. Hypersensitivity reactions vary from contact rashes to systematic responses which require life-saving interventions. Reactions are classified as follows:

Irritant Dermatitis:

This sensitivity is NOT a latex allergy. It is caused by powder or other chemicals in gloves, not latex content. Signs and symptoms include localized redness and itching.

- Irritant Dermatitis is confirmed by patient's history and physical examination

Contact Allergic Reactions/Delayed Hypersensitivity of TYPE IV REACTION:

This is a reaction to the chemicals in the latex product, not to the latex itself. The carrier of the chemicals is the powder. Reactions may be delayed up to 6 to 48 hours or, with continued exposure, may be within 30 minutes. Signs and symptoms include redness, itching, urticaria (rash), flushing localized edema, rhinitis, coughing, and/or conjunctivitis. Symptoms may resolve when a person is away from such source(s) for several days then reoccur or worsen upon further exposure.

- Contact Dermatitis is confirmed by the use of patch testing

True Allergic Reaction/Immediate Hypersensitivity or TYPE I REACTION:

This is a true allergic reaction to a latex protein antigen, resulting in the life-threatening release of histamine. Time of the reaction can occur within 5 to 30 minutes from time of exposure. Signs and symptoms include itchy eyes, generalized pruritus and urticaria, shortness of breath, feeling of faintness, feeling of impending doom, nausea/vomiting, abdominal cramping, diarrhea, wheezing, tachycardia, hypotension, flushing, facial and peripheral edema, and/or cardiopulmonary arrest. Patients with such a history MUST be placed in a latex-safe environment.

For the intubated, anesthetized patient, the two most common presenting signs are hypotension and bronchospasm along with tachycardia, sneezing, flushing, facial edema, laryngeal edema, urticaria, and cardiorespiratory arrest.

AFFECTED AREAS/PERSONNEL: *ALL AREAS AND PERSONNEL*

PROCEDURE:

EMPLOYEES

1. Reduction or Avoidance of Latex Exposure: Employees should take the following steps to protect themselves from latex reactions in the work place:

   a. Use non-latex gloves for activities that are not likely to involve contact with infectious materials (food preparation, routine housekeeping, maintenance, etc.). Select the proper glove for the intended purpose. Do not assume one type of glove works for everything.

   b. Appropriate barrier protection is necessary when handling infectious materials. Hypoallergenic latex gloves do NOT reduce the risk of allergy. However, they may reduce reactions to chemical additives in the latex (i.e., allergic contact dermatitis). Use powder free latex gloves to prevent aerosolized latex.

   c. Dispose of gloves properly; do not leave them on counter tops.

   d. Use appropriate work practices to reduce the chance of reactions to latex. When wearing gloves, do not use oil-based hand creams or lotions unless they have been shown to reduce latex related problems. After removing latex gloves, wash hands with a mild soap and dry thoroughly.

   e. Avoid touching your eyes and face while wearing gloves.

   f. If you have a latex allergy, consult your physician and Employee Health regarding avoidance of latex exposure.

2. ***Identification of Latex Sensitivity:***

   Employees must report symptoms of latex allergy or allergic contact dermatitis. Use the Electronic Occurrence Report for this purpose. Employees will be evaluated by the Employee Health Nurse and referred to the primary care provider for further evaluation, if deemed necessary.

PATIENTS

1. Patients with Latex Sensitivity or Known Latex Allergies

a. **Use non-latex products**. – on Latex-Free Cart. Call Central Processing. Carts are available in OB/OR/ER/Central Processing.

b. Do not place any latex products directly on the latex sensitive or allergic patient.

c. Place a **LATEX ALLERGY** sign on the patient's door.

d. Provide the patient with educational materials on latex sensitivity/allergy.

e. Include latex allergy in hand-off communication.

f. Enter allergy into electronic medical record.

2. ***Patients at HIGH RISK for latex sensitivity include:***

a. Patients with a history of an allergic reaction, including but not limited to, after touching balloons, rubber gloves or powder from rubber gloves, dental dams, latex natural rubber consumer products, Band-Aids, and medical devices.

b. Patients with a history of experiencing an anaphylactic reaction during a surgery, urinary catheterization, a rectal or vaginal examination, and/or bladder stimulation.

c. Patients with neural tube defects (spinal bifida):

- Myelomingocele / Meningocele
- Lipomyelomenigocele / Lipomeningocele
- Sacral Agenesis

d. Patients requiring chronic bladder catheterization:

- Spinal cord trauma
- Malformation of the bladder
- Neurogenic bladder

e. Patients with history of allergic symptoms to rubber tree plants or poinsettias, or food allergies to kiwi, bananas, avocados, pears, and/or chestnuts.

f. Patients with occupational exposure (i.e., workers in latex industry and health care workers).

g. Patients that have had multiple operations.

h. Patients with a history of atopy and multiple allergies, including food allergies.

ATTACHMENT #1: Latex Allergy Alternatives

ATTACHMENT #2: Products Containing Latex

REFERENCES:

- *A Complete Guide to Latex Allergies: What is a Latex Allergy?*. Allergy and Asthma Network. (2024). https://allergyasthmanetwork.org/allergies/latex-allergy/ Accessed January 15, 2024.
- *Latex Allergy Management Guidelines*. American Association of Nurse Anesthesiology. (2018). https://issuu.com/aanapublishing/docs/5__latex_allergy_management?fr=sZWU1NTU2NDAxMjU Accessed January 15, 2024.
- *Preventing Allergic Reactions to Natural Rubber Latex in the Workplace.* (2021). The National Institute for Occupational Safety and Health (NIOSH). https://www.cdc.gov/niosh/docs/97-135/default.html Accessed January 15, 2024. Accessed January 15, 2024.
- *Allergy to Latex.* Nationwide Childrens Hospital. (2024). https://www.nationwidechildrens.org/conditions/allergy-to-latex Accessed January 15, 2024.

ATTACHMENT #1

LATEX ALLERGY ALTERNATIVES

ACTIVITY	*ITEM*
VITAL SIGNS:	
• Stethoscope	Latex-free stethoscope on cart
• BP Cuff	Place stretchable cotton gauze/material on patients' extremity under cuff. Cover tubing with cloth towel to avoid skin contact.
• Tympanic Thermometer	• Probe covers are OK for use.
• Cardiac Monitors	• Use latex-free patches from cart. Cover cord and cable with cloth towel to avoid skin contact.
• Pulse Oximeter Probe	Cover digit with clear adhesive dressing.
LAB DRAWS / IV STARTS	
• Gloves	• Vinyl or other Latex-free product
• Tourniquet	• Latex-free product from cart, or stockinet or stretchable cotton gauze/material between extremity and tourniquet.
• IV Catheter	• Silicone catheter
• IV Solution bags	• Do not use injection ports. Cover ports with port seals or tape. Use 3-way stopcocks for administration of piggybacks or pushes. Flush through 100 cc of solution before connecting to patient.
MEDICATIONS	
• Medication Vials	

	• Do NOT Draw through stopper. Contact pharmacy for alternative dispensing of medication.
• Syringes	• Latex-free from cart. (Glass or non-rubber plunger.)
	• Do not use pre-filled syringes unless labeled Latex-free.
OXYGEN DELIVERY / AIRWAY	
• Oxygen Mask	
• Nasal airway	• Replace elastic with twill tape.
• Bag-valve-mask	• DO NOT USE!
• Oral airway	• Assure latex-free.
CATHETERS	• Assure latex-free.
• Urinary Catheter	
• Leg bag	• Silicone
• Drains	• Do not use leg straps
	• Jackson-Pratt, Silicone tubing, Hemovac
PPE	
• Rubber or latex gloves	
• Surgical mask	• Assure latex-free gloves
• Goggles	• Assure latex free PPE
• Face shield	
• Rubber apron	• Disposable aprons
DRESSINGS	
• Tape, etc…….	

• Ace bandage • Ted hose	• Skin barrier film, Hypoallergenic tape, Gauze • Place stretchable cotton gauze/material on patient's extremity under wrap. • Use sequential stockings.

ATTACHMENT #2

PRODUCTS CONTAINING LATEX

A wide variety of products contain latex: medical supplies, personal protective equipment, and numerous household objects. Most people who encounter latex products only through their general use in society have no health problems from the use of these products. Workers who repeatedly use latex products are at higher risk for developing sensitivities. The following examples of products that may contain latex:

Emergency Equipment
Blood pressure cuffs
Stethoscopes
Disposable gloves
Oral and nasal airways
Endotracheal tubes
Tourniquets
Intravenous tubing
Syringes
Electrode pads

Office Supplies
Rubber bands
Erasers

Personal Protective Equipment (PPE)
Gloves
Surgical masks
Goggles
Respirators
Rubber aprons

Hospital Supplies
Anesthesia masks
Catheters
Wound drains
Injection ports
Rubber tops of multi-dose vials
Dental dams

SUBJECT: **NOTIFICATION OF EXPOSURE OF EMERGENCY RESPONDERS**	SECTION: **Page 1 of 4**

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

PURPOSE:

To establish the procedure for notification of Emergency Response Employees who may have been exposed to potentially life threatening infectious disease included on the list issued pursuant to Section 2695(a)(1) [42 U.S.C. 300ff–131(a)(1)] as required by Part G of Section 2695 (USC 300ff-131) of Public Law 111-87 (also known as the Ryan White HIV/AIDS Treatment Extension Act of 2009).

AFFECTED AREAS/PERSONNEL:

THE INFECTION PREVENTION NURSE OR DESIGNEE (NURSING SUPERVISOR) WILL BE RESPONSIBLE FOR IMPLEMENTATION OF NOTIFICATION AND RESPONSE TO INQUIRIES.

DEFINITIONS:

A. Emergency Response Employee (ERE): Firefighters, law enforcement officers, paramedics, emergency medical technicians and other persons (including volunteers) who, in the course of professional duties, respond to emergencies.

B. Designated Officer (DO): Person selected by ERE employer to receive and request information from health care facilities about exposure of ERE.

PROCEDURE:

A. Facility will initiate reports to DO.

If a patient is determined to have an infectious disease transmitted through aerosolized airborne or aerosolized droplet means, including, but not limited to: active tuberculosis, measles, meningococcal disease, mumps, pertussis, or rubella (see Table 1), this facility will report to the DO of the EREs who t3ransported the patient to the facility.

1. Persons undergoing tuberculosis drug therapy and skin test converters who are not infectious are not required to be reported.

2. The facility must notify only the DO of the ERE who transported the victim, not those who may have treated the victim on the scene. However, any ERE who attended to the patient may request (via the DO) a determination of whether or not there was an exposure to an infectious disease (see Section B below).

3. The notification must be as soon as practicable, but not later than 48 hours after the initial determination is made.

   a. Hospital Infection Preventionist will report name of infectious disease and the date the patient was transported to the facility. No other information, including the name of the patient, should be released.

   b. If the required notification is by mail, the facility must inform the DO (in person or by telephone) that the notification has been sent. The DO must notify within 10 days to inform the facility whether the notification was received.

B. Facility Response to DO Inquiries

1. Persons undergoing tuberculosis drug therapy and skin test converters who are not infectious are not required to be reported.

2. The Infection Prevention Nurse evaluates the facts to determine if an exposure to an infectious disease included on the list issued pursuant to sec. 2695(a)(1) [42 U.S.C. 300ff–131(a)(1)] occurred

Information about the potential exposure incident and medical information about the victim should be used in the following manner to make one of the four possible determinations as required by sec. 2695B(d) [42 U.S.C. §300ff–133(d)]:

(1) The ERE involved has been exposed to an infectious disease included on the list: —Facts provided in the request document a realistic possibility that an exposure incident occurred with potential for transmitting a listed infectious disease from the victim of an emergency to the involved ERE; and —The medical facility possesses sufficient medical information allowing it to determine that the victim of an emergency treated and/or transported by the involved ERE had a listed infectious disease that was possibly contagious at the time of the potential exposure incident.

(2) The ERE involved has not been exposed to an infectious disease included on the list: —Facts provided in the request rule out a realistic possibility that an exposure incident occurred with potential for transmitting a listed infectious disease from the victim of an emergency to the involved ERE; or —The medical facility possesses sufficient medical information allowing it to determine that the victim of an emergency treated and/or transported by the involved ERE did not have a listed infectious disease that was possibly contagious at the time of the potential exposure incident.

(3) The medical facility possesses no information on whether the victim involved has an infectious disease included on the list: —The medical facility lacks sufficient medical information allowing it to determine whether the victim of an emergency treated and/or transported by the involved ERE had, or did not have, a listed infectious disease at the time of the potential exposure incident. —If the medical facility subsequently acquires sufficient medical information allowing it to determine that the victim of an emergency treated and/or transported by the involved ERE had a listed infectious disease that was possibly contagious at the time of the potential exposure incident, then it should revise its determination to reflect the new information.

(4) The facts submitted in the request are insufficient to make the determination about whether the ERE was exposed to an infectious disease included on the list: —Facts provided in the request insufficiently document the exposure incident, making it impossible to determine if there was a realistic possibility that an exposure incident

occurred with potential for transmitting an infectious disease included on the list issued pursuant to Section 2695(a)(1) [42 U.S.C. § 300ff–131(a)(1)] from the victim of an emergency to the involved ERE.

3. Responses must be as soon as possible, but not later than 48 hours after receiving the request. If notifications of infectious disease being present are made by mail, the Infection Prevention Nurse must notify the DO (by telephone or in person) that the notification was sent. The DO must, within ten (10) days, notify the Infection Prevention Nurse whether the notification was received.

ROUTINELY TRANSMITTED BY CONTACT OR BODY FLUID EXPOSURES	ROUTINELY TRANSMITTED THROUGH AEROSOLIZED AIRBORNE MEANS[1]	ROUTINELY TRANSMITTED THROUGH AEROSOLIZED DROPLET MEANS[2]	CAUSED BY AGENTS POTENTIALLY USED FOR BIOTERRORISM OR BIOLOGICAL WARFARE
• Anthrax, cutaneous (*Bacillus anthracis*) • Hepatitis B (HBV) • Hepatitis C (HCV) • Human immunodeficiency virus (HIV) • Rabies (Rabies virus) • Vaccinia (Vaccinia virus) • Viral hemorrhagic fevers (Lassa, Marburg, Ebola, Crimean-Congo, and other viruses yet to be identified)[3]	• Measles (Rubeola virus) • Tuberculosis (Mycobacterium tuberculosis)—infectious pulmonary or laryngeal disease; or extrapulmonary (draining lesion) • Varicella disease (Varicella zoster virus)—chickenpox, disseminated zoster	• Diphtheria (Corynebacterium diphtheriae) • Novel influenza A viruses as defined by the Council of State and Territorial Epidemiologists (CSTE)[4] • Meningococcal disease (Neisseria meningitidis) • Mumps (Mumps virus) • Pertussis (Bordetella pertussis) • Plague, pneumonic (Yersinia pestis) • Rubella (German measles; Rubella virus) • SARS-CoV • COVID-19 (SARS-CoV-2)	These diseases include those caused by any transmissible agent included in the HHS Select Agents List . [5] Many are not routinely transmitted human to human but may be transmitted via exposure to contaminated environments. The HHS Select Agents List is updated regularly and can be found on the National Select Agent Registry Web site: http://www.selectagents.gov/

Table 1: List of Potentially Life-Threatening Infectious Diseases to Which Emergency Response Employees May Be Exposed, by Exposure Type

[1] Section 2695(b) [42 U.S.C. § 300ff–131(b)].
[2] Section 2695(b) [42 U.S.C. § 300ff–131(b)].
[3] For most viral hemorrhagic fevers (VHFs), routine transmission is limited to transmission from a zoonotic reservoir or direct contact with an infected person (e.g. Ebola virus, Marburg virus) or through arthropod-borne transmission (Rift Valley fever, Crimean-Congo hemorrhagic fever). For a small number of VHF viruses, transmission may occur through droplet transmission (e.g. Nipah virus), however prolonged close contact is likely necessary. Aerosol transmission does not occur in natural (non-laboratory) settings.
[4] Council of State and Territorial Epidemiologists, Position Statement Number: 09-ID-48. Available at https://c.ymcdn.com/sites/www.cste.org/resource/resmgr/PS/09ID-48.pdf . Accessed January 15, 2019.
[5] 42 C.F.R. §§ 73.3, 73.4.

4. If the Infection Prevention Nurse receives updated information that a patient previously reported as "insufficient" or "no information" did have a listed infectious disease, the nurse will provide the DO with an update, according to above limits.

5. If the Hospital receives a request on a patient who dies prior to a determination being made, the DO inquiring will be forwarded to the facility responsible for determining the cause of death.

C. The Ryan White Act supplements but does not replace or supersede the obligations of hospitals to mail reports to the County Health Officer regarding ERE who provide services to a patient with a reportable disease or condition.

REFERENCES:

- Centers for Disease Control and Prevention. *Ryan White HIV/AIDS Treatment Extension Act of 2009.* Available at https://www.cdc.gov/niosh/topics/ryanwhite/default.html Accessed Jan. 9, 2024
- Centers for Disease Control and Prevention. *Infectious Diseases and Circumstances Relevant to Notification of Emergency Responses Employees: Implementation of Sec. 2695 of the Ryan White HIV/AIDS Treatment Extension Act of 2009* Available at https://www.cdc.gov/niosh/docs/2020-119/default.html Last reviewed Mar. 26, 2020. Accessed Jan. 9, 2024
- California Hospital Association. *California Hospital Consent Manual, 49th Ed.* Available at https://calhospital.org/publications/2023-hospital-compliance-manual/ Accessed Jan. 9, 2024.
- *Cal. Code Regs. Tit. 22, § 70723 - Employee Health Examinations and Health Records. https://www.law.cornell.edu/regulations/california/22-CCR-70723*

CROSS REFERENCES:

- Alaris System Cleaning and Disinfecting
- Bloodborne Pathogen Exposure Protocol for Healthcare Workers

SUBJECT: **PHARMACY ORGANIZATION**	SECTION: **Page 1 of 2**

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

POLICY:

The Sierra View Medical Center (SVMC) Hospital Pharmacy is under the direction of a licensed pharmacist with the responsibility to meet standards of care for pharmaceutical services. The Pharmacy is charged with responsibilities assigned by the Sierra View Local Health District Board of Directors through the hospital's Vice President of Professional Services & Physician Recruitment.

AFFECTED AREAS/PERSONNEL: *PHARMACY, NURSING*

PROCEDURE:

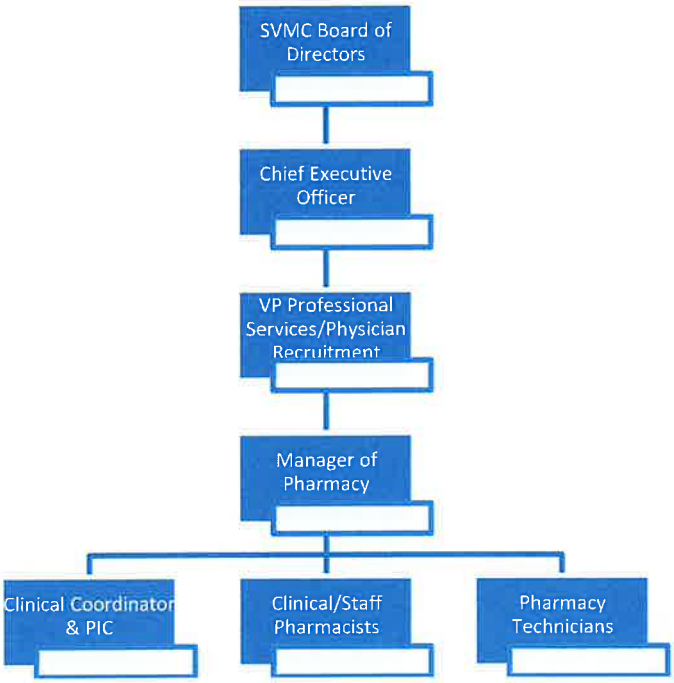
The Manager of Pharmacy, in conjunction with the Pharmacy and Therapeutics Committee, will initiate and develop policies and procedures pertaining to the pharmaceutical services of the hospital. These policies and procedures will meet the approval of Administration, the Medical Staff, and Board of Directors.

Standards of care for pharmaceutical services are those defined by nationally recognized organizations with expertise in medication preparation and administration. Examples of this organizations include but are not limited to the following: *American Society of Health-System Pharmacist, Institute for Safe Medication Practices, U.s Pharmacopeia.* These standards, in conjunction with State and Federal Law, will be used to develop all procedures pertaining to the acquisition, distribution, storage, dispensing and use of pharmaceuticals within the organization.

The chain of command is as follows:

- Sierra View Medical Center Board of Directors
- Chief Executive Officer
- Vice President of Professional Services
- Manager of Pharmaceutical Services
- Pharmacy Clinical Coordinator & PIC
- Clinical/Staff Pharmacist
- Licensed Pharmacy Technicians

Department of Pharmaceutical Services – Organizational Chart



REFERENCES:

- Pharmacy Law: California Edition.(2024) San Clemente, California: LawTech Publishing Group.
- Title 42 CFR 482.25 Condition of Participation: Pharmaceutical Services. Accessed February 29, 2024. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482.
- Hospital Accreditation Standards. (2024). Oak Brook, IL: Joint Commission Resources, Inc.
  - MM.03.01.01, EP 19

SUBJECT: **PYXIS ACCESS**	SECTION: *Medication Management (MM)* **Page 1 of 3**

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

PURPOSE:

To describe the management of Pyxis access privileges, to define what personnel will have access to Pyxis, and the termination process.

POLICY:

1. Access privileges to Pyxis shall be managed to ensure adequate security for medications, including controlled substance, to provide for proper and appropriate documentation of medication use.

2. A Pyxis user is defined as anyone with access to Pyxis. User templates will be created based on job titles; each user will be assigned user templates with specific access rights based upon their job duties.

3. Access privileges will be terminated immediately whenever the employee no longer works for the hospital.

4. Staff to complete a Pyxis Tutorial prior to Pyxis access being granted.

AFFECTED AREAS/PERSONNEL: *PHARMACY, NURSING, RESPIRATORY THERAPY, ANESTHESIA, EDUCATION*

PROCEDURES:

Access Definition

1. User access may be requested for the following hospital staff:

    a. Pharmacist

    b. Pharmacy Technician

    c. RN Clinical Director/ Manager/Chief Nurse Executive

    d. Charge Nurse

    e. Staff Nurse

    f. Nursing Instructor

    g. Respiratory Therapist

    h. Anesthesiologist

    i. CRNA (Certified registered nurse anesthetist)

j. Medical Assistants in Urology Clinic

k. Medical Assistants in Rural Health Clinic

l. Medical Assistants at Academic Health Center

m. Medical Assistants at Surgery Clinic

n. IR Technician

o. Medical Imaging Technologist

p. Ultrasonographers

2. The pharmacy department shall designate an individual as the system manager. The system manager or designee will be responsible for creating and maintaining user template. The template will be reviewed and approved by the pharmacist in charge prior to activation.

Request Access

1. Regular

   a. Access to Pyxis will be requested by the department director and/or manager on the Access Request Form initiated by Human Resources upon hire or on the Access Update Form located in the Approval Database in the FormStack database for an existing employee.

   b. Access Right will be assigned by Pharmacy System Manager based on employee's position.

   c. Anesthesiologist, Midwife, and CRNA

      - Access to Pyxis will be requested by Medical Staff on the Access Request Form initiated by Human Resources upon hire or on the Access Update Form located in the Approval Database in the Formstack database for an existing employee.

2. Travelers

   a. Access by travelers will have access for only the length of their contract. Their access will automatically terminate on the date their contract expires.

   b. Upon hire, human resources will initiate the Access Request form with the Traveler's name, user name, and date the contract will begin and expire.

c. Once the Access Request has been approved by Department Director, and sent to pharmacy via IT, access will be assigned by Pharmacy System Manager.

d. If a traveler's contract is extended beyond the original time specified, an Access Update form will be initiated by Human Resources at the time the contract is renewed. The form, which including the new contract dates (beginning and expiration dates), will be sent on for approval in the usual manner.

3. Temporary

a. A charge nurse may set up temporary users. These temporary users are given access to the particular Display Terminal (DT) for a limited timeframe (14 hours) with specified rights.

b. Temporary users include any nurse that has floated to a department where access has not been assigned.

c. Float Nurses and Registry Nurses will be given access for 14 hours to cover assign shift in the department only.

d. Traveling Nurse may be given Temporary Access for up to 14 hours if access for length of contract has not yet been approved.

Termination of Access

1. For routine voluntary termination, once the department director or manager receives the notice, a Termination Notice form located in the Approval Database in the Formstack database will be filled out by department director or manager and sent to Human Resources. Human Resources will forward this information to Pharmacy System Manager. Pharmacy System Manager will disable the user's login privileges at the end of the last scheduled day of work.

2. For immediate termination without advance notice, human resources will contact pharmacy immediately. Pharmacy System Manager or designee will disable the user's access privilege right away. The department director or manager will still need to fill out the Termination Notice form. If immediate access removal is needed after pharmacy operating hours, the house supervisor will contact the on-call pharmacist who will remove Pyxis access for that user.

3. Access may be revoked immediately at the discretion of the Pharmacist in Charge or their designee in their absence. Notification to Human Resources and the user's manager will be sent as soon as possible to initiate a full investigation of activity. Determination of reinstating the access will be dependent on the internal investigation.

REFERENCE:

- Hospital Accreditation Standards. (2024). Oak Brook, IL: Joint Commission Resources, Inc.
  a. MM.05.01.13, EP2

SUBJECT: **TRANSFER OF PATIENT TO HIGHER LEVEL OF CARE FROM CARDIAC CATH LAB**	SECTION: **Page 1 of 2**

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

PURPOSE:

To provide guidelines for a safe and timely transfer of the patient from the Cardiac Cath Lab (CCL) to a higher level of care in the event of an emergency situation, or when needed medical services are not offered at Sierra View Medical Center (SVMC).

POLICY:

A. Patients treated at the CCL who require a higher level of care due to unexpected complications, or who are in need of medical services not offered at SVMC, will be transferred to the accepting hospital for further medical treatment.

AFFECTED PERSONNEL/AREAS: *CARDIAC CATH LAB, RESPIRATORY THERAPY*

EQUIPMENT:

- Intra-Aortic Balloon Pump (IABP)
- Portable Ventilator

PROCEDURE:

A. Emergency Transfer

1. Immediately contact the CCL Director and notify of emergency.
2. Obtain order from attending Cardiologist to transfer patient to desired Hospital.
3. Cath lab personnel will contact contracted facilities for higher level of care and obtain acceptance from the facility and physician.
4. Call accepting facility and give report to transfer center or emergency department RN.
5. Contact EMS and advise dispatcher of need for emergency transfer from CCL to requested or nearest accepting facility.
6. Stabilize and prepare patient for transfer.
7. Obtain the following documentation:
   - Physician Transfer Certification Form (Pink) completed by RN and MD (copy goes with patient)

- Physician Certification Statement (White copy stays at SVMC, yellow copy goes with ambulance)
- Written copy of Transfer Agreement (copy goes with patient)
- CD of Images
- Copy of MAC lab reports
- Copy of patient's face sheet
- List of medications
- Copy of patient's history and physical

8. Notify patient's family if Physician has not already done so.
9. Patients requiring an IABP will be accompanied by a SVMC RN competent with management of IABP.
10. Patients requiring portable ventilators will be accompanied by a respiratory therapist.

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **TUBE FEEDING**	SECTION: **Page 1 of 3**

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

PURPOSE:

To standardize enteral feeding administration and promote patient safety while receiving enteral feeding.

POLICY:

Enteral feeding products will be ordered, received, and stored by the Food and Nutrition Services Department. Any damaged products will be disposed and customer service will be notified.

1. Enteral feeding containers will be rotated using first in, first out (FIFO).

2. Tube Feedings (enteral feedings) are handled and administered using methods that minimize the risk of contamination of the feeding. Formulas are purchased from approved vendors and closed system feedings are used as part of Hazard Analysis Critical Control Point (HACCP) procedures per Enteral Formulary endorsed by Pharmacy and Therapeutics Committee. Modular nutrient components, food grade coloring, medications or water (formula dilution) are not added to enteral formula containers. Full strength formulas are used.

3. Modality:

    a. Continuous Feeding: Pump-assisted continuous drip infusion.

    b. Cyclic Feeding: Pump or gravity drip over a time period that is less than 24 hours. Nocturnal feeding is a form of cyclic feeding.

    c. Intermittent Feeding: Feeding by pump or gravity drip, administered in a timeframe ranging from 20-60 minutes, provided anywhere from 4-6 times per day.

    d. Bolus Feeding: Providing a set volume of formula at specified times over a very short period of time. A typical feeding regimen might provide 240 mL of formula over a 4 to 10 minute timeframe, with infusions 3-6 times per day. Bolus feedings typically mimic normal meal patterns.

4. Open vs Closed Systems:

    a. Closed System: Ready to hang sterile closed system formulas can hang up to 48 hours per manufacturer's guidelines. If more than one feeding set is used or if more than one RTH container is used with a single feeding set, the maximum safe hang time is 24 hours.

    b. Open System (sterile decanted formula) are limited to a hang time of (8) eight hours. Reconstituted powder formula is limited to a hang time of (4) four hours. Administration sets, and feeding bag, for open system enteral feedings should be changed at least every 24 hours.

5. Formulas reconstituted in advance should be immediately refrigerated and discarded within 24 hours of preparation if not used. Formulas should be exposed to room temperature for no longer than 4

hours after which they should be discarded. Use purified water or sterile water for irrigation supply and formula reconstitution.

6. Orders for non-formulary products are substituted per protocol as approved by Pharmacy and Therapeutics Committee. If there is no equivalent formulary product, or "no substitution" is indicated by the ordering physician, the product will be special ordered, if able. Expired formulas are not used.

7. ICU Standard of Care order set: Please see electronic orders for TF regimen

8. Critical Care Area Guidelines for gastric residuals:
   Gastric residual volume (GRV) will be checked once per shift
   If < 500ml with **no** evidence of intolerance, continue infusion
   If > 500ml with symptoms of intolerance, replace 250ml of aspirate, continue infusion, and consult physician for prokinetic agent
   If ≥ 500ml or evidence of intolerance, hold tube feeding, return 250ml GRV and discard remaining volume, consult physician and recheck GRV after 2 hrs, if < 500ml restart feeds. Consult physician to consider post pyloric feeding tube.

9. Non-Critical Care Area Guidelines for gastric residuals:
   Gastric residual volume (GRV) will be checked once per shift
   If <250ml, then return residual, continue infusion
   If >250ml **and** symptoms of intolerance are present (abdominal distention, nausea, vomiting, diarrhea) hold feeding and notify MD. Return up to 250ml GRV
   If >250ml **without symptoms** of intolerance, return up to 250ml GRV, continue feeding and recheck in 2 hrs. If still greater than 250ml, hold feeding and notify MD

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRTITION SERVICE, PATIENT CARE AREAS*

PROCEDURE:

1. Food and Nutrition Services is notified of any patient/resident on enteral feeding via the electronic medical record as a Diet order, in the Dietary Special Needs category.

2. Nursing will order an enteral pump and tubing set from Distribution.

3. The enteral tube feeding order should specify the modality, feeding rate or amount per feeding, total number of feedings per (24) hours and water flushes. Food and Nutrition Services supplies the enteral products. The dietitian must be consulted for all enteral feeding orders.

4. Any pouring or mixing of a powdered product is done by Nursing or Nutrition Services according to the product label. Any mixed product is immediately placed in the delivery container in a quantity that would limit hang time to four hours. The formula should be labeled with the patient's/resident's name, room number, date, time, formula, #ml per hour, and strength.

5. All tube feedings are administered using clean technique.

6. Tube feedings should be started as per the physician's order. The rate should be increased to goal rate over the next 24 - 48 hours as tolerated.

7. DPSNF: The dietitian is responsible for completing a nutrition assessment on the patient/resident within 72 hours of the tube feeding initiation. Recommendations regarding the appropriateness of the product, volume, calories, protein, fluid needs, and percentage of the Dietary References Intake (DRI) for all vitamins and minerals will be addressed.

   Drug-Nutrient Interactions: All patients shall be monitored for potential drug-food interactions. Dietitians will calculate accordingly and change to bolus feeds if necessary. *Refer to policy: "Drug Nutrient Interaction and Enteral Tube Feeding Interaction."*

8. Cranberry juice and/or soda shall not be used to unclog a feeding tube. To unclog a tube, use warm water, or crushed sodium bicarbonate 325 mg tablets or crushed pancrease MT 10.

CROSS REFERENCES:

- DRUG/NUTRIENT INTERACTIONS AND ENTERAL TUBE FEEDING DRUG/NUTRIENT INTERACTION

REFERENCES:

- **Krames on Demand: Gastroenterology ->Tube Feeding**
- CIHQ Acute care Accreditation, Nutrition Assessment and Care Plans (2023) California Department of Public Health, Retrieved from https://www.cdph.ca.
- Centers for Medicare and Medicaid Services, Conditions of Participation (2023). Retrieved from https://www.cms.gov/Regulations-and-Guidance.
- American Society of Enteral/Parenteral Nutrition (ASPEN) Guidelines for the Provision and Assessment of Nutrition 2016
- 2019 Abbott Nutrition Best Practice for Managing Tube Feeding, A Nurse's Pocket Manual
- American Society of Enteral and Parenteral Nutrition (ASPEN) Critical Care Guidelines 2021
- The ASPEN Adult Nutrition Support Curriculum 3rd ed. 2017
- ASPEN 2014 Gastric Residual Volume in Critically Ill Patients: A Dead Marker or Still Alive?

SUBJECT: **TUBERCULOSIS CONTROL PLAN**	SECTION: **Page 1 of 31**

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

PURPOSE:

The Tuberculosis Control Plan (TCP) integrates Centers for Disease Control and Prevention (CDC) evidence-based research and guidelines across all entities and provides Sierra View Medical Center (SVMC) staff a comprehensive plan for the early detection, management, isolation and treatment of persons with active tuberculosis (TB). Adherence to the policies and procedures addressed in this TB Control Plan will assist in reducing the risk of exposure to patients, visitors and staff within the Sierra View Medical Center (SVMC) environment. This Tuberculosis Control Plan includes:

TB CONTROL PLAN – TABLE OF CONTENTS

POLICY:

Sierra View Medical Center (SVMC) is committed to providing a safe and healthful work environment for our staff, caregivers, and patients. In pursuit of this endeavor, the following TCP is provided to minimize or eliminate occupational exposure to TB in accordance with the corrected and updated 2005 CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Facilities. It is the intent of SVMC to comply with California Code of Regulations Title 8, Section 5144, Subchapter 7 concerning respiratory protective equipment and OSHA Standard 29 CFR 1910.139 concerning respiratory protection for Mycobacterium tuberculosis (MTB).

AFFECTED AREAS/PERSONNEL: *ALL HEALTHCARE WORKERS*

SECTION I - RESPONSIBILITY FOR THE TB INFECTION PREVENTION PROGRAM

A. The fundamentals of a TB Control Plan should consist of administrative controls, environmental controls, and a respiratory protection program.

1. Administrative Controls: These are management measures that are intended to reduce the risk of exposure to persons with infectious TB and include:

- Assigning someone the responsibility for TB infection control in the health care setting;
- Conducting a TB risk assessment of the setting;
- Developing and implementing a written TB infection-control plan;
- Ensuring the availability of recommended laboratory processing, testing, and reporting of results;
- Implementing effective work practices for managing patients who may have TB disease;
- Ensuring proper cleaning, sterilization, or disinfection of equipment that might be contaminated (e.g., endoscopes);
- Educating, training, and counseling health care personnel, patients, and visitors about TB infection and TB disease;
- Screening, testing, and evaluating personnel who are at risk for exposure to TB disease. Early identification, isolation, and treatment of persons with TB, (e.g., provide and practice early patient screening in the Emergency Department, to identify potentially infectious patients, and prevent employee exposures).
- Using posters and signs to remind patients and staff of proper cough etiquette (covering mouth when coughing) respiratory hygiene; and
- Coordinating efforts between local or state health departments and high risk healthcare and congregate settings.

2. Environmental Controls: The use of environmental controls to reduce the concentration and prevent the spread of infectious droplet nuclei.

    - Primary environmental controls consist of controlling the source of infection by using local exhaust ventilation (e.g., hoods, tents, or booths) diluting and removing contaminated air by using general ventilation.
    - Secondary environmental controls consist of controlling airflow to prevent contamination of air in areas adjacent to the source airborne infection isolation (AIIR) rooms; and cleaning the air by correctly using high efficiency particulate air (HEPA) filtration.

3. Respiratory-Protection Controls: Consists of the use of personal protective equipment in situations that pose a high risk of exposure to TB disease.

    - Implementing a respiratory protection program;
    - Training healthcare personnel on respiratory protection; and
    - Educating patients on respiratory hygiene and the importance of cough etiquette procedures.

B. The Tuberculosis Control Plan was developed and approved by the Administrative staff and the Board of Directors, who have ultimate responsibility for the development of programs that create a safe work environment for the employees.

The Infection Prevention and Control Committee has the authority for implementation and ongoing evaluation of the TB Control Plan. Leadership is responsible for monitoring compliance with the plan. All employees are expected to follow the policies and procedures contained in the TB Plan.

SECTION II – RISK ASSESSMENT

Risk assessment includes:

A. Analysis of the number of infectious TB patients admitted to the facility and each area in the facility
B. Analysis of Healthcare Worker (HCW) Tuberculin Skin Test (TST) conversion and possible patient-to-patient TB transmission.
C. Analysis of the management of infectious TB patients in the hospital, drug susceptibility patterns, and adequacy of treatment of TB patients.
D. Analysis of relevant current epidemiological information for the geographic area (locally, statewide and nationally)

SECTION III - PROTOCOL FOR EARLY DETECTION

In order to protect healthcare workers, patients and visitors from exposure to tuberculosis, patients (across all SVMC entities) with known or suspected infectious tuberculosis will be promptly screened and identified. Control measures will be employed in accordance with this policy and local, state, and federal regulations. *See other SVMC entity-specific policies as appropriate.*

Characteristics of TB:

Symptoms of TB disease depend on where in the body the TB bacteria are growing. TB bacteria usually grow in the lungs (pulmonary TB). TB disease in the lungs may cause symptoms such as:

A. Signs and symptoms of active TB:
    1. Productive, persistent cough of 3 weeks (or longer) duration (unclear etiology)
    2. Purulent bloody sputum/phlegm from deep inside the lungs (hemoptysis)
    3. Night sweats
    4. Pleuritic chest pain
    5. Unexplained weight loss
    6. Loss of appetite (anorexia)
    7. Easy fatigability
    8. Fever of unknown origin

Symptoms of TB disease in other parts of the body depend on the area affected.

B. Certain groups experience disease and infection rates in excess of the general population. These groups include:

1. Persons with certain comorbid medical conditions: diabetes, cancer, and HIV infection alter the immune system's ability to fight TB

2. Babies and young children with weak immune systems

3. Geographic disparities:

    a. Foreign-born persons from high prevalence countries (see listed reference)
    b. Medically underserved low-income populations, including high risk minority, African American, Hispanics, Native Americans and Southeast Asians
    c. Certain other populations that have been identified locally as having an increased prevalence of TB

4. Close contacts with known infectious TB cases

5. Persons with alcohol use disorder and intravenous drug users

6. Residents of high-risk congregated settings:

    a. Long-term care facilities (e.g., correctional facilities, skilled nursing)
    b. Individuals experiencing homelessness

C. Medical Risk Factors:

1. Persons with HIV infection
2. Silicosis
3. Abnormal chest radiograph showing fibrotic lesions
4. Prolonged corticosteroid therapy
5. Organ transplants
6. Immuno-suppressive therapy
7. Hematologic and reticuloendothelial diseases
8. End-stage renal disease
9. Intestinal by-pass
10. Post-gastrectomy
11. Chronic malabsorption syndromes
12. Carcinomas of the oropharynx and upper GI tract
13. Ten percent (10%) or more below ideal bodyweight

SECTION IV - SCREENING AND DIAGNOSIS

Diagnostic measures/assessment should be initiated on any person with suspected TB. The nursing staff shall notify the primary physician/hospitalist of any symptoms suggestive of TB upon initial patient assessment.

A. Diagnostic measures may include:

1. History and physical examination
2. Tuberculin Skin Test (TST)
3. Blood Assay for Mycobacterium tuberculosis (BAMT); Interferon Gama Release Assay (IGRA) or QuantiFERON-TB Gold test
4. Chest X-Ray
5. AFB sputum smear and culture
6. Others as prescribed

B. Tuberculin Skin test (TST): *See TST – ADMINISTRATION AND INTERPRETATION OF TB SKIN TEST POLICY*

1. PPD skin test results should be read by designated, trained personnel between 48-72 hours after injection. The skin test is to be read by the presence or absence of induration at the injection site. Redness or erythema are not to be measured. The transverse diameter of induration should be recorded in millimeters.
2. Test may be given to employees, healthcare providers, and patients. Patient results will be entered into the medical record.

3. Two-step TST Testing is used for new employees

C. Notification of the Nursing Unit and Infection Prevention Department

1. In addition to notifying the nursing unit, the Infection Prevention Department shall be notified (ext. 3781; Fax at 791-3819) by any person on the healthcare team in a timely manner of any suspect or confirmed TB diagnosis.

2. Notification can be accomplish by:

   a. The **nursing units** should notify Infection Prevention **ASAP** when placing a patient in Airborne Precautions
   b. **Physicians** can notify the nursing units/IP Department
   c. The interpreting **radiologist** (or Imaging designee) shall be responsible for immediately notifying attending imaging staff, who will inform the nurse and Infection Prevention of any abnormal radiological findings suggestive of TB
   d. The **laboratory** will notify the nursing unit, physician and Infection Prevention of any **positive** results of in-patient AFB smears, cultures or TST as soon as possible.
   e. **Pharmacy** should notify the Infection Prevention Department when a patient has been placed on a new regimen of TB medications.

SECTION V - MANAGEMENT AND ISOLATION OF PATIENTS WITH POSSIBLE TUBERCULOSIS

A. Decision to place in Airborne Precautions (See Figure 1)

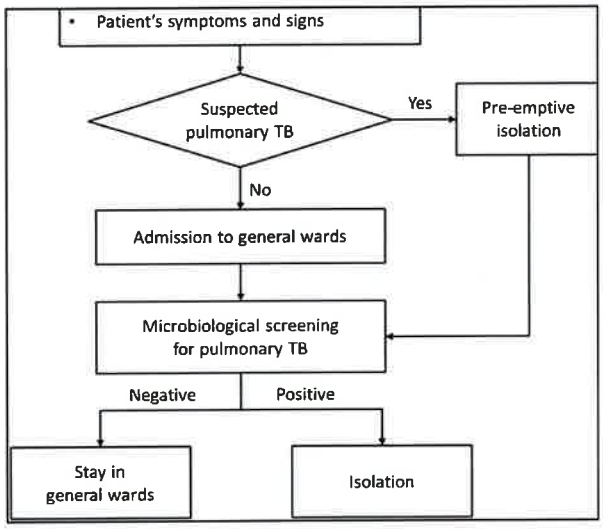
1. Signs and symptoms suggestive of TB may include:

    a. Productive, persistent cough 3 weeks duration (unclear etiology)
    b. Purulent or bloody sputum (hemoptysis)
    c. Night sweats
    d. Pleuritic chest pain
    e. Unexplained weight loss
    f. Loss of appetite (anorexia)
    g. Easy fatigability
    h. Fever of unknown origin
    i. Abnormalities (i.e., cavitation) in the chest X-Ray including apical and posterior segments of the upper lobe, in the superior segments of the lower lobe or diffuse nodular infiltrates

2. Any patient with signs and symptoms suggestive of TB, **and** any of the following circumstances will be considered suspect for TB and placed into Airborne Precautions as soon as possible:

    a. There is an order for sputum for AFB's
    b. The physician writes "R/O suspect or confirmed TB"

Figure 1. **Decision to Place Patient in Airborne Precautions (suspect or confirm TB)**
Modified from Han, S., Park, J., Ji, S., *et al.*, 2021



3. The physician, infectious disease physicians, nurse, nursing supervisor or infection preventionist shall have the authority to implement Airborne Isolation Precautions when signs and symptoms are suggestive of TB (suspected or confirmed). The physician and Infection Prevention Team should be consulted as part of the decision making process.

B. Airborne Precautions (Airborne Infection Isolation Room (AIIR)

When a patient is placed in Airborne Precautions, the following should take place:

1. Assure the room is negative pressure or has a HEPA filter at bedside.
2. An Airborne Precautions sign (caddy as needed) shall be placed on the door to the patient's room.
3. The door will remain closed, except when entering or leaving the room
4. A National Institute for Occupational Safety and Health (NIOSH) approved **respirator masks or Powered Air Purifying Respirator (PAPR)** should be donned by **all** staff (i.e., nursing, physicians, EVS, Lab, RT, Imaging, etc.) upon entering the room.
5. **Standard Precautions** will be implemented in addition to Airborne Precautions (i.e., wear a gown and/or gloves if exposure to additional bod fluids is anticipated)

C. Airborne Infection Isolation Room (AIIR) Location

Designated Airborne Infection Isolation Rooms (AIIR) appropriate for the placement of patients with known or suspected TB are located in the following areas:

1. **Main Hospital:**

    a. Telemetry Department - Room 260

b. Medical Surgical Department – Room 360

2. If a room is not a designated AIIR, it may be able to be adapted with an appropriately placed HEPA filter.

D. Inpatients with known or suspected TB:

1. Patient must be placed in Airborne Infection Isolation room (AIIR) or have a HEPA filter unit placed at bedside.
2. Patients on treatment for infectious TB who are re-admitted to SVMC shall be placed in the above designated room until infectiousness is ruled out.
3. Notify the Infection Prevention Department as soon as possible (Infection Prevention Department 3781).
4. Within 24 hours of diagnosis or strong suspicion of an active TB case, notification of the Tulare County TB Office must be done. The IP Team will initiate this process.
5. Adherence to Airborne Precautions/etiquette compliance by the staff and patient is mandatory.
6. Any incident of noncompliance with Airborne Precautions protocol shall be reported to the area Clinical Director/Manager.
7. The physician shall be notified if the patient will not comply with Airborne Precaution protocols.
8. The physician and/or nurse will provide the following education to the patient in respiratory precautions:
    a. Transmission of TB
    b. Reasons for respiratory precautions and importance of compliance
    c. Precautions, such as covering the mouth and nose with tissues when coughing or sneezing
    d. Importance of staying inside the patient's room
    e. Specific instructions for transportation to areas outside the patient's room

SECTION VI - OTHER CIRCUMSTANCES

A. Patient Movement to other locations:

1. A patient in Airborne Precautions shall not be routinely transported to other locations for a procedure/test unless it is deemed medically essential (and cannot be done in the patient's room).
2. If a patient in Airborne Precautions must be transported outside the patient's room for a medically essential procedure, the patient shall wear a surgical mask during the transfer and procedure. The mask should be changed if it is no longer effective (i.e., wet or soiled). If use of a mask is not possible during the procedure, the receiving department should use

Airborne Precautions. Patient should be placed in a single room with a HEPA-filter. Staff should don an N-95 respirator or (PAPR) and follow other Standard Precautions (gown, face shield/goggles, gloves) if further exposure to body fluids is anticipated. Room should be exhausted for one hour (door closed) after the procedure with the HEPA-filter on.

3. If the patient requires mechanical ventilation, a HEPA-filter must be used on the expiratory side of the resuscitation bag or ventilator circuit. Portable ventilators are ***not*** equipped with closed circuit capability, therefore should not be used in transport of active TB ventilated patients.
4. The minimum respirator is a fitting face-piece respirator and must be selected from those approved by CDC/National Institute for Occupational Safety and Health (NIOSH) under Title 42 CFR, Part 84. It must meet one of the following specifications:
    - Non-powered air-purifying respirators (N-95)
    - Powered air-purifying respirators (PAPRs) with high-efficiency filters; or
5. Outside the patient room, during transport within the hospital or clinics, the employee does not need respiratory protection because the patient is wearing a surgical mask.
6. Staff should make **all** attempts to schedule the procedure at a time when it can be performed rapidly, when the patient is in a single room, and when waiting areas are less crowded (i.e., end of day).

B. Outpatients with known or suspected TB

1. Facility staff should be notified by physician's office staff in **advance** regarding a possible TB patient arrival.
2. Patient should be instructed to wear a mask upon entering the facility and practice appropriate respiratory etiquette (i.e., use tissues while coughing, proper disposal, etc.).
3. Place patient in a room with a HEPA filter. If not readily available, patient is to wear a mask until placed in an appropriate room.
4. When appropriate, schedule suspect TB patients at times to avoid contact with immunocompromised patients

C. Aerosol-generating (high hazard, cough-inducing) procedures (i.e., bronchoscopy, airway surgeries, intubation/extubation, non-invasive positive pressure ventilation (e.g., CPAP, BIPAP, open Suctioning of tracheostomy or endotracheal tube)

1. Minimize such procedures when possible.
2. Use the HEPA units for aerosol-generating procedures.
3. HCWs should utilize "Enhanced Airborne Precautions" during the procedure (i.e., N-95 respirator mask/PAPR, goggles/face shield, gloves and gown).
4. Following the procedure, confine the patient to the room or enclosure until coughing subsides or until patient is discharged. Have patient use tissues to contain any secretions.

5. Allow at least 1 hour following the procedure before placing another patient in the procedure room.
6. Document precautions taken on the patient record, including area of recovery.

D. During Emergency Department Care

1. The patient shall wear a surgical mask when being transported via emergency medical services (EMS) if TB is suspected or confirmed. Staff should be alerted to a possible TB patient.
2. The suspect patient should be provided supplies for respiratory etiquette (mask, tissues and hand sanitizer) and instructed on respiratory hygiene. This process should begin in the waiting room. The patient should be separated from other patients as soon as possible.
3. The patient should be placed in a private room with HEPA filtration. Airborne Precautions should be implemented.
4. A mask should be worn at all times by the patient, until sufficient arrangements are made. The mask should be changed as necessary (i.e., when wet or soiled).
5. The patient should be processed as quickly as possible through the Emergency Department.

E. Operating Room (OR):

1. Elective operative procedures shall be deferred, if possible, until TB is no longer infectious.
2. OR procedures that must be done shall be completed with the door closed and traffic minimized.
3. If possible, procedures shall be performed at the end of the day.
4. A bacterial filter shall be placed on the endotracheal tube and/or expiratory side of the anesthesia breathing circuit.
5. OR personnel shall wear an N-95 respirator mask instead of a surgical mask during the procedure.
6. HEPA filtration should **not** be used during the operative procedure due to disruptions of normal air flow.
7. HEPA filtration will be required for air scrubbing the environment post-operation after the patient has been removed from the OR suite. Note: The HEPA unit must be disinfected prior to entry into the operating room.
8. Allow the HEPA-filter unit to run for at least 60 minutes after the patient has vacated the room.
9. Recovery shall be in an individual room meeting ventilation requirements.

F. PPD Positive Obstetric Patients

1. Obstetric patients and their newborns will be provided quality effective care that meets the requirements for effective management of TB.
2. Positive PPD skin test obstetric patients should have a documented chest radiograph in their medical records to verify disease status.
3. Asymptomatic PPD positive obstetrics patients **with** a documented x-ray within the last year do not require any additional precautions related to TB upon admission
4. Asymptomatic PPD positive obstetrics patients **without** a documented chest x-ray within the last year will require a chest x-ray as soon as possible after delivery. They (as well as the infants) will not require any additional precautions related to TB upon admission until the status of the x-ray is determined.

5. **Symptomatic positive PPD** patients will require Airborne Precautions:
    a. Separation may be necessary:
        1) Mothers who are too ill to care for their infants or who need higher levels of care.
        2) Neonates at higher risk for severe illness (e.g., preterm infants, infants with underlying medical conditions, infants needing higher levels of care).
    b. If the neonate remains in the mother's room, measures that can be taken to minimize the risk of transmission from a mother with symptomatic TB to her neonate include:
        1) Mothers should wear a mask and practice hand hygiene during all contact with their neonates. **Note**: Plastic infant face shields are not recommended and masks should **not** be placed on neonates or children younger than 2 years of age.

6. If an obstetric patient is undergoing active treatment for TB, the staff will contact the Infection Prevention Department. The Infection Prevention Department will communicate with the Tulare County TB Office. A determination will be made regarding the patient's current infectious status. Precautions will be taken if necessary. The Birth Center will notify the Infection Prevention Department when the patient is discharged. The Infection Prevention Department will notify Tulare County of the discharge.

SECTION VII - ENGINEERING CONTROLS

A. Ventilation
    1. Local exhaust ventilation
        a. Air from ventilation devices in the patient room is directly exhausted to the outside of the building, away from air intake vents.
        b. Precaution rooms and rooms used for treatment have a minimum of twelve (12) air exchanges per hour. Air is exhausted to the outside and not recirculated.

B. Negative Pressure Rooms (AIIR)

1. Monitoring
    a. Negative airflow pressure rooms are kept at a constant "negative pressure". An alarm will notify HCW if negative pressure is disrupted. HCW may notify the Engineering Department for assistance.

C. HEPA Filtration

A HEPA air filtration unit is a portable device used to "clean" the air of a non-negative pressure patient room or area by creating high efficiency particulate air filtration (removal of respirable particles).

1. Installation of Unit

    a. Call Engineering when a HEPA unit is needed in a patient room.
    b. Engineering staff will install the unit in required area as per nursing staff and use appropriate particulate respirator and other protective equipment, as required due to patient condition.

2. Monitoring

    Negative airflow pressure check is conducted by engineering. AIIR rooms are kept at a constant "negative pressure". An alarm will notify HCW if negative pressure is disrupted. HCW may notify the Engineering Department for assistance.

3. Unit Removal

    Upon notification from nursing that the unit is no longer necessary:

    a. Engineering will be called to remove the HEPA unit.
    b. HEPA unit will remain "ON" in the patient's room (to scrub the air) for at least one (1) hour, prior to being removed by Engineering (necessary only if patient had infectious TB).
    c. Unit will be cleaned by Environmental Services staff.
    d. Intake filter will be removed and cleaned in a non-common open area by Bio-med every 3 months.

e. Unit will be stored by Engineering.

4. Maintenance Procedure

a. HEPA filters are to be properly installed, tested, and maintained per manufacturer's instructions. HCW will maintain documentation in the patient's record indicating the time that the unit was used.
b. Filters are to be installed to prevent leakage between filter segments and between the filter bed and its frame.
c. A pressure sensing device in the filter system will determine the need for filter replacement. Changes will take place per manufacturer's recommendations by Engineering.
d. Installation should allow for maintenance without contaminating the delivery system or area served.
e. Engineering personnel are adequately trained on the installation and maintenance procedures. Respiratory protection is worn during maintenance and testing.

SECTION VIII - DISCHARGE PLANNING

A. Discontinuance of Airborne Precautions:

1. The following persons are authorized to discontinue isolation:
   a. Attending physician
   b. Infection Preventionist
2. Isolation may be discontinued if the patient is:
   a. On effective therapy (usually four TB drugs)
   b. 3 daily consecutive sputum smears for AFB are rare or negative
   c. With permission of Tulare County Health Department
   d. When patients are found not to have infectious TB

B. TB Inpatient Notification/Discharge Planning:

Every health care provider who provides treatment for a patient with active tuberculosis must promptly report to the local health officer each diagnosis or suspected diagnosis of active TB. Also reportable are instances when the patient discontinues treatment for active TB.

A healthcare facility cannot discharge a person who is known or reasonably suspected to have active TB until after the discharge plan for the patient is approved by a Tulare County Public Health Official.

To comply with the above regulations, the Infection Prevention Department will be the overall coordinator for the reporting process. Problems or concerns should be directed to the Infection Prevention Department. However, a team approach should be used to facilitate the initial reporting mechanism and discharge planning process between the facility and the Tulare County Health and Human Services Agency (TCHHSA) TB Office. Nursing, the patient's physician, Case Management and the Infection Prevention Practitioner will collaborate to expedite the communication of information necessary to report TB cases and to obtain approval for the patient's discharge plan.

1. Within **24 hours** of diagnosis or strong suspicion of an active TB case (i.e. patient with symptoms suggestive of TB, positive chest radiograph with positive PPD or AFB smear), notification of the Tulare County TB Office must be done. Nursing staff or the patient's physician shall notify the IP Nurse to initiate this process.

2. When the Infection Preventionist receives notice of the patient actual or suspected diagnosis, the completed TB Suspect Case Report will be faxed or input in CalREDIE by the IP.

3. The Infection Preventionist and staff will communicate with Tulare County TB Office as necessary, to facilitate patient treatment/progress. Documentation of any communication shall be recorded in the patient's medical record.

4. As soon as a projected discharge date is known and at **least one day prior to discharge,** the Tuberculosis Discharge Treatment Plan will be completed and faxed to the Tulare County TB Office by IP.

5. Notification of approval of the discharge plan will be sent from the Tulare County TB Office within approximately 24 to 48 hours after the plan was submitted as above. **The patient may not be discharged prior to receiving approval of the TB discharge plan.** If the patient refuses to wait for the facility to receive the approved discharge plan form from the Health Department, the patient must sign out AMA and the TCHHSA TB Office must be informed immediately by hospital staff.

6. For medically necessary transfers to other acute care hospitals or correctional institutions, notification of the Tulare County TB Health Officer should be done ASAP. Document in the patient's medical record that the transfer was reported and to whom it was reported. The TB discharge plan will need to be completed.

SECTION IX - RESPIRATORY PROTECTION OF EMPLOYEES/FIT-TESTING

7. All employees are required to be fit-tested by Employee Health Services (EHS).
8. for a NIOSH-approved N-95 respirator mask.
9. Must seal the mask around the nose and mouth.

10. The mask must be "seal checked" for an effective seal each time before entry into an Airborne Precautions room. To do so, blow forcefully into the mask as it expands. The wearer should not feel air escaping around the edges of the mask.

11. As with any disposable mask, N-95 respirator shall be removed and disposed of immediately after a single use.

12. If the employee fails the N-95 fit test, they must wear a Powered Air Purifying Respirator (PAPR).

SECTION X - EVALUATION OF CONVERSIONS/TRANSMISSION

A. Exposure to TB in a HCW (See APPENDIX D: Employee Health Policy *Tuberculosis screening Program* and Employee Screening Form)

1. A contact investigation among other HCWs, patients, and visitors after a confirmed exposure to active TB will be initiated by Infection Prevention and Employee Health.
2. The Infectious Disease Department Chair will also be consulted.
3. Employee Health and Infection Prevention will follow current CDC recommended guidelines for exposure of employees (i.e., baseline TST and follow up at 8 - 10 weeks).
4. An employee exposure line list will be developed. Any employee converting to positive will be managed by Employee Health. Appropriate measures will be implemented based on each individual case.
5. Previous positive TST employees will be evaluated for symptoms and will be recommended for a chest x-ray.
6. The Tulare County Office will be notified for community contact investigation and consultation as required.
7. Investigation will be performed to determine the cause of transmission.
8. An evaluation of the TB exposure/TB Control Plan and processes will be conducted, with possible opportunities for improvement to be developed and recommendations implemented.
9. Summary of findings and recommendations will be presented to the Infection Prevention Committee.

B. Patient-to-Patient/Visitor TB Transmission

1. Surveillance will be conducted by Infection Prevention to determine any additional cases of TB transmission related to other patients and visitors.
2. Potential patient/visitor (as possible) exposures will be identified and the primary physician will be notified for recommended follow-up.

3. Tulare County TB Office will be notified as necessary.

C. Exposure Follow-up for Unrecognized TB at Time of Hospitalization

1. Investigation will be conducted to determine areas and persons potentially exposed.
2. All persons exposed shall be handled as above in A and B.

SECTION XI – DEFINITIONS/VOCABULARY

Acid-fast bacilli (AFB) - Bacteria that retain certain dyes after being washed in an acid solution. Most acid-fast organisms are mycobacteria. When AFB are seen on a stained smear of sputum or other clinical specimen, a diagnosis of TB should be suspected; however, the diagnosis of TB is not confirmed until a culture is grown and identified as M. tuberculosis.

Active TB - TB bacteria are dividing and multiplying within an affected individual's body, causing tissue and organ damage. A person with active TB is likely to be or soon become symptomatic.

Aerosol - The droplet nuclei that are expelled by an infectious person (e.g., by coughing or sneezing); these droplet nuclei can remain suspended in the air and can transmit M. tuberculosis to other persons.

Anergy - The inability of an individual to react to skin-test antigens (even if the person is infected with the organisms tested) because of immunosuppression.

Bacille Calmette-Guérin (BCG) – The only vaccine currently used to prevent tuberculosis. It was developed by the French scientists Albert Calmette and Camille Guérin at the Institute Pasteur, Lille, between 1907 and 1921. It is a living, attenuated (weakened) variant of the bovine tubercle bacillus.

Bronchoscopy - Examination of the airways by means of a flexible or rigid tube. Modern instruments are fiber-optic and highly flexible and they enable specimens to be obtained from the lung by aspiration, washing, brushing and biopsy.

Cavity, pulmonary - A necrotic tuberculous lesion which communicates with the airways, enabling tubercle bacilli to enter the sputum and to be coughed out.

Cluster - Two or more PPD skin-test conversions occurring within a 3-month period among HCWs in a specific area or occupational group, and epidemiologic evidence suggests occupational (hospital acquired) transmission.

Culture - The process whereby bacteriological specimens are grown in an incubator. In the case of tuberculosis, this can take weeks.

Droplet nuclei - Microscopic particles (i.e., 1-5 mm in diameter) produced when a person coughs, sneezes, shouts, or sings. The droplets produced by an infectious TB patient can carry tubercle bacilli and can remain suspended in the air for prolonged periods of time and be carried on normal air currents in the room.

Ethambutol **-** One of the first-line anti-tuberculosis drugs, given during the first 2 months of therapy. Care is required in its use as it can cause visual disturbance (blurred and red/green color disturbance) and irreversible eye damage. Patients should be told that if they experience any visual disturbance they should stop taking the drug and seek medical advice.

Ethionamide **-** A drug used to treat cases of drug resistant tuberculosis.

Exposure -- The condition of being subjected to something (e.g. infectious agents) that could have a harmful effect. A person exposed to M. tuberculosis does not necessarily become infected.

First line drugs **-** Active, drug-sensitive TB disease is treated with a standard six-month course of four antimicrobial drugs: Isoniazid, Rifampicin, Pyrazinamide and Ethambutol. These are referred to as first line drugs for treating TB.

Fluoroquinolones **-** A class of antibiotics used to treat drug-resistant tuberculosis and some diseases caused by environmental mycobacteria. Examples include ofloxacin, ciprofloxacin and moxafloxacin.

Haemoptysis **(or Hemoptysis) -** Expectoration (coughing up) of blood or of blood-stained spit from the bronchi, larynx, trachea, or lungs.

Health Disparity **-** a higher burden of illness, injury, disability, or mortality experienced by one group relative to another.

Healthcare Worker (HWC) - Those working for the agency that care directly for patients/clients.

Immunosuppressed - A condition in which the immune system is not functioning normally (e.g., severe cellular immunosuppression resulting from HIV infection or immunosuppressive therapy). Immunosuppressed persons are at greatly increased risk for developing active TB after they have been infected with M. tuberculosis. No data are available regarding whether these persons are also at increased risk for infection with M. tuberculosis after they have been exposed to the organism.

Incubation period **-** The interval between infection and the development of clinically evident disease.

Isoniazid **-** A synthetic agent and one of the first line anti-tuberculosis drugs. It is particularly effective against actively replicating bacilli in the lung cavities. It is also used for preventive therapy in those with latent tuberculosis.

Latent tuberculosis **-** A term applied to the status of those infected with the tubercle bacillus but remaining healthy. It is assumed that the tubercle bacilli are in some dormant or resting 'persister' state.

Miliary tuberculosis **-** A form of disseminated tuberculosis occurring in patients with relatively good immune responses. The lesions are millet-seed sized granulomas (Latin: milium – a millet seed) that are easily seen on chest radiographs and, sometimes, on the retina by use of an ophthalmoscope. Miliary lesions differ from those of cryptogenic disseminated tuberculosis.

Multidrug-resistant TB (MDR TB) – TB disease caused by bacteria resistant to two of the most important medicines: INH and RIF.

Mycobacterium - The genus of bacteria which includes the tubercle and leprosy bacilli and the environmental mycobacteria. The name means 'fungus bacteria', in allusion to the mould-like pellicles they form on liquid culture media.

M. tuberculosis complex -- A group of closely related mycobacterial species that can cause active TB (e.g. M. tuberculosis, M. bovis, and M. africanum); most TB in the United States is caused by M. tuberculosis.

Negative Pressure - An isolation room used for infectious patients from which the air is constantly being extracted to result in slight negative pressure in the room compared with the outside corridor. Any bacteria coughed by the patient will then be extracted through a filter system rather than blowing into the corridor.

Percutaneous - The route of administration through or via the skin.

Prevalence - Prevalence is a measurement of all individuals affected by the disease at a particular time. This is distinct from incidence, which is a measurement of the number of new individuals who contract a disease during a particular period of time.

Positive PPD reaction - A reaction to the purified protein derivative (PPD)- tuberculin skin test that suggests the person tested is infected with M. tuberculosis. The person interpreting the skin-test reaction determines whether it is positive on the basis of the size of the induration and the medical history and risk factors of the person being tested.

Pulmonary tuberculosis - Tuberculosis of the lung. The most common form of tuberculosis. Pulmonary TB is the only form of TB that may be infectious.

Purified Protein Derivative (PPD) - A derivative of tuberculin prepared by harvesting precipitated proteins. It is less likely to give non-specific reactions than unpurified tuberculin.

Purified protein derivative (PPD) - tuberculin - A purified tuberculin preparation that was developed in the 1930s and that was derived from old tuberculin. The standard Mantoux test uses 0.1 ml of PPD standardized to 5 tuberculin units.

Rifampicin (Rifampin in the USA) - A member of a class of antibiotics termed the rifamycins, it is the most powerful of the first-line anti-tuberculosis drugs. It has the unique property of killing very slowly, replicating bacilli that persist in lesions.

Smear positive/smear negative - Smear positive means that bacteria can be seen when a sample of sputum is specially stained and examined under a microscope. It usually indicates an infectious patient. Smear negative means that the bacteria could not be seen in a specimen. It may mean that disease is absent or that bacteria are too few to be seen.

Sputum – Phlegm coughed up from deep inside the lungs. Sputum is examined for TB bacteria using a smear; part of the sputum can also be used to do a culture.

TB blood test – A test that uses a blood sample to find out if you are infected with TB bacteria. The test measures the response to TB proteins when they are mixed with a small amount of blood. Examples of these TB blood tests include QuantiFERON®-TB Gold In-tube (QFT-GIT).

Tuberculosis - A chronic infectious disease caused by the closely related species Mycobacterium tuberculosis, M. bovis, and M. africanum.

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CROSS REFERENCES:

- TST- Administration and Interpretation of TB Skin Test

APPENDIX A

Fit Testing Procedure

1. Assignment of Responsibility- Employee Health Services.

2. Identify those HCWs to be fit-tested.

3. Select respirator- NIOSH-approved (minimum N- 95).

4. Instruct each HCW to abstain from eating, drinking, and chewing gum for a minimum of 15 minutes prior to being fit-tested.

5. HCW to fill out questionnaire/medical evaluation entitled, "Mandatory Information for those Employees Selected to use a Respirator" to determine the employee ability to use a respirator (see attachment). Evaluate the employee potential health problems that might limit the employee's ability to wear a respirator during performance of normal job duties. (Using a respirator may place a physiological burden on employees that varies with the type of respirator worn, the job and workplace conditions in which the respirator is used and the medical status of the employee.)

6. Fit-tester to review and determine HCW's ability to be fit-tested and wear N-95 in the clinical setting. If questionnaire results indicate health concerns and inability to wear respirator safely, do not continue with fit-testing. (Refer if needed, as designated by EHS.)

7. Describe to the employee the limitation of the respirator and the consequences for not wearing it correctly.

    A. Limitations:

        i) Respirator face-seal: leakage is not necessarily 100%.
        ii) Lack of fit-checking each time used may increase risk of leakage.
        iii) Qualitative tests rely on the subjective response of the HCW being fit-tested.
        iv) Considerations of hygiene, damage, and breathing resistance all are factors in its use.

    B. Consequences:

        i) Risk of exposure to *M. tuberculosis*.

8. Train the healthcare worker on:

    A. How the N-95 respirator is to be applied to the face and how to adjust it.
    B. How to inspect the integrity (physical damage or soil) of the N-95 respirator.
    C. How to fit-check with each use.
    D. How to maintain the N-95 respirator (protect from elements.)
    E. How to store the N-95 respirator (clean, convenient, sanitary area, if it is to be reused due to shortage.)

F. When to dispose of the N-95 respirator (damaged or noticeable breathing resistance.)
G. How to dispose of the N-95 respirator (regular trash.)
H. How to obtain additional respirators.
I. To return for refit-testing if the employee has facial changes (through weight loss/gain, medical conditions, facial surgery, etc.) or if there are any questions. Training can recur annually or as needed.
J. Fit-testing and N-95 respirators are at no cost to the employee.

9. Inform the HCW of the ingredients of the fit-test solution and that they will be exposed to a fine mist.

10. Qualitatively (saccharin) fit-test an appropriate size respirator to the HCW following the instructions of the manufacturer's fit-test kit.

11. Allow the healthcare worker to practice how it should be worn.

12. If the HCW cannot be fitted with the available respirators, assign HCW to use (PAPR)
13. Maintain documentation of fit-testing in personnel file.

APPENDIX B: MANDATORY INFORMATION FOR THOSE EMPLOYEES SELECTED TO USE A RESPIRATOR

MANDATORY INFORMATION FOR THOSE EMPLOYEES SELECTED TO USE A RESPIRATOR		
1.	Name: Date:	
2.	Age: 3. Sex: ☐ M ☐ F 4. Height: _____ 5. Weight: _____	
6.	Job Title:	
7.	Telephone #: Best time to be reached at this #	
8.	Has your employer ever told you how to contact the health care professional who will review this questionnaire:	☐ Yes ☐ No
9.	Check the type of respirator you will use: (make, model, style)	☐ N ☐ R or ☐ P
10.	Have you ever worn a respirator: If "yes", what type (s):	☐ Yes ☐ No
11.	Do you currently smoke tobacco, or have you smoked tobacco in the last month:	☐ Yes ☐ No
12.	Have you ever had any of the following conditions?	
	A. Seizures (fits):	☐ Yes ☐ No
	B. Diabetes (sugar disease):	☐ Yes ☐ No
	C. Allergic reaction that interferes with your breathing:	☐ Yes ☐ No
	D. Claustrophobia (fear of closed-in places):	☐ Yes ☐ No
	E. Trouble smelling odors:	☐ Yes ☐ No
13.	Have you ever had any of the following pulmonary or lung problems?	
	A. Asbestosis:	☐ Yes ☐ No
	B. Asthma:	☐ Yes ☐ No

	C. Chronic Bronchitis:	☐ Yes	☐ No
	D. Emphysema:	☐ Yes	☐ No
	E. Pneumonia:	☐ Yes	☐ No
	F. Tuberculosis:	☐ Yes	☐ No
	G. Silicosis:	☐ Yes	☐ No
	H. Pneumothorax (collapsed lung):	☐ Yes	☐ No
	I. Lung Cancer:	☐ Yes	☐ No
	J. Broken ribs:	☐ Yes	☐ No
	K. Any chest injuries or surgeries:	☐ Yes	☐ No
	L. Any other lung problem that you've been told about:	☐ Yes	☐ No
16.	Do you currently have any of the following symptoms of pulmonary or lung illness?		
	A. Shortness of breath:	☐ Yes	☐ No
	B. Shortness of breath when walking fast on level ground or walking up a slight hill or incline:	☐ Yes	☐ No
	C. Shortness of breath when walking with other people at an ordinary pace on level ground:	☐ Yes	☐ No
	D. Have to stop for breath when walking at your own pace on level ground:	☐ Yes	☐ No
	E. Shortness of breath when washing or dressing yourself:	☐ Yes	☐ No
	F. Shortness of breath that interferes with your job:	☐ Yes	☐ No
	G. Coughing that produces phlegm (thick sputum):	☐ Yes	☐ No
	H. Coughing that wakes you early in the morning:	☐ Yes	☐ No
	I. Coughing that occurs mostly when you are lying down:	☐ Yes	☐ No
	J. Coughing up blood in the last month:	☐ Yes	☐ No
	K. Wheezing:	☐ Yes	☐ No
	L. Wheezing that interferes with your job:	☐ Yes	☐ No
	M. Chest pain when you breathe deeply:	☐ Yes	☐ No
	N. Any other symptoms that you think may be related to lung problems:	☐ Yes	☐ No
17.	Have you ever had any of the following cardiovascular or heart problems?		
	A. Heart attack:	☐ Yes	☐ No
	B. Stroke:	☐ Yes	☐ No
	C. Angina:	☐ Yes	☐ No
	D. Heart failure:	☐ Yes	☐ No
	E. Swelling in your legs or feet (not caused by walking):	☐ Yes	☐ No
	F. Heart arrhythmia (heart beating irregularly):	☐ Yes	☐ No
	G. High blood pressure:	☐ Yes	☐ No
	H. Any other heart problem that you've been told about:	☐ Yes	☐ No
18.	Have you ever had any of the following cardiovascular or heart symptoms?		
	A. Frequent pain or tightness in your chest:	☐ Yes	☐ No
	B. Pain or tightness in your chest during physical activity:	☐ Yes	☐ No
	C. Pain or tightness in your chest that interferes with your job:	☐ Yes	☐ No
	D. In the past two years, have you noticed your heart skipping		

	or missing a beat:	☐ Yes	☐ No
	E. Heartburn or indigestion that is not related to eating:	☐ Yes	☐ No
	F. Any other symptoms that you think may be related to heart or circulation problems:	☐ Yes	☐ No
19.	Do you currently take medication for any of the following problems?		
	A. Breathing or lung problems:	☐ Yes	☐ No
	B. Heart trouble:	☐ Yes	☐ No
	C. Blood pressure:	☐ Yes	☐ No
	D. Seizures (fits):	☐ Yes	☐ No
20.	If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check the following box and go to question 21: ☐)		
	A. Eye irritation:	☐ Yes	☐ No
	B. Skin allergies or rashes:	☐ Yes	☐ No
	C. Anxiety:	☐ Yes	☐ No
	D. General weakness or fatigue:	☐ Yes	☐ No
	E. Any other problem that interferes with your use of a respirator:	☐ Yes	☐ No
21.	Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire:	☐ Yes	☐ No

APPENDIX C: FIT TESTING RECORD FOR RESPIRATOR USERS

SIERRA VIEW MEDICAL CENTER

Fit Testing Record for Respirator Users

Employee: _____ **Job Title:** _____

Department: _____ **Extension:** _____ **Date of Birth:** _____

Description of condition requiring RPE use:

_____

_____

Since your last fit test, has a physician diagnosed you with any major medical conditions that would interfere with your ability to use a respirator?

Yes/No

Employee Signature: _____

Fit Testing Record

PE Manufacturer: 3M 1860 **Model Number:** N95
NIOSH Approval #: TC-84A-0006
Face-piece Type and Size: Regular

Medical Restriction Noted by Physician? Yes / No

Odor Detection Adequate? Yes / No

Date Fit Tested: _____ **Qualitative Analysis:** ____X____

Pass / Fail: _____ **Comments:** _____

_____
Signature of Fit Tester

W:\EHS FORMS\Current EHS forms Revised 2009\fit testing\Fit Testing Record for Respirator Users - 3M 1860.docx

APPENDIX D: TUBERCULOSIS SCREENING PROGRAM AND EMPLOYEE TB SCREENING FORM

1. General Information

   A. Participation in the MTB screening program is mandatory initially for all, and for HCWs annually thereafter.

   B. PPD skin tests are available to employees at no cost.

   C. Determination shall be made concerning any medical condition or treatment that leads to severely impaired cell-mediated immunity, thereby affecting the reading of a PPD skin test.

   D. An employee shall be counseled regarding the meaning of a PPD skin test result.

   E. PPD skin test results should be read by designated, trained personnel between 48-72 hours after injection. The skin test is to be read by the presence or absence of induration at the injection site. Redness or erythema are not to be measured. The transverse diameter of induration should be recorded in millimeters.

   F. PPD Positive Interpretation (definition):

      i) A reaction of ≥ 5 mm is classified as positive in:

         - Persons with HIV infection or risk factors for HIV infection with unknown HIV status.
         - Persons who have had recent contact with persons with active TB
         - Persons who have abnormal chest radiographs consistent with old healed TB

      ii) A reaction of ≥ 10 is classified as positive in all persons who do not meet any of the criteria above but who have other risk factors for TB including:

         - High-Risk Groups

            a) Intravenous drug users known to be HIV seronegative
            b) Persons with other medical conditions that have been reported to increase the risk of progressing from latent TB infection to active TB, including silicosis, gastrectomy, jejuno-ileal bypass surgery, being 10% or more below ideal body weight, chronic renal failure, diabetes mellitus, high dose corticosteroid and other immunosuppressive therapy, some hematologic disorder (e.g. leukemia and lymphomas), and other malignancies.

- High-Prevalence Groups
  a) Foreign-born persons from high prevalence countries in Asia, Africa and Latin America
  b) Persons from medically underserved low income populations
  c) Persons from high-risk populations in their communities, as determined by local public health authorities

iii) Induration of ≥ 15 mm increase within a 2-year period is classified as positive for persons who do not meet any of the above criteria.

iv) Recent converters are defined on the basis of both induration and age:
- ≥ 10 mm increase within a 2-year period is classified as positive for persons < 35 years of age
- ≥ 15 mm increase within a 2-year period is classified as positive for persons ≥ 35 years of age
- ≥ 5 mm increase under certain circumstance (see "i" above).

2. New Healthcare Workers and PPD Skin Testing:

A. Healthcare workers with no documented evidence of PPD skin testing or those with history of BCG vaccine or those new healthcare workers who have documentation of a PPD (-) status, yet the documentation is greater than 12 months:

i) New healthcare workers with undocumented history of PPD testing or (PPD- more than 12 months ago) or treatment with BCG shall be tested upon hire using the two-step tuberculin skin testing method. If the first tuberculin test is negative, a second 5-TU shall be administered 1-3 weeks later. A positive second result probably indicates boosting from a past infection or prior BCG vaccination. Persons having a boosted reaction should be classified as a reactor, not a converter. If the second result is negative, the person is probably uninfected and a positive reaction to subsequent tests indicates a true tuberculin skin-test conversion.

ii) Use intermediate strength PPD 5 TU/0.1cc intradermal in the forearm.

B. PPD Positive New Healthcare Workers

i) Known PPD (+) new healthcare workers with professionally documented previous positive reaction or TB infection/treatment, or both, are exempt from further PPD screening and shall be evaluated by symptom review and risk evaluation using the employee screening form. Obtain chest x-ray if indicated.

ii) New healthcare workers with a history of possible significant previous reaction which is undocumented should be: 1) strongly encouraged to obtain documentation of previous (+) as many people are unclear on their medical history/testing, 2) probed to describe the "positive" test (i.e. where was it given,

what did it look like, who told you it was positive, what was the follow-up?), 3) considered for skin testing if answers to questions in 2) clearly indicate that the HCW does not know their PPD history, 4) if unable to obtain documentation of skin test, then obtain chest x-ray at the hospital's provider of employee health services, 5) if the chest x-ray is clear, consider the employee cleared for patient care activities. If the chest x-ray is abnormal, employee health services provider will evaluate for further follow-up/clearance for work. All new healthcare workers who react or convert to PPD (+) will need to be evaluated by chest x-ray and should be medically evaluated for further treatment and clearance for work.

3. Annual Healthcare Worker Evaluation for Clinical Employees:

All employees must have a PPD skin test annually (unless already documented positive). If the HCW converts their skin test to a (+), assess for symptoms of TB and refer to hospital's provider of employee health services for chest x-ray, further medical evaluation, treatment if indicated, and clearance for work:

4. TB Exposure Incident:

A. Definition- An exposure incident is defined as any unprotected exposure to a patient/client with a (+) AFB smear, which results in identification as MTB, or if clinical diagnosis of MTB is confirmed by the health department.

B. Follow-up- Administer PPD skin testing to non-reactors at time of exposure and at 8-10 weeks after the exposure.

i) If the skin test is negative, the healthcare worker shall revert to annual skin testing schedule.

ii) If the skin test is positive, refer to PPD converter section above and work with the health department for proper follow-up.

C. Investigate the exposure incident for transmission risks, need for further education, procedural changes, and further employee contacts/exposures.

APPENDIX E: CLIENT/FAMILY EDUCATION MATERIAL

1. Healthcare workers from SVMC are practicing **Airborne Precautions** until deemed unnecessary. SVMC is dedicated to protecting the health and safety of its employees. The healthcare workers entering the patient's room will wear a special mask called a respirator at all times. The reason for these **Airborne Precautions is that the patient has been diagnosed with or has symptoms/diagnostic test results indicating suspicion of active tuberculosis:**

- ☐ The patient has been diagnosed by a physician as having clinical signs/symptoms of active tuberculosis.
- ☐ The health department has determined that the patient has or is suspicious for having active tuberculosis.

- ☐ One of the laboratory tests done by the hospital indicates that they may have active tuberculosis (+ AFB sputum test).

2. You may contact the Tulare County Department of Health Services if you have additional questions. They will be involved with following up on contacts and exposed individuals. You may also contact your primary care physician.

3. Active pulmonary/laryngeal TB is carried in airborne particles, or droplet nuclei, that can be generated when persons who have pulmonary or laryngeal TB sneeze, cough, speak, or sing. The particles are tiny, and normal air currents can keep them airborne for prolonged periods of time. Infection occurs when a susceptible person inhales droplet nuclei containing the TB bacteria.

4. It is important that you take your anti-TB medicines exactly as prescribed.

5. Visitors in the home- the Health Department will determine when it is safe for you to have visitors in the home.

6. Do not leave your home until deemed safe by the health department. If you must go to a doctor's appointment or the Health Department, wear a regular mask until you are no longer considered infectious.

7. While at home, always use tissues to cover your mouth and nose when coughing or sneezing. Take any other precautions that the Health Department has instructed you in.

APPENDIX F: TUBERCULOSIS DISCHARGE TREATMENT PLAN

Tulare County
Health & Human Services Agency
Public Health Branch
Tuberculosis Program

TUBERCULOSIS DISCHARGE TREATMENT PLAN

☐ In Patient ☐ Out Patient

Prior to anticipated discharge…Complete this form in entirety and FAX to Tulare County TB Control Program: 559-713-3720

Patient Name	Date of Birth	Facility

PART I: DISCHARGE INFORMATION

Anticipated Discharge Date:	Discharge to: ☐ Home ☐ Skilled Nursing Facility ☐ Shelter ☐ Jail/Prison ☐ Other (specify)			
Discharge Address: STREET	CITY	ZIP CODE	COUNTY	PHONE NUMBER

People In Household?	Children Under 4?	Any Immunocompromised Individuals?

Name Of Medical Provider After Discharge	Pager Number	Phone Number	Fax Number

Meds to last until appointment ☐ YES ☐ NO	Follow Up Appointment Date:	Time:	SPECIAL INSTRUCTIONS:

PART II: DISCHARGE MEDICATIONS/TREATMENT PLAN (Complete upon discharge)

CURRENT BACTERIOLOGY: Include all negative and positive

DATE (Month/Day/Year)	SOURCE	SMEAR +/-	CULTURE +/-

DISCHARGE MEDICATIONS Weight:

Medication	Daily Doses In Mgms	Start Date
ISONIAZID		
RIFAMPIN		
PYRAZINAMIDE		
ETHAMUTOL		
B6		
OTHER		
OTHER		
OTHER		

INCLUDE DATES OF UNSUCCESSFUL SPUTUM COLLECTION ATTEMPTS:( )( )( )( )( )( )( )( )( )( )( )( )( )( )( )( )

Current CXR Report: Date: ☐ Stable ☐ Improved ☐ Worse Describe:	D.O.T. Recommended? ☐ YES ☐ NO START DATE:
	DOT Legal Order Required? ☐ YES ☐ NO DOT to occur where? ☐ Clinic ☐ Home ☐ Worksite Other?

PHN Home Assessment Received? ☐ Yes ☐ No Reviewed? ☐ Yes ☐ No	COMPLETED BY:	PHONE #	FAX #	DATE

PART III: HEALTH DEPARTMENT REVIEW

Discharge Approved: ☐ Yes ☐ No Problems Identified: _____

Actions Required Prior to Discharge: _____

Authorized By: _____ Date: _____
NAME OF HEALTH OFFICER/DESIGNEE

Policy 40-25___ (Jan 2018) Page 1 of

Tulare County
Health & Human Services Agency
Public Health Branch
Tuberculosis Program

TUBERCULOSIS DISCHARGE TREATMENT PLAN

Discharge of a Suspected or Confirmed Tuberculosis Patient

As of January 1, 1994, California State Health and Safety Codes mandate that patients suspected of or confirmed as having TB may not be discharged or transferred without prior Health Department approval. To facilitate timely and appropriate discharge, the provider should notify the Health Department 1-2 days prior to anticipated discharge to review the discharge criteria. (See Below)

Tuberculosis Control Program (TBC) Response Plan

For Weekday Discharge- Non Holiday: Monday – Thursday 8:am – 5:00pm. Upon a receipt of a completed discharge request form, TB staff will provide a response within 24 hours. To expedite your request, please include all laboratory and/or radiology reports.

TBC staff will review the request and notify the submitter of approval, or will inform the submitter if additional information or action is required prior to discharge approval. If a home evaluation is needed to determine if the environment is suitable for discharge, the TBC staff will make a home visit within (1) working day notification.

Holiday and Weekend Discharge

If you anticipate a discharge on a weekend or holiday, please contact the TB Control Program immediately. For discharge planned Friday through Sunday, a completed form must be received no later than 5pm on Wednesday. For holiday discharge, a completed form must be received no later than 5pm on the second preceding business day.

Discharge Criteria

Approval of patient discharge is dependent upon compliance of the discharge treatment plan meeting the guidelines included below. Final approval for discharge is granted by the Health Officer after receipt and review of the discharge plan. Forms must be filled out in entirety to avoid delay in approval.

1. Home with no at risk individual(s) in the home:
   - Patient is on appropriate drug regimen
   - Patient is clinically stable
   - Patient deemed an acceptable candidate for home isolation
2. Home with high risk individual(s) in the home who have not been exposed:
   - Patient is on appropriate drug regimen >1 week
   - Patient is clinically stable
   - Patient deemed an acceptable candidate for home isolation
   - Contact(s) considered for or placed on prophylaxis
3. High Risk Setting:
   - Patient is on appropriate drug regimen >2 weeks
   - Patient clinically improving
   - Three consecutive negative AFB smears

In all instances, an accurately completed Discharge Treatment Plan must be submitted at least 24 hours prior to consideration for approval for discharge. If these criteria cannot be satisfied, discharge cannot be approved and the patient **MUST** be held until the next business day for appropriate arrangements to be made.

Contact Information: Kayla Christensen
Phone: (559) 685-5841; Mobile: (559) 740-6077

Policy 40-25___ (Jan 2018)

SUBJECT: **Use of Externally Supplied Medications in Clinic Settings**	SECTION: **Page 1 of 2**

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

PURPOSE:

To define Sierra View Medical Center's position on externally supplied medications in clinic settings.

DEFINITIONS:

Brown Bagging-
Situation where medication is procured from an external pharmacy is dispensed directly to a patient & brought by the patient to the health system or clinic for administration.

DSCSA- (Drug Supply Chain Security Act)- Federal law enacted in 2013 to enhance the U.S. Food and Drug Administration's ability to protect customers by improving detection and removal of potentially dangerous products from the pharmaceutical supply chain. The law requires hospital pharmacy chain of custody and end-to-end product traceability for medications from manufacturer to patient.

White Bagging- practice where patient-specific medication is procured from an external pharmacy (typically a specialty pharmacy owned or contracted with a patient's health insurance plan) and delivered to Sierra View Medical Center outpatient or clinic for compounding and patient administration.

POLICY:

The responsibility & accountability for purchasing, mixing, and administering injectable medications resides with Sierra View Medical Center & the providers who administer these medications. As such, their legitimacy of source and subsequent storage and handling should be assured by Sierra View Medical Center. Sierra View Medical Center will not administer any drug to a patient that Sierra View does not purchase directly from either the manufacturer or an accredited wholesaler.

Sterile medications dispensed, compounded or administered at a Sierra View Medical Center outpatient or clinic setting must be procured by Sierra View Medical Center via an approved manufacturer or wholesaler in order to meet the requirements consistent with DSCSA.

Brown bagging at Sierra View Medical Center outpatient or clinic settings is prohibited.

White bagging of injected and infused medications in the hospital outpatient or clinic setting is prohibited. If the patient's insurance requires white bagging, Sierra View may try to obtain insurance approval for Sierra View to procure, compound and dispense the medication to the patient.

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.

- Title 22 (n.d.).Retrieved on April 8, 2024, from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- Title II of the Drug Quality and Security Act. Retrieved on April 8, 2024. https://www.fda.gov/drugs/drug-supply-chain-security-act-dscsa/title-ii-drug-quality-and-security-act

SUBJECT: **WITHHOLDING OR WITHDRAWING LIFE-SUSTAINING TREATMENT**	SECTION: ***Ethics, Rights and Responsibilities (RI)*** **Page 1 of 7**

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

PURPOSE:

To define the guidelines for decision-makers to determine that life-sustaining treatment may be withheld or withdrawn.

POLICY:

Rights of the Patient

Sierra View Medical Center (SVMC) recognizes that an adult person who has capacity has the right to make his/her own health care decisions after having been fully informed about the benefits, risks and consequences of treatment alternatives, even when such decisions might result in shortening the individual's life.

For adult patients who lack capacity, the patient may have his/her wishes followed, if they are known, or decisions made on their behalf by a decision-maker, as described below.

For the purposes of this policy:

"**Capacity**" means a patient's ability to understand the nature and consequences of a decision and to make and communicate a decision, and includes in the case of proposed health care, the ability to understand its significant benefits, risks, and alternatives. Capacity shall be determined by the patients. A patient is presumed to have the capacity to make a healthcare decision, to give or revoke an advance health care directive, and to designate or disqualify a surrogate. The physician is required by law to document any finding regarding a patient's capacity in the patient's medical record.

"Health care decision" – means a decision made by a patient or the patient's Power of Attorney for Health Care (PAHC) agent, conservator, or surrogate, regarding the patient's health care, including the following:

- Selection and discharge of health care providers and institutions.
- Approval or disapproval of diagnostic tests, surgical procedures, and programs of medication.
- Directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.

"Individual health care instruction" means a patient's written or oral direction concerning a health care decision for the patient.

"**Life-sustaining treatment**" -- includes, but is not limited to, medically administered hydration and nutrition, blood products, antibiotics, chemotherapy and radiation therapy, pressor agents, renal dialysis, surgery, endotracheal intubation, and mechanical ventilation. Cardiopulmonary resuscitation is the subject of a separate DNR policy.

Decision-Makers for Adult Patients Who Lack Capacity

1. The decision-maker for an adult patient who lacks capacity is, in the following descending order of legal priority:

   a. the patient's designated agent under a valid power of attorney for health care (PAHC);

   b. a court appointed conservator; or

   c. a surrogate decision-maker designated by the patient or otherwise selected by the physician as provided in Section 2 below.

   Unless otherwise stated in the PAHC, the agent in the PAHC has priority over all other decision-makers including court-appointed conservators. When no agent under a valid PAHC, court appointed conservator, or designated surrogate decision-maker is reasonably available and willing to make the decision, the physician may identify an appropriate surrogate decision-maker.

2. In seeking to identify the appropriate surrogate decision-maker for a patient who has no PAHC agent, conservator or designated surrogate decision-maker reasonably available and willing to make the decisions, the physician may consider family members who:

   a. know the patient's feelings and wishes regarding treatment,

   b. have expressed concern for the patient's comfort and welfare, and

   c. have expressed an interest in the patient by visits or inquiries to the patient's physician or hospital staff.

   California law provides no guidance on the order of family members for physicians to select to make a patient's health care decisions. In addition to family members, the physician may select as a surrogate decision-maker a non-family member who satisfies the above criteria and is willing to make decisions.

3. The PAHC agent, conservator or surrogate decision-maker must make the decision in accordance with the patient's individual health care instructions, if any, and other wishes to the extent known to the PAHC agent, conservator or surrogate decision-maker.

4. If the patient did not write or otherwise express individual healthcare instructions, or the PAHC agent, conservator or surrogate decision maker does not know the patient's wishes, the decision is to be made in accordance with the PAHC agent's, conservator's or surrogate decision-maker's determination of the patient's best interest. That determination is to be made by analyzing the patient's personal values to the extent known to the PAHC agent, conservator or surrogate decision-maker, the comparative benefits and burdens of continued treatment and such factors as relief of suffering, the preservation or restoration of function, and the quality and the extent of life sustained.

Communication with Patient and Surrogate Decision-Maker

1. If the patient is an adult and has capacity, proposed treatment should be discussed with the patient. The physician should provide the patient with information on diagnosis, prognosis and recommended treatments, including their risks and benefits and alternative treatments, as well as the patient's prognosis without such treatments. Precedence must be given to the patient's right to self-determination. If the patient's physician determines that the patient has capacity to make health care decisions, the patient's wishes for treatment should be determined through discussion with the physician. This discussion should be held with the surrogate decision-maker if the patient lacks capacity. For the patient who lacks capacity, his/her wishes may be expressed in an Advance Directive, or may have been expressed orally.

2. If the patient is an adult who lacks capacity, the decision to withdraw or withhold life-sustaining treatment should nevertheless be discussed with the patient as well as the patient's PAHC agent, conservator or surrogate decision-maker.

3. If the patient lacks capacity has no Advance Directive and no PAHC agent, conservator or surrogate decision-maker, the case may be presented for discussion by the Biomedical Ethics Committee upon request of the attending physician. In rare circumstances, the opinion of legal counsel may be sought.

4. If the patient is a minor (a person under the age of 18), the minor's parents or legally appointed guardian have the legal authority to make treatment decisions, unless the minor is emancipated or other special circumstances exist (e.g. the minor is a member of the Armed Forces or has been married or is financially self-sufficient *(see CHA Consent Manual – "Who May Give Consent")*.

5. In the event the minor's parents are divorced, the physician should discuss the decision with the parent who has been granted sole legal custody of the child. If the parents have joint "legal" custody (i.e., joint decisions relating to health, education, and welfare), either parent has the right and responsibility to make health care decisions unless the court's custody order places that responsibility with one parent alone (e.g. joint physical custody but sole legal custody).

6. If uncertainty exists concerning the authority of a divorced parent, or a conflict which cannot be resolved exists between divorced parents, a copy of the custody order should be obtained, placed in the medical record, and used to determine which parent has the authority to make decisions. If the custody order requires the consent of both parents (e.g., joint legal custody), the parents can be instructed to obtain a court order to resolve the conflict. If the situation is complex legally, consultation with the SVMC on-call administrator or legal counsel is strongly advised.

Conflict Resolution

1. In the event that a patient or decision-maker for a patient requests that certain treatments be withheld or withdrawn, but the attending physician does not concur, resolution may be obtained by:

    a. Consulting with another physician or the Chief of Service;

b. Transferring care to another physician; and/or

c. Consultation with the Biomedical Ethics Committee.

2. If the patient or decision-maker for a patient disagrees with the attending physician's recommendations for withholding or withdrawal of life-sustaining treatments, the patient or the patient's decision-maker may initiate a consultation with the Biomedical Ethics Committee.

NOTE: The Biomedical Ethics Committee functions only in an advisory capacity, NOT as a decision-maker. It can be very helpful and assist in dealing with decisions to withhold or withdraw life support.

The Committee may be helpful in discussing and exploring alternative approaches to the issues, clarifying legal or ethical issues, facilitating communications, resolving any disputes or questions among members of the healthcare team, or identifying perspectives on the issues not previously considered by the physician or by a decision-maker.

3. In all cases, pain relief and palliative care must be continued.

Role of the Courts

1. The California Legislature has found that in the absence of controversy, a court is normally not the proper forum in which to make health care decisions, including decisions regarding life-sustaining treatment.

2. There are some cases, however, when it may be advisable to seek judicial intervention. For example, when there are disputes about a decision among the patient's family members or significant others and the person has not specifically named a PAHC agent or orally designated a surrogate decision-maker. In the event of disagreement and several equally vocal family members or others, the following should occur:

   a. Consultation with the Biomedical Ethics Committee,

   b. Consultation with legal counsel,

   c. Patient care conference with all members of the health care team and the patient or surrogate decision-maker.

3. Death that results from withholding or withdrawing life-sustaining treatment at the direction of a patient or appropriate decision-maker, in good faith and in accordance with generally accepted health care standards, does not constitute a suicide or homicide.

4. Compliance with the direction of a patient or appropriate decision-maker, in good faith and in accordance with generally accepted health care standards, does not subject the physician, the hospital, or its staff to civil or criminal liability or to discipline for unprofessional conduct.

PAHC and Documentation of Patient Treatment Preferences

1. Physicians should be familiar with the PAHC and should encourage its use because it identifies and appoints a person (and alternates) to act as agent to make health care decisions for the patient and allows the patient to specify particular wishes. In addition, the PAHC agent has priority as a decision-maker. It offers the opportunity for discussion and reflection concerning treatment issues and helps to assure that the patient's wishes will be followed. The PAHC is generally the most powerful and flexible method available by which a person may attempt to assure future medical treatment in accordance with his/her preferences. It is best if the patient provides his/her physician with a copy of any Advance Directive, including a PAHC, although that is not legally required.

2. Any communication by a patient concerning treatment preference(s), whether written or oral, may provide helpful guidance in determining an appropriate course of treatment. Patients with clear treatment preferences should be encouraged to state them in writing. If a copy is provided to the physician, it shall be included in the medical record. Patients should be cautioned, however, that any specific written instruction, unless later revoked, controls the decision-maker, who may not act to the contrary. Any oral statements of treatment preferences must be documented in the medical record and are also legally binding.

Physician Orders

1. All orders to withhold or withdraw treatment from a patient must be dated, timed and **signed by the physician** and must be specific. Such orders should be given only after discussion with the patient or the surrogate decision-maker and documentation thereof.

   NOTE: Required supporting documentation listed in Item 3(a-d) below.

   Options:

   a. The primary care physician may send a facsimile (FAX) copy of a written, signed order regarding withhold/withdrawal of life-sustaining treatment to the nursing unit – **Attention to the specific patient's nurse.** All FAX orders must be verified by initial or signature as soon as possible but in no case longer than 24 hours.

   b. As a general rule, orders to withhold/withdraw life-sustaining treatment should not be given by telephone. In extremely extenuating circumstances only, the primary care physician may communicate telephone orders regarding withholding/withdrawal of life-sustaining treatment to a registered nurse utilizing a conference call allowing another licensed nurse to witness and co-sign the telephone orders. **The nurses must identify themselves to the physician at the time the order is taken. Both nursing signatures will appear on the written physician order.** All telephone orders must be verified by initial or signature as soon as possible but in no case longer than 24 hours.

c. The primary care physician may communicate directly with the Emergency Room physician regarding decision-making and orders to withhold/withdraw life-sustaining treatment.

2. The physician shall verbally inform the nursing staff that such an order has been given to ensure that the order is known, understood at the time it is written, and carried out in a timely fashion.

3. The orders or decision to withhold or withdraw life-sustaining treatment must be supported by the following being present in the patient's medical record:

a. Complete written documentation in the progress notes. Such dictated or written documentation may include, but is not limited to: a summary of the medical situation which specifically addresses that patient's situation. This summary must include reference to the patient's capacity, mental status, diagnoses, and prognosis at the time the order is written or the decision is made and test results or an explanation if no tests were performed.

b. The outcome of any consultations, if any, with other physicians. Physicians who provide consultations must document their findings and recommendation.

c. A statement indicating the basis upon which a particular person(s) have been identified as appropriate decision-maker(s) for the patient.

d. A statement summarizing the outcome of consultations with the patient, or, if the patient lacks capacity, the patient's parent, agent under a valid PAHC, court appointed conservator, guardian, or surrogate decision-maker.

4. The patient's physician is responsible for the decision regarding disconnecting medical devices such as ventilators, pacemakers, etc.

a. A physician may delegate the function of discontinuing life-sustaining treatment to a registered nurse.

b. If the registered nurse wishes to decline, the nursing manager must be notified immediately and an alternate qualified healthcare provider be assigned who is willing to comply.

5. Brain Death: When an individual is pronounced dead by determining that the individual has sustained an irreversible cessation of all functions of the entire brain, including the brain stem, there shall be an independent confirmation by another physician.

AFFECTED AREAS/PERSONNEL: *ALL*

REFERENCES:

- California Hospital Association (2023). 2023 California Hospital Consent Manual. *Refusal of Treatment and End-of-Life Issues* (48th Edition, Chapter 6). California Hospital Association.

CROSS REFERENCES:

- DIAGNOSIS OF DEATH BY NEUROLOGIC CRITERIA

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Senior Leadership Team	6/25/2024
Board of Director's Approval	
Bindusagar Reddy, MD, Chairman	6/25/2024

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA
June 25, 2024
BOARD OF DIRECTOR'S APPROVAL

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

	Pages	Action
Policies:		Approve ↓
Exempt Employee Compensation	1-3	
Fire Safety Ansul System R102 Wet Chemical Fire	4	
Flexing Staff Protocol (Temporary Reduction)	5-7	
Food Preparation	8-9	
Food Service Corrugated Cardboard Management	10-11	
Inpatient Pharmacy Downtime Procedure	12-15	
Jury Duty and Witness Duty	16-17	
Lactation/Breastfeeding Policy	18-19	
Meal Trays	20-22	
Nourishment Room Floor Stock	23-24	
Patient Food From Home – Acute	25	
Performance Improvement – Food and Nutrition	26	
Referral Bonus	27-30	
Sick Leave	31-34	

SUBJECT: **EXEMPT EMPLOYEE COMPENSATION**	SECTION: ***Human Resources*** **Page 1 of 3**

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

PURPOSE:

To define Sierra View Medical Center (SVMC) process of compensating exempt employees for partial and full-day absences.

POLICY:

In accordance with the Fair Labor Standards Act regulations, exempt employees are required to be paid on a salary basis. "Salary basis" means that exempt employees may not have their pay reduced as a result of variations in the quantity or quality of work performed. However, exempt employees need not be paid for any workweek in which they perform no work. Subject to exceptions below, exempt employees must receive their full salary for any week in which work is performed without regard to the number of days or hours worked.

Employees who feel their pay has been improperly reduced should report this immediately following the procedures specified below.

AFFECTED PERSONNEL/AREAS: *ALL EXEMPT EMPLOYEES*

PROCEDURE:

1. Deductions from pay cannot be made as a result of absences during any portion of a workweek resulting from the circumstances listed below, even if no work is performed in a workweek. Such improper pay deductions during a workweek are therefore specifically prohibited by Sierra View Medical Center. Directors or Managers violating this policy will be subject to investigation of their pay practices and appropriate corrective action in accordance with normal procedures.

    a. Jury duty.
    b. Appearance in a judicial or administrative proceeding as a witness.
    c. Temporary military leave.
    d. Partial day absences other than those specifically discussed below.

2. This section sets forth the exceptions to the requirement to pay exempt employees on a salary basis. Salary deductions from the pay of an exempt employee is prohibited with the exception as set forth below.

    a. Full day salary deductions will be made for absences of one or more full days for personal reasons, including sickness or disability. Hours worked in one day, if less than the regularly scheduled shift, will be compensated as a full-day based on the employee's regularly worked schedule (8 hrs. or 10 hrs.)
    b. Holiday hours during the first ninety (90) days of employment when Vacation/Holiday time has been accrued may not be utilized per SVMC's policy. However, to avoid a deduction in salary, an exempt employee may report to work on the holiday. Any employee who has questions or concerns that no work may be available to be performed should contact his or her supervisor in advance of the holiday. The employee's

supervisor will be responsible for ensuring that the employee may report to work if she or he wishes to do so.

c. If the exempt employee does not have enough hours to cover the holiday/vacation day, and they do not work any amount of hours on the holiday/vacation day, no vacation/holiday hours will be used and a full day of salary will be reduced from their pay. (Please refer to the policy HOLIDAY PAY and VACATION/HOLIDAY LEAVE policy.)

d. Fees received by the employee for jury or witness duty or pay to the employee while on military leave may be applied to offset the pay otherwise due to the employee for the week. However, the Hospital will not make any deductions in pay for failure to work a portion of a workweek for jury or witness duty or pay while on military leave.

e. Deductions for the first and last week of employment, when only part of the week is worked by the employee. In these cases, employee's salary will be prorated to commensurate with the days worked.

f. Deductions will be made for unpaid leave taken in accordance with a legitimate absence under the Family and Medical Leave Act (FMLA) or California Family Rights Act (CFRA).

- Vacation/Holiday time must be taken for full day absences only during intermittent FMLA/CFRA use unless the employee is receiving disability payments (i.e., state disability, Worker's Comp). In this case, Vacation/Holiday time may be utilized by the employee to supplement the disability payment or to cover the cost of the employee's health premium payment during a protected leave of absence. For greater detail, please refer to the policy Vacation/Holiday.

Complaint Procedure

1. Employees who believe their pay has been improperly reduced should contact the Vice President of Human Resources immediately to request an investigation.

2. The employee will be asked to specify in writing, using the guidance above, the circumstances of the pay deduction and whether it has occurred on other occasions.

3. SVMC will review pay records and interview the supervisor or manager, as well as the payroll representatives handling the employee's pay, to determine if the allegation is correct.

4. If the deduction was in fact improper, SVMC will reimburse the employee as promptly as possible (but in no case longer than two pay periods from the identification of the problem).

5. The individual(s) responsible for the error will be investigated further to determine if this was an isolated incident or a pattern of conduct that requires further action on the part of SVMC. If

warranted, the responsible person(s) will be held accountable for the error(s) made, consistent with SVMC's disciplinary policy.

6. The resolution of the situation will be documented (including confirmation on the part of the employee that the situation has been resolved) and placed with the employee's pay records.

CROSS REFERENCES:

- Vacation/Holiday Leave Policy Link
- Holiday Pay Policy Link
- Jury Duty and Witness Duty Policy Link

SUBJECT: **FIRE SAFETY ANSUL SYSTEM R102 WET CHEMICAL FIRE**	SECTION: **Page 1 of 1**

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

PURPOSE:

To outline preventative maintenance schedules for the fire suppression system and cleaning schedules for the exhaust ducts system.

POLICY:

Inspection and servicing of the kitchen hood fire extinguishing system, Ansul R102 Wet Chemical Fire, will be conducted by qualified personnel semi-annually. The grease exhaust duct system will be cleaned and chemically treated to retard the accumulation of grease quarterly. The manual pull stations will be inspected monthly to ensure the ring and tiepins are properly secured.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE, ENGINEERING*

PROCEDURE:

1. The Engineering Department will perform preventative maintenance and inspect all actuation components, including the remote manual pull stations and actuators, etc., for proper operation using the manufacturers listed procedures.

2. The Engineering Department will inspect fusible links and automatic sprinkler heads at least annually to assure proper operation of the system. In addition, they will visually inspect the control cylinders and pressure gauges to determine if cylinders have been activated and assure no falling weights may activate the tension cable.

3. A contracted company will clean hoods, grease removal devices, ducts, and other apparatus and coat them with an approved fire retardant material. At no time will flammable solvents be utilized for cleaning.

4. Food service employees will clean hoods and vents a minimum of weekly. At no time will flammable solvents be utilized for cleaning.

5. In the event of the Ansul system failure, manual fire extinguishers will be utilized.

REFERENCES:

- California Retail Food Code (Revised January 2022) California Department of Public Health
    - Chapter 6, Article 2: Ventilation

- The Joint Commission (2024). Hospital accreditation standards. EC.03.02.05

SUBJECT: **FLEXING STAFFING PROTOCOL (TEMPORARY REDUCTION)**	SECTION: **Page 1 of 3**

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

PURPOSE:

To provide management and employees with appropriate guidelines for the temporary reduction of staff (FLEX time).

POLICY:

Sierra View Medical Center's (SVMC) intent is to stabilize the work climate through careful planning and balancing of staffing. However, due to circumstances such as low census and/or work volume, financial constraints or lack of work, the need may arise to temporarily reduce staffing. In the event that a temporary reduction in staffing is necessary, the organization will follow an orderly procedure as outlined in this policy.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

PROCEDURE:

1. Department Management is responsible for monitoring patient census, work volume and staffing levels on a daily basis, or sooner if the situation requires, in order to ensure any adjustments during a temporary reduction are consistent with the requirements of patient care, essential operational needs and customer service.

2. Department Management will monitor trends in fluctuating workload and revenues or increased expenses within their department and will implement any indicated reductions in the departmental workforce to achieve budgetary goals.

3. During a temporary reduction in staffing, employees will be retained based upon their category (i.e. full-time, part-time, per diem, seasonal per diem, travelers, and external registry) and their qualifications to fill remaining positions.

4. In order to achieve necessary staffing levels, the following steps and considerations should be evaluated to reduce staffing:

    a. Eliminate or decrease overtime

    b. Discontinue the use of the following employees:

        - Travelers
        - External Registry
        - Seasonal Per Diem
        - Per Diem

    c. Implement the use of Vacation/Holiday time.

    d. Grant requests for voluntary work hour reductions and leaves of absence without pay.

e. Implement involuntary reduction of work hours based upon staffing needs of the department as follows:

- Management must initiate and approve FLEX time.
- Classification and skill level of employees will be prime consideration in requiring or assigning FLEX time.
- Involuntary staff reductions will be open for volunteers who will be considered first at the Director/Manager's discretion. If an employee volunteers to be reduced, such time will be counted as one rotation.
- If no staff member volunteers to be flexed off, or the volunteer is not selected, employees will be assigned FLEX time, consistent with the staff licensure and skill level of employees, in the following order
  - External Registry Per Diem employees
  - Travelers
  - Seasonal Per Diem
  - Per Diem
  - Regularly-scheduled part time employees
  - Regularly-scheduled full-time employees
- Re-occurring FLEX time will normally be assigned on a rotating basis to employees in the same status, classification and skill level ranges
- Directors or managers will maintain a record of FLEX assignments for future reference
- Employees may elect to use accrued Vacation/Holiday time
- Based on previously established parameters, employees assigned FLEX time may be placed on On-call as determined by management
- FLEX time will not affect an employee's employment status (e.g. full-time, part-time, etc.) The District reserves the right to re-evaluate periodically.

If conditions necessitate a permanent staff reduction, the procedures in Human Resources policy *Reduction in Force Selection* and *Severance Pay* will be followed.

Adjustments to management personnel levels will be coordinated on an individual basis by the Senior Management Team.

Management reserves the right to make any and all final decisions regarding temporary reduction in staff.

CROSS REFERENCES:

- Vacation/Holiday Leave
- Reduction in Force Selection and Severance Pay
- Employment Status
- Per Diem Protocol (Non-Exempt Employees)

SUBJECT: **FOOD PREPARATION**	SECTION:

PURPOSE:

To establish safe principles for food preparation.

POLICY:

Employees will prepare food in a clean and safe manner to protect patients, residents, staff and visitors from food borne illness. Food shall be prepared by methods which conserve nutritive value, flavor and appearance. Food shall be served attractively at appropriate temperatures and in a form to meet individual needs.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE*

PROCEDURE:

1. Foods must be defrosted from the freezer using proper thawing methods. Frozen foods will be thawed under refrigeration. When frozen food needs to be thawed expeditiously, food may be thawed in a clean sink under running potable water.

2. The use of latex gloves is prohibited in food facilities and retail food establishments. Food employees shall use non-latex utensils, including scoops, forks, tongs, paper wrappers, gloves, or other implements, to assemble ready-to-eat food or to place ready-to-eat food on tableware or in other containers.

3. Single-use gloves shall be used for only one task, such as working with ready-to-eat food or with raw food of animal origin, used for no other purpose, and shall be discarded when damaged or soiled, or when interruptions in the food handling occur. Employees will wash hands and change gloves after any source of possible contamination.

4. Foods will be cooked to minimum temperature or greater:

   - Poultry/Ground Poultry 165ºF
   - Casserole Dishes 165ºF
   - Ground Meat & Eggs 155ºF
   - Pork, Beef, Veal, Lamb 145ºF
   - Fish 145ºF
   - Vegetables & Grains 135 ºF

5. Foods which are prepared and not served on the day of preparation will be cooled from 140ºF - 70ºF within two (2) hours and from 70ºF - 41ºF within the next four (4) hours, with a total cooling time not to exceed 6 hours. Foods that have not cooled to these guidelines must be reheated to 165º and the cooling process repeated. If product does not meet the criteria on the second attempt, food must be discarded.

6. To cool food rapidly, leave all or partially uncovered during cooling period, separate food into smaller portions, place foods in shallow pans and place foods in refrigerator or use ice bath and stir frequently. Food may also be placed in the freezer for a short period of time.

7. Foods which are prepared and not served on the day of preparation are to be stored appropriately, covered, clearly identified and dated with the date of preparation. These foods will be used within 2 days.

8. All foods reheated will be heated to a minimum of 165ºF. Foods may only be reheated once.

9. All hot foods will be held at 140ºF or above. Cold foods will be held at 41ºF or below.

10. All eggs will be pasteurized.

REFERENCES:

- California Retail Food Code (Revised January 2022) California Department of Public Health
  - Article 1.113980: Protection from contamination
  - Article 2: Time and Temperature Relationships
  - Article 3.114024: Egg and milk products, pasteurized
- The Joint Commission (2024). Hospital accreditation standards. PC.02.02.03, EP 6
- GACH Title 22 Regulations: Article 3: §70273.(h)(k)

SUBJECT: **FOOD SERVICE CORRUGATED CARDBOARD MANAGEMENT**	SECTION: **Page 1 of 2**

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

PURPOSE:

The purpose for this document is to define procedures for management, use and storage of corrugated cardboard boxes in the Food & Nutrition Service (FNS) department.

POLICY:

Food and supplies are purchased, received and stored in accordance to regulatory standards to maintain optimal nutritional composition and prevent all sources of contamination. FNS assures that all food and supplies are stored in accordance with the Food & Drug Administration (FDA) guidelines recommended for cardboard containers.

AFFECTED PERSONNEL/AREAS: *ALL DEPARTMENTS, PATIENT CARE AREAS, PHYSICIANS, VOLUNTEERS*

PROCEDURE:

1. To retain information such as manufacturer's production data, expiration dates, ingredients and other vital information required for product recall, food and supplies are stored in the original cardboard packaging in compliance with the FDA 3-201.11; *21 Code of Federal Regulations (CFR) 101, 9 CFR 317*, unless original cardboard packaging is compromised.

2. Food & supply pallets are transferred directly from the delivery truck to the hall adjacent to the kitchen to be disassembled. Perishable items are delivered to appropriate areas within the kitchen. Shelf stable supplies are delivered to the storage room or staged in the hall adjacent to the kitchen area until time permits for appropriate storage. At no time are food and supplies left unattended on the external loading dock.

3. Products are rejected at delivery when packaging is compromised and easily assessed visually. All compromised cardboard packaging discovered subsequent to delivery exhibiting potential pest damage is removed immediately from the kitchen to eliminate potential pest propagation.

4. The storeroom is an integral part of the kitchen design and opens directly to the food preparation area. The storeroom is in close proximity to the delivery area. It has sufficient light and ventilation, and is of solid construction to discourage rodent and insect access. The storeroom is maintained at a comfortable temperature.

5. The storeroom floor, shelves and adjacent areas are cleaned and monitored daily. Sierra View Medical Center maintains a contracted pest control company. The pest control company monitors the kitchen areas monthly at a minimum and is available anytime for consultation.

REFERENCES:

- California Department of Public Health (2024). Retrieved from https://www.cdph.ca.gov.

- Centers for Medicare and Medicaid Services, Conditions of Participation (2024). Retrieved from https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance

- The Joint Commission (2024). Hospital accreditation standards. LD.04.01.01., IC.02.02.01 EP 4. Joint Commission Resources. Oak Brook, IL.

- Food and Drug Administration 2024. FDA Food Code Version 2022 https://www.fda.gov/food/fda-food-code/food-code-2022

- Code of Federal Regulation 1011. CFR 21 CFR 101. https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?CFRPart=101.

SUBJECT: **INPATIENT PHARMACY DOWNTIME PROCEDURE**	SECTION: **Page 1 of 4**

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

PURPOSE:

To provide guidelines for pharmacy personnel in the management and delivery of pharmaceutical care in the event of computer system(s) downtime.

DEFINITIONS:

1. EMR-Electronic Medical Record.

2. MAR-Medication Administration Record.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) Department of Pharmacy to provide pharmaceutical care while computer systems are nonoperational.

AFFECTED PERSONNEL/AREAS: *NURSING; PHARMACY*

EQUIPMENT:

- Meditech computer operating system
- Pyxis automated dispensing cabinets
- Medication refrigerators
- Wholesaler ordering software.

PROCEDURE:

A. Pharmacy Medi-Tech System Downtime

1. Upon notification from nursing staff office or an established command center or other senior leadership, the inpatient pharmacy will initiate downtime procedures as follows:

   a. The last available patient medication profiles will be printed and available for pharmacist review. A second copy will be printed for nursing staff if they are unable to print their own.

   b. The MAR will be stored in a pharmacy downtime binder that is filed according to patient location.

   c. Orders for medications will be faxed to inpatient fax number or hand delivered to the pharmacy for processing.

   d. Orders will be screened for allergies, route, strength, interactions manually.

e. Orders verified will be processed with two identical labels. One label will be affixed to the patient's printed paper MAR and the other label will be affixed to medication that is to be dispensed.

i. Labels should have the following information at minimum

SVMC 465 W Putman Ave Porterville, CA 93257
PATIENT_____
ACCOUNT#_____
ROOM#_____RX#_____DOB_____
DRUG_____
SIG_____
TOTAL VOLUME RATE ML/HR

Expiration's for IV's will be on the Beyond use date label affixed to the individual product dispensed.

f. The orders will then be stored with the rest of the patient's MAR in the downtime binder.

2. During hours where pharmacy is not on sight the following downtime procedure will be initiated as follows:

a. Pyxis will be placed on override to allow access to medications while the pharmacy is closed.

b. Orders written at night will be collected and brought to the pharmacy for verification and to update the paper MAR patient profile as soon as pharmacy resumes operations on sight.

c. Providers will be instructed to phone in all discharge medications to outside pharmacies during this time. If a Scheduled II medication is to be part of discharge medications it will require security paper.

i. Security paper

a) Providers needing security paper to write orders for schedule II narcotics may call pharmacy for a single sheet of security paper, while they are on site. The pharmacist will log the information required on the "security paper log" (see Addendum A). The paper will be delivered directly to the prescriber.

b) When Pharmacy staff are not on sight it is expected that discharges will only come from the Emergency Department that may require Schedule II's. The Medical Director of the Emergency Department will be provided a batch of their security paper & a paper log to allow the providers of that unit access to complete their discharge prescriptions.

B. Pyxis Downtime

1. A call to Pyxis customer service will be placed to notify downtime trouble shoot with expert instruction if necessary.

2. Pyxis will be placed on a critical override to allow access to medications in the event of a computer system failure. If Pyxis is unable to execute critical override, then medications will be dispensed from the inpatient pharmacy.

3. Medications withdrawn will be reviewed on the Pyxis override report when systems become operational.

C. Medication Refrigerators and Freezers

1. Medications may be relocated to the main pharmacy refrigerator or freezer as they are connected to the hospital's backup power generator, until the problem is corrected. The pharmacist in charge will be consulted to ensure the proper relocation of medications.

D. Drug Wholesaler Computer System

1. Any downtime with ordering software will be managed by calling the distributor and placing orders verbally over the phone.

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **INPATIENT PHARMACY DOWNTIME PROCEDURE**	SECTION: **Page 4 of 4**

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

Addendum A

Batch #	Beginning No. Ending No.	Date Sign Out	Department Dispense To	RX Signature	Dept. Signature

SUBJECT: **JURY DUTY AND WITNESS DUTY**	SECTION: **Page 1 of 2**

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

PURPOSE:

Employees are encouraged to participate in jury selection and service and serve as witnesses.

POLICY:

Public statute requires that employees be granted time away from work for jury and witness service.

DEFINITIONS:

Jury Duty – Time off to serve as required by law on an inquest jury or trial jury.

Witness Duty – Time off to appear in court when the employee has been a victim of a crime to comply with a subpoena or other court order as a witness in any judicial proceeding.

AFFECTED PERSONNEL/AREAS: *ALL ELIGIBLE EMPLOYEES*

PROCEDURE:

Eligible employees include exempt and non-exempt full and part-time employees as noted.

Employees must notify their supervisors of the potential need for time off for jury or witness duty as soon as a notice or summons is received. Failure to provide sufficient advance notice may result in disciplinary action. A copy of the notice or summons must be submitted to the employee's Director/Manager.

Deduction from exempt employees' pay cannot be made as a result of absences for jury or witness duty unless no work is performed during the workweek, once the five (5) days of jury/witness duty has been paid. If no work is performed during the workweek, exempt staff may elect Vacation/Holiday time off for that week. However, if Vacation/Holiday time is available and work is performed during the week along with jury or witness duty, Vacation/Holiday time must also be used to cover time spent at jury or witness duty if the five days of jury/witness duty has already been paid

Non-exempt employees who have completed the introductory period receive their base hourly rate of pay while serving on a jury and/or as a witness to a judicial proceeding up to five (5) days per calendar year. Reimbursable hours may not exceed regularly scheduled hourly commitments. Following exhaustion of the five (5) day period, non-exempt staff may elect Vacation/Holiday time off for further jury and witness service. If the employee does not have sufficient Vacation/Holiday time and/or elects not to utilize Vacation/Holiday time for further jury and witness service, the time spent on jury duty and/or as a witness to a judicial proceeding will be unpaid.

This policy applies to night shift employees who are on jury duty. Night shift employees are not expected to work all night and then report to jury duty after the completion of their shift or go to jury/witness duty

all day and report to work that night. This will be evaluated on a case-by-case basis for purposes of fatigue management and safe patient care.

If requested, employees must provide proof of completion of jury/witness duty service to their Director/Manager.

All employees who have called the night before for jury/witness duty and are placed on-call by the Court must report to their regularly scheduled shift the following day. If called to appear, employee will be released from their shift to attend the jury/witness duty.

In the case of federal grand jury service or federal regular jury service, this policy and procedure shall apply except that if federal law requires a different procedure, then federal law shall be complied with to the extent necessary.

Exceptions to this policy will be considered on a case-by-case basis.

No employee will be threatened or disciplined when complying with this policy.
It is the responsibility of the Department Directors to comply with this policy.

Jury duty, whether paid or unpaid time, is reported using KRONOS time reporting procedures and is not counted as an attendance occurrence.

https://hrcalifornia.calchamber.com/hr-library/qa/employee-time-jury-duty.

Labor Code – Section 230 (a)

SUBJECT: **LACTATION /BREASTFEEDING POLICY**	SECTION: **Page 1 of 2**

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

PURPOSE:

As part of our family-friendly policies and benefits, Sierra View Medical Center supports breastfeeding mothers by accommodating the mother who wishes to express breast milk during her workday when separated from her newborn child. The provisions of this Lactation Policy meet the requirements of the Fair Labor Standards Act as it relates to breaks for nursing mothers.

POLICY:

Any employee who is breastfeeding her child will be provided reasonable break times to express breast milk for her newborn. The employee and her immediate supervisor will agree on the times for these breaks.

AFFECTED PERSONNEL/AREAS: *ALL NON-EXEMPT EMPLOYEES*

PROCEDURE:

Sierra View Medical Center has designated Staff Lactation Lounge areas: We have Lactation Lounges in our Main Hospital located on the 4th floor next to the NICU along with another location next to the Laboratory draw station. For staff located at our Medical Office Building (MOB), employees can utilize the Breastfeeding Resource Center. In the event these locations are all in use, please contact the HR department for back-up location options.

SVMC will provide the following:

- A sink with running water
- A refrigerator for the storage of breast milk will be made available close to the employee's workspace (Any breast milk stored in the refrigerator must be labeled with the name of the employee and the date of expressing the breast milk. Any non-conforming products stored in the refrigerator may be disposed of. Employees storing milk in the refrigerator assume all responsibility for the safety of the milk and the risk of harm for any reason, including improper storage, refrigeration and tampering)
- A clean, safe area free of toxic or hazardous materials, as defined in Section 6382. Area must be cleaned daily and a waste basket provided
- Seating with a comfortable chair
- A surface to place a breast pump and personal items
- Access to electricity along with good lighting and ventilation
- An occupied sign for the door with a lock on the door. (If the room is multi-purpose, lactation use takes precedence)

Nursing mothers wishing to use the Staff Lactation Lounge must utilize the signage to indicate the room is "In Use". Additional rules for use of the room and refrigerator storage are posted in the room. Employees who work off-site or in other locations will be accommodated and should contact Human Resources for assistance with locating a private area as necessary.

Lactation break time shall, if possible, run concurrently with the paid break time already provided by the District. (Please see Meal and Break Period Policy). Break time that does not run concurrently with the break time provided by SVMC policy, and/or break time lasting longer than twenty (20) minutes in duration, will be unpaid, and the employee should indicate this additional break time/period on her time record Vacation/Holiday time may be utilized for unpaid additional breaks and break time.

Retaliation, harassment and discrimination in any way against an employee who chooses to express breast milk in the workplace are strictly prohibited.

Any employee who feels they have not been afforded Lactation space, may report a violation to the Labor Commissioner's field enforcement unit.

REFERENCES:

- Break Time for Nursing Mothers. U.S. Department of Labor Seal. (n.d.). https://www.dol.gov/agencies/whd/nursing-mothers.
- Bill Text. Bill Text - SB-142 Employees: lactation accommodation. (n.d.). https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB142.
- California Labor code 6382. Sec. § 6382. California Labor Code Section 6382 (2016). (n.d.). https://california.public.law/codes/ca_lab_code_section_6382.
- Fair Labor Standards Act Reference Break Time for Nursing Mothers. United States Department of Labor. (n.d.). https://www.dol.gov/agencies/whd/nursing-mothers.
- Labor commissioner
  Welcome to the Office of the Labor Commissioner. Labor Commissioner. (n.d.). https://labor.nv.gov/.

CROSS REFERENCES:

- MEAL AND BREAK PERIODS

SUBJECT: **MEAL TRAYS**	SECTION: **Page 1 of 3**

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

PURPOSE:

The purpose of this policy is to establish the processes by which meal trays are ordered, prepared, delivered, and intake recorded.

POLICY:

Meal trays for patients are prepared and served in accordance with the physician diet order. A minimum of three (3) meals are served daily with no more than fourteen (14) hours between the dinner meal and the breakfast meal. Patient tray line begins at 0700, 1130 and 1700.

AFFECTED PERSONNEL/AREAS: *FOOD & NUTRITION SERVICE (FNS), NURSING, PATIENT CARE AREAS*

PROCEDURE:

1. All food is prepared in the kitchen and served in accordance with the patient's diet order as determined by the physician.

2. Trays are appropriately identified with the patient's name, room number and diet order. Assembled trays are checked by the diet aide for accuracy.

3. FNS personnel transport trays to the patient units in enclosed or covered food carts. On the occasion trays are transported in open carts, all food items not under a protective dome are covered with plastic wrap or other type of covering.

4. Utilizing two (2) patient identifiers, FNS personnel distribute, retrieve and record meal trays for acute care patients. Skilled nursing staff distributes, retrieve and record meal trays for long-term care residents. Prior to being served to the patient/resident, nursing compares trays against the diet census sheet to assure patients are receiving the diet as ordered.

5. Isolation trays will be sent on re-usable dining wares unless otherwise specified by the physician order, nursing, or the FNS Director. Isolation trays will be delivered into, and retrieved from, the patient room by nursing staff, and will be cleaned by FNS using proper sanitation and disinfection procedures.

6. Patients placed on a "NPO" (nothing by mouth) tray hold will not receive a tray. The NPO order shall be communicated through the electronic medical record system. A call will be placed to FNS for any NPO tray holds that occur within a half hour of meal periods.

7. Nursing will request a late tray for any patients admitted after the scheduled meal periods. A tray with hot food will be sent upon request when available. Hot food is available 0700-0930, 1130-1400 and 1700-1900. Cold sandwiches are available from the kitchen between meal service and until 2000.

8. Nourishment rooms located on each unit have food available at all times for all patients.

9. Courtesy trays may be provided to breastfeeding mothers, one parent of a pediatric patient, caregivers of developmentally disabled patients and law enforcement officers assigned to guard a patient. Meals provided will be the same as the non-select regular diet for patients. The FNS director, nursing unit supervisor or dietitian will approve any exceptions.

10. Special lunch meals will be served on Thanksgiving Day and Christmas Day.

11. FNS personnel are responsible for recording meal intake. Nursing staff are responsible for recording meal intake if they remove the tray from the room. Percentage of meal intake is recorded in the EMR.

Meal Intake Reference

Percent Intake	Description of Meal Intake	Photo Example for Reference
100%	Entire meal is consumed except for a minimal amount of food (i.e., less than 25% of vegetable is remaining)	
75%	Majority of the meal is consumed, but a significant amount of one or more items is left (i.e., 25% of entrée, or 75% of vegetable is remaining).	

50%	Approximately half of food is consumed (i.e., 50% of entrée, 25% of vegetable and soup remaining).	
25%	Approximately 25% of entrée or 50% of one item consumed.	
0%	Refused meal completely, or consumed only 1-2 bites.	

REFERENCES:

- GACH Title 22 Regulations. § 70273(a)
- Centers for Medicare and Medicaid Services, Conditions of Participation (2024). 482.28(b)(2)
- The Joint Commission (2024). Hospital accreditation standards. PC.02.01.03

SUBJECT: **NOURISHMENT ROOM FLOOR STOCK**	SECTION: **Page 1 of 2**

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

PURPOSE:

To establish protocol for stocking patient nourishment rooms.

POLICY:

Adequate quantities of nourishments and condiments will be delivered to the patient nourishment rooms on the nursing units according to par levels developed for each area.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICES, ENVIRONMENTAL SERVICES, NURSING, PATIENT CARE AREAS*

PROCEDURE:

1. Food & Nutrition Service (FNS) will inventory and stock nourishment rooms daily.
2. The designated FNS employee(s) will deliver floor stock daily.
3. All items placed in the refrigerators will have an expiration date, be labeled, and appropriately sealed. The stock will be rotated to ensure FIFO (first in first out).
4. All items found to be outdated will be discarded. Any items found to be open or not clearly labeled and dated will be discarded.
5. All employee items will be stored in an area other than the patient nourishment rooms. All employee items found in patient nourishment rooms will be discarded immediately. FNS employees will not be responsible for discarding employee items found in the patient nourishment room.
6. Patient nourishments will be stored and maintained under sanitary conditions.
7. FNS employees will be responsible for cleaning the inside of refrigerators and inside of floor stock drawers daily.
8. Environmental Services will be responsible for cleaning the general area of the nourishment rooms. The outside of the refrigerator, counters, floors, ice machine, and microwave will be cleaned daily.
9. Opened items, e.g. cans, milk cartons are NOT to be placed in the refrigerator. All partially used items will be discarded immediately.
10. Any person who spills food is responsible for cleaning it up.

11. All food items will be handled under sanitary conditions and using clean hands.

12. All items intended for a specific patient stored in the nourishment room areas will be identified with patient's name, room number, and will be properly covered, labeled, and dated. No items that have been in a patient room may enter the patient nourishment areas. No partially consumed items may be stored in patient nourishment areas.

13. Perishable items shall not be left on the counters.

14. Nutritional supplements will be routinely checked by nursing and FNS employees for expired dates. Expired items will be discarded.

15. FNS employees are responsible for monitoring the temperature of refrigerators in the patient nourishment rooms, maintaining a thermometer, and storing the recorded data.

16. At no time will medications, lab specimens or items other than patient designated food items be stored in patient nourishment areas.

REFERENCES:

- The Joint Commission (2024). Hospital accreditation standards. PC.02.02.03 EP 11

SUBJECT: **PATIENT FOOD FROM HOME - ACUTE**	SECTION: **Page 1 of 1**

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

PURPOSE:

Sierra View Medical Center (SVMC) may permit family members to bring food to patients. This policy defines the procedure for patient food brought from home.

POLICY:

Food that may be brought into the hospital for patients will be for that specified meal. All leftover food will be disposed or removed from the hospital. Patient food will not be stored in the nourishment rooms.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE, PATIENT CARE AREAS*

PROCEDURE:

1. Visitors are not permitted to bring food to the hospital for patients on a mechanically altered diet unless approved by their physician, dietitian, nurse or speech therapist.

2. Visitors may bring food for patients that are on a regular textured diet (not a pureed, ground, chopped or thickened liquid diet).

3. The physician, dietitian, nurse, or social service may recommend the need for food from home.

4. Food brought into the hospital for patients will be for one meal at a time. All leftover food will be disposed or removed from the hospital. Patient food will not be stored in the nourishment rooms.

REFERENCES:

- The Joint Commission. (2024). Hospital Accreditation Standards. PC.02.02.03

SUBJECT: **PERFORMANCE IMPROVEMENT - FOOD AND NUTRITION**	SECTION: **Page 1 of 1**

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

PURPOSE:

To establish protocol for measurable performance improvement.

POLICY:

The Food and Nutrition Service (FNS) Department demonstrates a consistent endeavor to deliver clinical care and food service that is optimal with available resources and consistent with achievable goals. In order to reach optimal service, the FNS department participates in the hospital performance improvement program. The program is designed to enhance clinical care and food service through the ongoing objective assessment of important aspects of FNS and the correction for improvement of the identified problems.

AFFECTED PERSONNEL/AREAS: *FOOD AND NUTRITION SERVICE*

PROCEDURE:

1. The FNS Director and Clinical Nutrition Manager (CNM) are responsible for quality assurance /performance improvement (QAPI).

2. The FNS Director and/or CNM will identify QAPI opportunities, determine desired results, and develop measurable goals for resolution.

3. The collected data results will be presented to the Performance Improvement/Patient Safety (PIPS) Committee at least annually.

REFERENCES:

- The Joint Commission (2024). Hospital accreditation standards.
  - PI.01.01.01
  - PI.02.01.01, EP 2
  - LD.03.07.01, EP 2

SUBJECT: **REFERRAL BONUS**	SECTION: **Page 1 of 2**

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

PURPOSE:

Sierra View Medical Center (SVMC) will identify targeted full-time positions that are generally considered critical and difficult to fill during the recruitment process to be considered for a referral bonus under this policy. These positions will be identified by the VP of Human Resources.

POLICY:

A referral bonus will be paid to any employee who refers a candidate and they are hired for a targeted full-time position. The amount of the referral bonus will be determined at the time of each job posting and is subject to change at management's discretion.

AFFECTED PERSONNEL/AREAS: All employees may refer and receive the referral bonus, with the exception of Board Members, Senior Team Members, Directors, Managers, Supervisors and Human Resources staff.

PROCEDURE:

Full-time positions that are eligible for a referral bonus are marked with an asterisk (*) on the job posting board.

In order to be eligible for the referral bonus, the employee who is referring an applicant should instruct the applicant to list their name as the referral source on the application at the time of submission. Human Resources will validate the referral during the interview process to determine eligibility.

The referring person's name must appear on the employment application at the time it is completed and submitted to Human Resources to be considered for the referral bonus payment.

If the referred applicant lists more than one employee on the employment application as being the referral source, the bonus payment will be split equally among the employees named as having referred the new employee.

There is no maximum number of referral bonuses that can be paid to any one employee.

There will be no referral bonus paid for a referral of an employee who is re-hired at SVMC within two (2) years of their termination date. Existing SVMC staff are not eligible applicants for this referral bonus meaning they cannot be referred by another employee.

Eligibility of Payment of Referral Bonus:

Both the newly hired employee and the employee who made the referral must be on SVMC's active payroll at the time each payment is due.

Schedule of Payout:

The referral bonus will be paid in three (3) installments over the course of the newly hired employee's first year of employment if the above eligibility requirements are met.

First Installment – Twenty-five percent (25%) will be paid at the completion of the newly hired employee's (3) three-month anniversary date.

Second Installment – Twenty-five percent (25%) will be paid upon the newly hired employee's (6) six-month anniversary date.

Third and Final Installment – Fifty percent (50%) will be paid upon the newly hired employee's (12) twelve-month anniversary.

REFERENCES:

- The Joint Commission (2019). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **REFERRAL BONUS**	SECTION: **Page 1 of 2**

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Third and Final Installment – Fifty percent (50%) will be paid upon the newly hired employee's (12) twelve-month anniversary.

REFERENCES:

- The Joint Commission (2019). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **PAID SICK LEAVE**	SECTION: *Human Resources* **Page 1 of 4**

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

PURPOSE:

To define the purpose and scope of Sick Leave benefits provided at Sierra View Medical Center (SVMC).

POLICY:

PAID SICK LEAVE ELIGIBILITY AND ACCRUALS

All Full Time and Part Time Employees: The Hospital will provide a lump sum of 40 hours or five (5) days (whichever is greater) of paid sick leave (PSL) at the beginning of each 12-month period (employee's date of hire). An employee is not eligible to begin using any PSL until the 91st day of employment with the Hospital.

All Per Diem Employees: Per diem Employees are eligible to accrue PSL beginning with their first day of employment. Employees will accrue PSL at the rate of one hour for every 30 hours of work. Employees may begin to utilize their hours on their 91st day of employment. Unused accrued PSL will carry over from one year to the next. However, an employee's accrued PSL may not exceed 80 hours or 10 days, whichever is greater If the cap is met, no further PSL will accrue until the employee falls below the cap. Employees are limited to 5 days of PSL usage per year from their date of hire.

PERMITTED USE OF SICK LEAVE

An employee will not be discriminated against or retaliated against for requesting or using PSL for qualifying reasons protected by the Healthy Workplaces Healthy Families Act (HWHFA).

An employee may submit a verbal or written request to use PSL for the following reasons:

A. Diagnosis, care, or treatment of an existing health condition for an employee or covered family member, as defined below:
B. Preventive care for an employee or covered family member. Preventive care may include annual physicals or vaccinations.
C. For an employee who is a victim of domestic violence, sexual assault, or stalking, to take time off (i) to obtain or attempt to obtain any relief to help ensure the health, safety, or welfare of the employee or the employee's child, such as a temporary restraining order, restraining order or other injunctive relief, (ii) to seek medical attention, obtain services from a shelter, program or rape crisis center, (iii) to obtain psychological counseling, (iv) to participate in safety planning, or (v) to take other actions to increase safety from future incidents.

For purposes of PSL, a covered "family member" includes:

- A "child" defined as a biological, foster or adopted child, or a legal ward, regardless of the age or dependency status of the child. A "child" also may be someone for whom you have accepted the duties and responsibilities of raising, even if they are not your legal child.
- A "parent" is defined as a biological, foster or adoptive parent; a stepparent; or a legal guardian of an employee or the employee's spouse or registered domestic partner. A parent may also be someone who accepted the duties and responsibilities of raising you when you were a minor child, even if they are not your legal parent.
- A spouse
- A registered domestic partner
- A grandparent
- A grandchild
- A sibling
- A "designated person". A designated person is any individual you identify at the time you request paid sick leave. You are limited to one designated person per 12-month period for purposes of paid sick leave.

AFFECTED PERSONNEL/AREAS: *ALL EMPLOYEES*

PROCEDURE:

TERMS AND CONDITIONS

- An employee shall provide reasonable advance notice of their need to use available accrued PSL to their supervisor if the need for such PSL use is foreseeable (e.g., doctor's appointment scheduled in advance). If the need is unforeseeable (*e.g.*, employee is ill at time of shift), the employee shall provide notice of the need for the leave to their supervisor as soon as practicable.
    - If the absence is foreseeable, the employee's time sheet must be completed in advance of the absence. If the absence is unforeseen, the employee must complete their time sheet upon return from the absence. If the absence extends beyond the close of the payroll period, it is the employee's responsibility to request PSL be added to the time sheet at the time the absence is reported. If PSL is not noted on the time sheet, the absence is considered an unexcused absence. The employee is required to approve/attest the PSL entry on the time sheet upon return.
- Departments may require an employee who uses available PSL hours from their leave bank to do so with a minimum increment of two hours.
- PSL use will not be counted as an absence occurrence or used as a basis for disciplining an

employee for absenteeism. However, if an employee does not have any PSL hours to use for an absence, the absence will be counted as a full occurrence under the Attendance and Punctuality policy. In a declared emergency/disaster related to a medical situation like a pandemic, a physician's note will be required after the third day of work missed not protected under PSL.

- Full Time employees will receive compensation for their unused PSL each year on their anniversary date. Employee must still be employed on their anniversary date to qualify for the payout.Employees will not receive compensation upon termination, resignation, retirement or other separation reasons. If an employee is rehired within one year from date of separation, the employee shall receive upon new hire date, 40 hours or 5 days (whichever is greater) of PSL to be used on or after the 91st day of re-employment.
- Per Diem employees who have not used all accrued PSL prior to the last day of employment will not be paid out at the time of termination, resignation, retirement or other separation reasons. If an employee is rehired within one year of the date of separation, any accrued and unused PSL will be reinstated and available for the employee to use.

- PSL will not be considered hours worked for purposes of overtime calculation.
- PSL will be compensated at the same wage as the employee normally earns during regular work hours. The rate of pay will be based on the employee's regular hourly wage.
- Any available PSL must be used simultaneously with an employee's FMLA/CFRA leave and may be used on Pregnancy Disability Leave (PDL) leave.
- Transfers from Per Diem to Full Time: A partial frontload of the difference between what was already used and the full amount of the front load (e.g., per diem used 2 days' worth of PSL since their date of hire prior to transferring to Full Time status, will be frontloaded an additional of 3 PSL days at time of transfer. If the Per Diem used 5 days' worth of PSL since their date of hire, no additional PSL hours will be added.).
    - If an employee has more than 5 days at time of transfer, they would forfeit the difference.
- Transfers from Full Time to Per Diem: Employee will maintain their PSL balance at time of transfer and then switch to the accrual method.

REQUIRED RECORD KEEPING:

As part of a department's routine process of receiving information from employees who call in sick, procedures need to be in place to inquire about the following:

- Whether the sick day is due to a covered reason under this policy.

- If the sick day is used to care for a covered person as listed above, what is that person's relationship to the employee? (Mother, child, etc.)

- Whether the illness is a serious health condition also may be covered under FMLA/CFRA/PDL. Employees do not need to disclose a diagnosis. If the illness qualifies as a serious health condition, employees should be directed to contact Human Resources. Directors/Managers must notify Human Resources once they learn an employee/employee's family member may have a qualifying illness/serious health condition, so the employee may be informed of leaves available to them.

CAUTION: The scope of the questions must be limited, to protect the confidentiality of medical information of an employee or family member's health condition. For example, the department cannot ask the employee to reveal what the specific health condition is.

A Leave of Absence does not need to be requested unless the employee will be absent for more than three (3) continuous workdays and the absence qualifies as an FMLA/CFRA, PDL or other medical leaves.

An employee taking PSL is not required to submit a doctor's note.

REFERENCES:

- **AB 1522- The Healthy Workplaces, Healthy Families act of 2014**

CROSS REFERENCES:

- Reasonable Accommodation policy
- Attendance & Punctuality policy
- Leave of Absence – FMLA/CFRA policy

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MINUTES OF A REGULAR MEETING OF THE
BOARD OF DIRECTORS OF
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The Annual meeting of the Board of Directors of Sierra View Local Health Care District was held **May 28, 2024 at 5:00 P.M.** in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California

Call to Order: Chairman REDDY called the meeting to order at 5:02 p.m.

Directors Present: **REDDY, LOMELI, MARTINEZ, KASHYAP, PANDYA**

Others Present: Donna Hefner, President/Chief Executive Officer, Jeffery Hudson, VPPCS/CNO/DIO, Tracy Canales, VP of Human Resources, Doug Dickson, Chief Financial Officer, Melissa Mitchell, VP Quality and Regulatory Affairs, Ron Wheaton, VP of Professional Services/Physician Recruitment, Cindy Gomez, Compliance Privacy Officer, Julie Franer, Director of Revenue Cycle, Staci Bowles, Patient Registration Manager, Dan Blazer, Patient Experience Officer, Maddie Hunt, Public Relations, Alex Reed-Krase, Legal Counsel, Harpreet Sandhu, Chief of Staff, Craig McDonald, Mark Nanamura, Mutual Advisors LLC, Patrick Nanamura, Mutual Advisors LLC

I. Approval of Agenda:

Chairman REDDY motioned to approve the Agenda. The motion was moved by Director PANDYA, 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	Yes
KASHYAP	Yes

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:03 p.m. to discuss the following items:

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

B. Pursuant to Evidence Code Section 1156 and 1157.7:

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

2. Quality Division Update – Quality Report

3. Compliance Report – Quarter 3

Closed Session Items C, D, E, F and G were deferred to the conclusion of Open Session as there was not enough time for discussion prior to Open Session.

III. Open Session: Chairman REDDY adjourned Closed Session at 5:45 p.m., reconvening in Open Session at 5:47 p.m.

Pursuant to Gov. Code Section 54957.1; Action(s) taken as a result of discussion(s) in Closed Session.

A. Chief of Staff Report provided by Chief of Staff Sandhu.
Information only; no action taken.

B. Pursuant to Evidence Code Section 1156 and 1157.7:

1. Evaluation – the Quality of Care/Peer Review

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director MARTINEZ, and carried to approve the Quality of Care/Peer Review as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

2. Quality Division Report – Quality Repot

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director PANDYA, and carried to approve the Quality of Care/Peer Review as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

3. Compliance Report – Quarter 3

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director PANDYA, and carried to approve the

Compliance Report for Quarter 3 as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

IV. Public Comments

Sherri Shields, Porterville – Expressed her dissatisfaction with the surgeon that performed her colonoscopy procedure and a written letter that provided details of her complaint.

Richard Sandoval, Porterville – Expressed his concern with the complications that resulted from his wife's colonoscopy procedure and a written letter that provided details of his complaint.

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	Yes

VI. Approval of Minutes:

Following review and discussion, it was moved by Vice Chairman LOMELI and seconded by Director MARTINEZ to approve the April 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	Yes

VII. Business Items

A. Moss Adams Entrance Presentation FY '23 Audit (Virtual)

Information Only: No Action Taken

B. April Financials

Doug Dickson, CFO presented the Financials for April 2024. A copy of this presentation is attached to the file copy of these minutes.

Total Operating Revenue was $13,890,504. Supplemental Funds were $2,629,792. Total Operating Expenses were $14,356,216. Loss from operations of $465,712.

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director KASHYUP and carried to approve the April 2024 Financials as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

C. Capital Budget Report Quarter 3

Following review and discussion, it was moved by Director PANDYA, seconded by Director KASHYAP and carried to approve the Capital Budget Report as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

D. Investment Policy

Following review and discussion, it was moved by Director PANDYA, seconded by Vice Chairman LOMELI and carried to approve the investment policy as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

E. Investment Report Quarter 3

Following review and discussion, it was moved by Director PANDYA, seconded by Director MARTINEZ and carried to approve the Investment Report for Quarter 3 as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

Business Items F, G and H deferred until remaining closed session items were presented in closed session.

VIII. CEO Report

Donna Hefner, President/CEO provided a report of activities and happenings around Sierra View.

IX. Closed Session: Board adjourned Open Session at 6:50 p.m., reconvening in Closed Session at 6:50 p.m. to discuss the following items.

C. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets Pertaining to Service to Fill the Chief Financial Officer Position– One (1) Item. Estimated Date of Disclosure September 1, 2024 for materials that are not part of an individual's private personnel file.

D. Pursuant to Gov. Code Section 54957(b): Discussion Regarding Confidential Personnel Matter Chief Financial Officer Agreement Mutual Termination – One (1) Item. Estimated Date of Disclosure May 28, 2024 for materials that are not part of an individual's private personnel file.

X. Open Session: Chairman REDDY adjourned Closed Session at 6:57 p.m., reconvening in Open Session at 6:57 p.m.

C. Discussion Regarding Filling Position of Chief Financial Officer
Recommended Action: Information Only: No Action Taken

D. Discussion Regarding Chief Financial Officer Agreement Mutual Termination
Recommended Action: Information Only: No Action Taken

XI. Business Items

F. Incoming Chief Financial Officer Employment Contract and Negotiation of Salary

Following review and discussion, it was moved by Director PANDYA, seconded by Director MARTINEZ, and carried to approve the CFO Employment Contract as presented and offer the new CFO Craig McDonald a four-year contract with a salary of $215,180 a year, which he can renegotiate after two years.

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

G. Current Chief Financial Officer Agreement Mutual Termination

Following review and discussion, it was moved by Director PANDYA, seconded by Director KASHYAP, and carried to approve the Mutual Termination Agreement as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

Business Item H deferred until remaining closed session items were presented in closed session.

XII. Closed Session: Board adjourned Open Session at 7:05 p.m., reconvening in Closed Session at 7:05 p.m. to discuss the following items.

E. Pursuant to Gov. Code Section 54957(b): Discussion Regarding Confidential Personnel Matter Chief Executive Officer Performance Evaluation 2023 – One (1) Item. Estimated Date of Disclosure May 28, 2024 for materials that are not part of an individual's private personnel file.

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

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

XIII. Open Session: Chairman REDDY adjourned Closed Session at 7:45 p.m., reconvening in Open Session at 7:45 p.m.

E. Discussion Regarding Chief Executive Officer Performance Evaluation 2023
Recommended Action: Information Only: No Action Taken

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

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

IV. Business Item

H. CEO 2024 Performance Evaluation and Salary Negotiations

Following review and discussion, it was moved by Vice Chairman LOMELI, seconded by Director PANDYA, and carried to approve a total 2% increase in CEO salary over the automatic annual 2% increase per contract over prior year base salary. Salary increase from $425,318.40 annually to $442,332.80 annually effective May 1st, 2024. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

XI. Announcements:

A. Special Board of Directors Meeting – June 3, 2024 at 5:00 p.m.
B. Regular Board of Directors Meeting – June 25, 2024 at 5:00 p.m.

XII. Adjournment
The meeting was adjourned at 7:52pm

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors

AM: tv

MINUTES OF A SPECIAL MEETING OF THE BOARD OF DIRECTORS OF SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The special meeting of the Board of Directors of Sierra View Local Health Care District was held **June 3, 2024 at 5:00 P.M.** in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California.

Directors Present: **REDDY, LOMELI, MARTINEZ, KASHYAP and PANDYA**

Others Present: Donna Hefner, President and CEO
Tracy Canales, VP of Human Resources and Marketing
Jeff Hudson, VP of Patient Care Services and CNE
Craig McDonald, VP and CFO
Melissa Mitchell, VP of Quality and Regulatory Affairs
Ron Wheaton, VP Physician Recruitment & Professional Services
Terry Villareal, Executive Assistant and Clerk to Board of Directors
Barbra Reigel, CEO, Strategic HealthCare Advisors
Kyle Adams, RN Clinical Manager, Med/Surg
Jill Black, Director of Revenue Integrity & Financial Services
Dan Blazer, Patient Experience Officer
Staci Bowles, Patient Registration Manager
Bryan Brassfield, Director of Pharmacy
Merly Camat, Director of General Accounting/Controller
Susie Cartwright, Director of Medical Staff Services
Bre Celaya, RN Clinical Manager, Emergency Department
Crystal Davis, Director of Cancer Treatment Center
Josue Fernandez, Clinic Administrator
Traci Follett, Director of Informatics and Technology
Julie Franer, Director of Revenue Cycle-Patient Financial Services
Cindy Gomez, Compliance/Privacy Officer
Veronica Gutierrez, RN Clinical Manager, ASD, ENDO, PACU & Flex Care
Richard Hernandez, Director of Imaging Services, Physical Therapy & Speech Therapy, Cancer Treatment Center & Outpatient Clinics
Nancy Hurtado-Ziola, Infection Prevention Manager
Corina Joseph, Clinical Nutrition Manager
Hannah Lam, RN Clinical Manager, ICU
Gerald Likewise, Director of Radiology
Autumn Leypon, Manager of IT Operations and Infrastructure
Anthony Nungaray, Laboratory Manager, CLS Education Coordinator
Kim Pryor-DeShazo, Director of Marketing/Community Services
Lizette Razon, Patient Account Manager
Jennifer Regalado, Respiratory Manager
Paul Ridge, Manager, EVS
Christen Rios, Director of Surgical Services
Silvia Roberts, Manager of Care Integration

Zaelin Stringham, Director of Food & Nutrition
Gary Wilbur, Director of General Services & IT
Colleen Wilson, Human Resource Manager
Leif Williams, Director of Materials Management
Debbie Zeboskey, Director of Health Information Management

I. Call to Order: Chairman REDDY called the meeting to order at 5:07 p.m.

II. Approval of Agendas: Director Reddy asked for approval of the agenda. It was moved by Director PANDYA and seconded by Vice Chairman LOMELI, and carried to approve the agenda as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Yes
MARTINEZ	Yes
KASHYAP	Yes
PANDYA	Yes

III. Public Comments: No Comments were made

IV. Closed Session: Board adjourned Open Session and went into Closed Session at 5:08 p.m. to discuss the following items:

A. Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secret, Pertaining to Service and Strategic Planning (1 Item). Estimated Date of Disclosure - June 2029

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

V. Open Session: Board adjourned Closed Session at 7:36 p.m. and went into Open Session at 7:36 p.m. to discuss the following items:

A. Discussion Regarding Trade Secret, Pertaining to Service and Strategic Planning
Information only; no action taken.

B. Conference With Legal Counsel
Information Only: no action taken

VI. Announcements:

A. Regular Board of Directors Meeting – June 25, 2024

VII. Adjournment

The meeting was adjourned at 7:37 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors
AM: tv

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FINANCIAL PACKAGE
May 2024

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
May 2024

Statistic	May-24 Actual	May-24 Budget	May-24 Over/ (Under)	May-24 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 23 YTD	Increase/ (Decrease) May-23	% Change
Utilization											
SNF Patient Days											
Total	-	108	(108)	-100.0%	450	1,188	(738)	-62.1%	1,393	(943)	-67.7%
Medi-Cal	-	29	(29)	-100.0%	450	696	(246)	-35.3%	1,020	(570)	-55.9%
Sub-Acute Patient Days											
Total	1,034	871	163	18.7%	10,719	9,581	1,138	11.9%	9,397	1,322	14.1%
Medi-Cal	941	560	381	68.1%	9,346	6,408	2,938	45.9%	6,286	3,060	48.7%
Acute Patient Days	1,615	1,848	(233)	-12.6%	18,261	20,331	(2,070)	-10.2%	19,665	(1,404)	-7.1%
Acute Discharges	459	480	(21)	-4.4%	4,768	5,280	(512)	-9.7%	5,006	(238)	-4.8%
Medicare	181	201	(20)	-9.8%	1,864	2,033	(169)	-8.3%	1,925	(61)	-3.2%
Medi-Cal	205	208	(3)	-1.4%	2,309	2,532	(223)	-8.8%	2,404	(95)	-4.0%
Contract	70	68	2	3.4%	561	689	(128)	-18.5%	649	(88)	-13.6%
Other	3	4	(1)	-18.8%	34	30	4	13.3%	28	6	21.4%
Average Length of Stay	3.52	3.85	(0.33)	-8.6%	3.83	3.85	(0.02)	-0.5%	3.93	(0.10)	-2.5%
Newborn Patient Days											
Medi-Cal	128	172	(44)	-25.5%	1,782	1,881	(99)	-5.3%	1,890	(108)	-5.7%
Other	48	33	15	44.6%	341	374	(33)	-8.8%	346	(5)	-1.4%
Total	176	205	(29)	-14.1%	2,123	2,255	(132)	-5.9%	2,236	(113)	-5.1%
									0.0%		
Total Deliveries	94	116	(22)	-19.0%	1,092	1,276	(184)	-14.4%	1,223	(131)	-10.7%
Medi-Cal %	76.84%	82.81%	-5.97%	-7.2%	83.84%	82.81%	1.03%	1.2%	82.95%	0.89%	1.1%
Case Mix Index											
Medicare	1.5775	1.6395	(0.0620)	-3.8%	1.6145	1.6395	(0.0250)	-1.5%	1.6406	(0.0261)	-1.6%
Medi-Cal	1.0954	1.1881	(0.0927)	-7.8%	1.1955	1.1881	0.0074	0.6%	1.1868	0.0087	0.7%
Overall	1.2870	1.3732	(0.0862)	-6.3%	1.3710	1.3732	(0.0022)	-0.2%	1.3747	(0.0037)	-0.3%
Ancillary Services											
Inpatient											
Surgery Minutes	8,196	9,041	(845)	-9.3%	91,356	99,451	(8,095)	-8.1%	94,466	(3,110)	-3.3%
Surgery Cases	90	104	(14)	-13.5%	1,022	1,144	(122)	-10.7%	1,127	(105)	-9.3%
Imaging Procedures	1,473	1,479	(6)	-0.4%	15,642	16,272	(630)	-3.9%	16,286	(644)	-4.0%
Outpatient											
Surgery Minutes	14,567	12,448	2,119	17.0%	140,015	136,928	3,087	2.3%	141,696	(1,681)	-1.2%
Surgery Cases	213	190	23	12.1%	2,237	2,090	147	7.0%	2,113	124	5.9%
Endoscopy Procedures	198	141	57	40.4%	2,014	1,558	456	29.3%	2,034	(20)	-1.0%
Imaging Procedures	4,393	3,715	678	18.3%	44,237	40,867	3,370	8.2%	42,966	1,271	3.0%
MRI Procedures	283	295	(12)	-4.1%	3,335	3,245	90	2.8%	3,222	113	3.5%
CT Procedures	1,310	1,178	132	11.2%	13,719	12,958	761	5.9%	13,202	517	3.9%
Ultrasound Procedures	1,531	1,102	429	38.9%	14,288	12,122	2,166	17.9%	11,621	2,667	22.9%
Lab Tests	33,750	33,247	503	1.5%	353,186	365,717	(12,531)	-3.4%	372,462	(19,276)	-5.2%
Dialysis	4	3	1	33.3%	42	33	9	27.3%	59	(17)	-28.8%

Sierra View Medical Center
Financial Statistics Summary Report
May 2024

Statistic	May-24 Actual	May-24 Budget	May-24 Over/ (Under)	May-24 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 23 YTD	Increase/ (Decrease) May-23	% Change
Cancer Treatment Center											
Chemo Treatments	2,353	1,713	640	37.4%	19,340	18,843	497	2.6%	17,869	1,471	8.2%
Radiation Treatments	1,966	1,653	313	18.9%	20,614	18,183	2,431	13.4%	18,137	2,477	13.7%
Cardiac Cath Lab											
Cath Lab IP Procedures	22	10	12	120.0%	150	110	40	36.4%	102	48	47.1%
Cath Lab OP Procedures	42	28	14	50.0%	333	308	25	8.1%	305	28	9.2%
Total Cardiac Cath Lab	64	38	26	68.4%	483	418	65	15.6%	407	76	18.7%
Outpatient Visits											
Emergency	3,804	3,411	393	11.5%	38,086	37,521	565	1.5%	37,034	1,052	2.8%
Total Outpatient	15,216	12,811	2,405	18.8%	151,180	140,921	10,259	7.3%	143,617	7,563	5.3%
Staffing											
Paid FTE's	861.16	841.56	19.60	2.3%	861.20	841.56	19.64	2.3%	892.26	(31.06)	-3.5%
Productive FTE's	764.40	735.98	28.42	3.9%	739.91	735.98	3.93	0.5%	764.80	(24.89)	-3.3%
Paid FTE's/AOB	4.97	5.06	(0.09)	-1.8%	5.02	4.97	0.04	0.8%	5.25	(0.23)	-4.4%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	11,691	11,032	660	6.0%	10,750	11,032	(282)	-2.6%	10,818	(68)	-0.6%
Cost/Adj.Patient Day	2,697	2,600	97	3.7%	2,681	2,618	62	2.4%	2,719	(38)	-1.4%
Revenue/Adj. Discharge	54,246	53,107	1,139	2.1%	53,413	53,108	306	0.6%	53,338	76	0.1%
Cost/Adj. Discharge	12,515	12,518	(3)	0.0%	13,320	12,605	715	5.7%	13,404	(85)	-0.6%
Adj. Discharge	1,157	1,070	86	8.1%	11,576	11,775	(198)	-1.7%	11,557	19	0.2%
Net Op. Gain/(Loss) %	4.93%	-1.46%	6.39%	-438.5%	-4.61%	-1.46%	-3.15%	216.1%	-11.72%	7.11%	-60.7%
Net Op. Gain/(Loss) $	751,214	(192,490)	943,704	-490.3%	(6,790,086)	(3,160,732)	(3,629,354)	114.8%	(16,250,530)	9,460,444	-58.2%
Gross Days in Accts Rec.	92.17	88.87	3.30	3.7%	92.17	88.87	3.30	3.7%	91.52	0.65	0.7%
Net Days in Accts. Rec.	48.71	72.82	(24.10)	-33.1%	48.71	72.82	(24.10)	-33.1%	72.73	(24.02)	-33.0%

COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

	MAY 2024	APR 2024
ASSETS		
CURRENT ASSETS:		
CASH & CASH EQUIVALENTS	$ 16,134,432	$ 9,469,940
SHORT-TERM INVESTMENTS	20,830	0
ASSETS LIMITED AS TO USE	64,019	61,795
PATIENT ACCOUNTS RECEIVABLE	178,337,176	175,472,439
LESS UNCOLLECTIBLES	(21,777,352)	(23,403,888)
CONTRACTUAL ALLOWANCES	(134,809,105)	(130,362,934)
OTHER RECEIVABLES	20,877,648	26,126,223
INVENTORIES	4,097,600	4,186,395
PREPAID EXPENSES AND DEPOSITS	3,519,579	3,380,596
LEASE RECEIVABLE - CURRENT	299,577	299,577
TOTAL CURRENT ASSETS	66,764,406	65,230,142
ASSETS LIMITED AS TO USE, LESS CURRENT REQUIREMENTS	35,772,664	35,180,291
LONG-TERM INVESTMENTS	127,984,655	127,316,902
PROPERTY, PLANT AND EQUIPMENT, NET	78,173,086	79,051,159
INTANGIBLE RIGHT OF USE ASSETS	435,299	447,276
SBITA RIGHT OF USE ASSETS	2,578,120	2,683,718
LEASE RECEIVABLE - LT	1,018,804	1,044,144
OTHER INVESTMENTS	250,000	250,000
PREPAID LOSS ON BONDS	1,531,512	1,552,491
TOTAL ASSETS	$ 314,508,545	$ 312,756,122

COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

	MAY 2024	APR 2024
LIABILITIES AND FUND BALANCE		
CURRENT LIABILITIES:		
BOND INTEREST PAYABLE	$ 653,083	$ 522,467
CURRENT MATURITIES OF BONDS PAYABLE	4,055,000	4,055,000
CURRENT MATURITIES OF LONG TERM DEBT	1,201,171	1,201,171
ACCOUNTS PAYABLE AND ACCRUED EXPENSES	3,908,924	3,898,593
ACCRUED PAYROLL AND RELATED COSTS	7,572,123	7,072,186
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	3,731,945	4,056,945
LEASE LIABILITY - CURRENT	133,974	133,974
SBITA LIABILITY - CURRENT	1,272,203	1,272,203
TOTAL CURRENT LIABILITIES	22,528,424	22,212,539
SELF-INSURANCE RESERVES	1,202,433	1,239,219
CAPITAL LEASE LIAB LT	1,023,852	1,107,643
BONDS PAYABLE, LESS CURR REQT	37,510,000	37,510,000
BOND PREMIUM LIABILITY - LT	2,760,631	2,819,201
LEASE LIABILITY - LT	321,845	333,247
SBITA LIABILITY - LT	1,497,293	1,605,470
DEFERRED INFLOW - LEASES	1,250,246	1,276,547
TOTAL LIABILITIES	68,094,723	68,103,866
UNRESTRICTED FUND	245,134,891	245,134,891
PROFIT OR (LOSS)	1,278,932	(482,634)
TOTAL LIABILITIES AND FUND BALANCE	$ 314,508,545	$ 312,756,122

COMBINED INCOME STATEMENT FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

MAY 2024 ACTUAL	MAY 2024 BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE		Y-T-D ACTUAL	Y-T-D BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE
				***** OPERATING REVENUE *****				
5,231,113	5,730,675	499,562	(9)%	INPATIENT - NURSING	58,583,078	63,037,425	4,454,347	(7)%
19,695,129	19,760,695	65,566	0%	INPATIENT - ANCILLARY	196,546,029	217,370,612	20,824,583	(10)%
24,926,242	25,491,370	565,128	(2)%	TOTAL INPATIENT REVENUE	255,129,107	280,408,037	25,278,930	(9)%
37,826,560	31,358,697	(6,467,863)	21%	OUTPATIENT - ANCILLARY	363,205,118	344,908,236	(18,296,882)	5%
62,752,802	56,850,067	(5,902,735)	10%	TOTAL PATIENT REVENUE	618,334,226	625,316,273	6,982,047	(1)%
				DEDUCTIONS FROM REVENUE				
(21,009,614)	(17,105,659)	3,903,955	23%	MEDICARE	(202,679,826)	(188,162,249)	14,517,577	8%
(18,571,057)	(20,103,940)	(1,532,883)	(8)%	MEDI-CAL	(194,672,396)	(221,143,340)	(26,470,944)	(12)%
(8,435,875)	(6,634,411)	1,801,464	27%	OTHER/CHARITY	(74,490,993)	(72,978,521)	1,512,472	2%
(108,964)	(13,158)	95,806	728%	DISCOUNTS & ALLOWANCES	(203,732)	(144,738)	58,994	41%
(22,669)	(439,236)	(416,567)	(95)%	BAD DEBTS	(4,977,383)	(4,831,596)	145,787	3%
(48,148,178)	(44,296,404)	3,851,774	9%	TOTAL DEDUCTIONS	(477,024,329)	(487,260,444)	(10,236,115)	(2)%
14,604,624	12,553,663	(2,050,961)	16%	NET SERVICE REVENUE	141,309,896	138,055,829	(3,254,067)	2%
624,083	654,369	30,286	(5)%	OTHER OPERATING REVENUE	6,092,908	7,198,059	1,105,151	(15)%
15,228,707	13,208,032	(2,020,675)	15%	TOTAL OPERATING REVENUE	147,402,804	145,253,888	(2,148,916)	2%
				***** OPERATING EXPENSE *****				
5,623,958	5,343,779	280,179	5%	SALARIES	61,818,818	58,226,313	3,592,505	6%
521,266	572,118	(50,853)	(9)%	S&W PTO	7,598,578	6,220,134	1,378,444	22%
1,414,107	1,445,059	(30,952)	(2)%	EMPLOYEE BENEFITS	15,363,977	16,437,172	(1,073,195)	(7)%
1,517,923	1,393,848	124,075	9%	PROFESSIONAL FEES	15,643,151	15,357,438	285,713	2%
866,199	824,586	41,613	5%	PURCHASED SERVICES	9,520,957	9,275,776	245,181	3%
2,543,509	1,969,781	573,728	29%	SUPPLIES & EXPENSES	22,985,873	21,720,091	1,265,782	6%
240,605	227,633	12,972	6%	MAINTENANCE & REPAIRS	2,656,016	2,677,185	(21,170)	(1)%
229,313	263,897	(34,584)	(13)%	UTILITIES	2,686,093	2,902,867	(216,774)	(8)%
45,873	11,255	34,618	308%	RENT/LEASE	361,214	146,993	214,221	146%
120,816	118,267	2,549	2%	INSURANCE	1,330,323	1,300,937	29,386	2%
974,833	930,102	44,731	5%	DEPRECIATION/AMORTIZATION	10,817,681	10,648,212	169,469	2%
379,092	300,197	78,895	26%	OTHER EXPENSE	3,410,207	3,501,502	(91,295)	(3)%
0	0	0	0%	IMPAIRED COSTS	0	0	0	0%
14,477,493	13,400,522	1,076,971	8%	TOTAL OPERATING EXPENSE	154,192,889	148,414,620	5,778,269	4%
751,214	(192,490)	(943,704)	(490)%	NET GAIN/(LOSS) FROM OPERATIONS	(6,790,085)	(3,160,732)	3,629,353	115%
226,495	116,558	(109,937)	94%	DISTRICT TAXES	1,392,075	1,282,138	(109,937)	9%
360,137	277,386	(82,751)	30%	INVESTMENTS INCOME	3,681,972	3,051,246	(630,726)	21%
49,084	43,282	(5,802)	13%	OTHER NON OPERATING INCOME	602,767	476,102	(126,665)	27%
(87,214)	(105,551)	(18,337)	(17)%	INTEREST EXPENSE	(984,260)	(1,081,743)	(97,484)	(9)%
(21,381)	(36,775)	(15,394)	(42)%	NON-OPERATING EXPENSE	(493,281)	(404,525)	88,756	22%
527,120	294,900	(232,220)	79%	TOTAL NON-OPERATING INCOME	4,199,274	3,323,218	(876,056)	26%
1,278,334	102,410	(1,175,924)	1,148%	GAIN/(LOSS) BEFORE NET INCR/(DECR) FV INVSMT	(2,590,811)	162,486	2,753,297	(1,695)%
483,232	0	(483,232)		NET INCR/(DECR) IN THE FAIR VALUE OF INVSTMT	3,869,743	0	(3,869,743)	
1,761,566	102,410	(1,659,156)	1,620%	NET GAIN/(LOSS)	1,278,932	162,486	(1,116,446)	687%

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
05/31/24

	CURRENT MONTH	YEAR TO DATE
Cash flows from operating activities:		
Operating Income/(Loss)	751,214	(6,790,085)
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation and amortization	974,833	10,817,681
Provision for bad debts	(1,626,536)	(5,964,450)
Change in assets and liabilities:		
Patient accounts receivable, net	1,581,430	10,201,464
Other receivables	5,248,575	(5,200,974)
Inventories	88,795	(79,641)
Prepaid expenses and deposits	(138,983)	(1,136,600)
Advance refunding of bonds payable, net	20,979	230,776
Accounts payable and accrued expenses	10,331	(1,862,005)
Deferred inflows - leases	(26,301)	(441,737)
Accrued payroll and related costs	499,937	215,162
Estimated third-party payor settlements	(325,000)	576,675
Self-insurance reserves	(36,786)	(463,523)
Total adjustments	6,271,274	6,892,828
Net cash provided by (used in) operating activities	7,022,488	102,743
Cash flows from noncapital financing activities:		
District tax revenues	226,495	1,392,075
Noncapital grants and contributions, net of other expenses	14,707	(53,496)
Net cash provided by (used in) noncapital financing activities	241,202	1,338,579
Cash flows from capital and related financing activities:		
Purchase of capital assets	(84,783)	(3,709,096)
Proceeds from lease receivable, net	25,340	431,775
Principal payments on debt borrowings	-	(3,880,000)
Interest payments	(2,173)	(1,682,414)
Net change in notes payable and lease liability	(97,771)	(1,239,797)
Net changes in assets limited as to use	(594,597)	(891,357)
Net cash provided by (used in) capital and related financing activities	(753,984)	(10,970,889)
Cash flows from investing activities:		
Net (purchase) or sale of investments	(184,521)	7,644,374
Investment income	360,137	3,681,972
Net cash provided by (used in) investing activities	175,616	11,326,346
Net increase (decrease) in cash and cash equivalents:	6,685,322	1,796,779
Cash and cash equivalents at beginning of month/year	9,469,940	14,358,483
Cash and cash equivalents at end of month	16,155,262	16,155,262

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
May 2024

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
Jun-23	10,589,289	5,045,026	15,634,315
Jul-23	9,542,222	1,209,276	10,751,498
Aug-23	11,411,456	2,278,509	13,689,964
Sep-23	11,153,141	297,374	11,450,515
Oct-23	10,806,912	1,614,798	12,421,710
Nov-23	11,048,937	5,395,178	16,444,115
Dec-23	9,261,593	1,749,227	11,010,820
Jan-24	12,040,509	3,417,973	15,458,481
Feb-24	10,531,309	1,474,392	12,005,701
Mar-24	11,275,398	3,178,205	14,453,603
Apr-24	13,314,378	6,920,700	20,235,078
May-24	**11,564,879**	**10,488,610**	**22,053,489**

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

May 2024 Summary of Other Activity:

785,555	Health Net HQAF8 IGT CY23
3,142,222	Anthem Blue Cross HQAF8 IGT CY23
2,963,076	Anthem Blue Cross Rate Range IGT CY22
846,043	State of CA HQAF8 Direct Grant CY23
2,073,076	Anthem Blue Cross QIP IGT CY22
94,086	Property Taxes
270,001	M-Care Cost Report Final Settlement FY21
314,551	Miscellaneous
10,488,610	05/24 Total Other Activity