SUBJECT: FAILURE OF NURSE CALL SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The nurse call system provides audible communication between patients and nursing staff for assistance in routine or emergency situations. Warning signs or indicators of failure include:

- Lack of audible communication
- Call lights not illuminated
- Lack of system response
- Inability to cancel audible or visual alarms

Reasons for nurse call system failure:

- Equipment malfunction
- Individual component failure
- Power supply failure in call system control panel
- Circuit breaker trip

PROCEDURE:

In the event of a malfunction and/or failure of the nurse call system, the following procedure will be followed:

Containment:

In the event of nurse call system failure, notify all affected areas.

- When notified by nursing of a failure in the nurse call system, instruct staff members to set up an alternative method of communication.
- Identify the cause of the failure and attempt to repair.

Resolution:

- If the nurse call system has been disabled and the problem is not remedied immediately, notify nurse call system vendor to dispatch immediate emergency service technician.
- Notify House Supervisor.
- Notify affected departments on estimated repair time.
- Notify affected departments when service has been restored.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and immediate steps taken to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Nurse Call System include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF BLOOD, BONE, AND TISSUE STORAGE SYSTEMS

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The electrical and alarm system provides utilities and detection services to refrigerators used in the storage of blood, bone, and tissue. The Blood Bank refrigerator should maintain a temperature of 2-6 degrees C. When the temperature rises above 6 degrees C, the alarm at the Blood Bank will sound. Warning signs or indicators of failure include:

- Audible alarms

- Visual observance

Reasons for systems failure:

- Mechanical malfunction
- Failure in electrical system

PROCEDURE:

Containment:

In the event of systems failure, notify all affected areas including:

- Laboratory Director
- Administrative Director of General Services or his designee
- Notify maintenance that there is a utility or equipment failure.
- Notify the Nursing Supervisor on duty.
- Identify the cause of failure and attempt to repair.

Resolution:

- If repairs cannot be completed by Biomed and Engineering Services Staff, call equipment repair Service Company.
- If repairs cannot be completed in a timely manner, the Laboratory Director will make arrangements for an alternate location for refrigerated storage.
- Notify Laboratory Director and Nursing Supervisor of estimated time system will be out of service.
- Notify affected departments when service has been restored.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.

- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Blood, Bone and Tissue Storage Systems include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF THE HVAC SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The HVAC system provides control of the desired temperature, humidity and air purity for the health, safety and comfort of patients and employees. Warning signs or indicators of failure include:

- Sudden drop or rise of temperatures in any area of the facility
- Audible alarms
- Inability to control humidity
- Loss of air balance (positive and negative airflow)

Reasons for HVAC system failure:

- Mechanical malfunction
- Failure in electrical system
- Extreme temperatures

PROCEDURE:

Containment:

In the event of systems failure, notify all affected areas including:

- Administrative Director of General Services

- Engineering Manager
- If repairs are beyond scope of the Engineering Services staff, call the appropriate vendor to request immediate dispatch of a service technician.

Resolution:

- The Engineering staff will determine the cause of the failure.
- The time for repair will be estimated and departments will be notified of period that the system will be out of service.
- In the event of a prolonged failure, the Engineering Department will coordinate with affected units to mitigate temperature extremes.
- Notify affected departments and House Supervisor when service is restored.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and take immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the HVAC system include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF MEDICAL AIR SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The medical air system provides medical air to patient care areas on nursing units, surgery, recovery, labor and delivery, special procedure rooms and the emergency department. Warning signs or indicators of failure include:

- Audible alarm
- Drop in pressure
- Call from user staff

Reasons for medical air system failure:

- Equipment malfunction
- Rupture of air lines
- Contamination of system
- Electrical failure

PROCEDURE:

In the event of medical air system failure, notify all affected areas.

Containment:

- Check compressors to ensure they are functioning properly.
- If one compressor has failed, switch valves and isolate the defective unit.
- Check filter to ensure they are not plugged.
- If the main supply line has ruptured, attempt to repair or request outside emergency assistance from our certified medical gas testing and repair vendor.
- If a total loss of medical air has occurred, notify the Respiratory Therapy Department, House Supervisor, and Administrative Director of General Services.
- The Director of Respiratory Services shall be responsible for ordering additional medical air supplies until the failure has been corrected and purity tests have been completed if necessary.

Resolution:

- If service cannot be restored by Maintenance Staff, call for assistance from our certified medical gas testing and repair vendor.
- Notify affected departments of estimated time system will be out of service.
- Nursing will monitor and support patients during the interim period. Assist with the relocation of patients if necessary.
- Notify affected departments and House Supervisor when service is restored.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Medical Air System include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF MEDICAL VACUUM SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The medical vacuum system provides medical vacuum to patient care areas on nursing units, surgery, recovery, labor and delivery, special procedure rooms and the emergency department. Warning signs or indicators of failure include:

- Audible alarm
- Drop in suction

- Call from user staff

Reasons for medical vacuum system failure:

- Equipment malfunction
- Rupture of vacuum lines
- Contamination of system
- Electrical failure

PROCEDURE:

In the event of medical vacuum system failure, notify all affected areas.

Containment:

- Check pumps to ensure they are functioning properly.
- If one pump has failed, switch valves and isolate the defective unit.
- If the main supply line has ruptured, attempt to repair or request outside emergency assistance from our certified medical gas testing and repair vendor.
- If a pump failure occurs to the vacuum system, notify the Administrative Director of General Services or designee and Administrator on Call.
- Deliver portable vacuum pumps to Special Care Units, Surgery and Medical/Surgical floors as needed.

Resolution:

- Notify affected departments as to the length of time required to make repairs for their planning purposes. If repairs are beyond the scope of the Maintenance Department, call for outside assistance from SVMC's certified medical gas testing and repair vendor.
- Notify affected departments and House Supervisor when service is restored.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.

- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Medical Vacuum System include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF MEDICAL GAS OXYGEN SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The medical gas piping systems provides oxygen to all parts of all inpatient and nursing units, labor and delivery, surgery and recovery, emergency area, radiology, and other clinical areas of the medical center. Warning signs or indicators of failure include:

- Audible alarm
- Drop in pressure
- Call from user staff

Reasons for medical gas oxygen system failure:

- Equipment malfunction
- Depletion of oxygen
- Rupture of oxygen line
- Shut-off of zone valve

PROCEDURE:

In the event of medical gas oxygen systems failure, notify all affected areas.

Containment:

- Notify Administrative Director of General Services or his designee.
- Identify the cause of the failure. Use extreme caution as the risks of combustion are much greater in an environment of pure oxygen. Avoid skin contact with liquid oxygen due to its extremely low temperature. No smoking.
- If both the oxygen supply and the reserve have been disabled and the problem is not remedied immediately, notify Respiratory Therapy Department to deliver portable cylinders to the critical care areas immediately.
- Ensure that the reserve supply is on line.
- Notify Nursing Services and request that it alert all affected areas.
- Call and request immediate emergency delivery of oxygen as needed.

Resolution:

- Make minor repairs and request outside assistance from SVMC's certified medical gas testing and repair vendor as required.
- If tests of the medical gas oxygen system are necessary, coordinate them with the Respiratory Therapy Department.
- Notify affected departments, House Supervisor, and Respiratory Therapy when medical gas oxygen system is back online.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the failure of the medical gas oxygen system include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF MEDICAL GAS NITROUS OXIDE SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The medical gas piping systems provides nitrous oxide to Labor and Delivery and Surgery. Warning signs or indicators of failure include:

- Audible alarm
- Drop in pressure
- Call from user staff

Reasons for medical gas nitrous oxide system failure:

- Equipment malfunction
- Depletion of nitrous oxide
- Rupture of nitrous oxide line
- Shut-off of zone valve

PROCEDURE:

In the event of medical gas nitrous oxide systems failure, notify all affected areas.

Containment:

- Notify Administrative Director of General Services or his designee.
- Identify the cause of the failure. Check the nitrous oxide bulk supply tank to be sure that the manifold valve and regulator are properly aligned and correct as necessary.
- Replace empty tanks as necessary.
- If the tanks are not empty and the alignment is correct, check for point of disruption in the system.
- If Engineering Services staff are unable to correct the problem, request outside assistance from our

certified medical gas testing and repair vendor.

- If the problem cannot be corrected immediately, notify the affected departments.

Resolution:

- Notify the House Supervisor.
- Call and request immediate emergency delivery of nitrous oxide.
- If tests of the medical gas nitrous oxide system are necessary, coordinate them with the Surgery Department.
- Notify affected departments, House Supervisor, and Surgery when medical gas nitrous oxide system is back on-line.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Medical Gas Nitrous Oxide System include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF NATURAL GAS SUPPLY SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The natural gas supply system provides natural gas to the central plant and the kitchen areas. Warning

signs or indicators of failure include:

- Drop in pressure
- Call from user staff

Reasons for natural gas supply system failure:

- Equipment malfunction
- Rupture of gas line
- Shut-off of valve

PROCEDURE:

In the event of natural gas supply system failure, notify all affected areas.

Containment:

- Notify Administrative Director of General Services or his designee immediately.
- Identify the cause of the failure. Use extreme caution as the risks of combustion are much greater in an environment of natural gas.
- If the natural gas supply has been disabled and the problem is not remedied immediately, notify the gas company to dispatch immediate emergency service technician.
- Notify Dietary Services, House Supervisor, Laboratory, and Administration.

Resolution:

- Make minor repairs and request outside assistance as required.
- Notify affected departments, House Supervisor, Laboratory, Dietary and Administration when service is restored.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and taken immediate steps to eliminate.

- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Natural Gas Supply System include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF BOILER SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The boiler equipment generates hot water and heating water. Warning signs or indicators of failure include:

- Loss of hot water
- Pressure gauge readings
- Call from user staff

Reasons for boiler steam system failure:

- Equipment malfunction
- Disruption of supply lines (water or fuel)

PROCEDURE:

In the event of boiler system failure of all boilers at the same time, notify all affected areas.

Containment:

- Notify Administrative Director of General Services or his designee immediately.
- Check operation of fuel supply valves.

- Check boiler control panel.
- Check boiler water level.
- If boiler is functioning properly but water is not being supplied to end user, check circulating loop distribution system or valve closure for restriction and end user's equipment.
- If boiler system is estimated to be out of service during critical time frame of departmental activities, notify Administration, Surgery, Nursing, Housekeeping and Dietary Services.

Resolution:

- Attempt to repair or request outside emergency assistance from boiler service contractor.
- Notify affected departments and House Supervisor when service is restored.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and take immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Boiler Steam System include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF WATER DISTRIBUTION SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The water distribution system serves all areas of the medical center. Warning signs or indicators of failure include:

- Decreased water pressure or flow at the delivery points

- Pressure gauge readings
- Call from user staff
- Change of color, odor, taste, and texture

Reasons for water distribution system failure:

- Disruption or breakage of main water line into medical center
- Contamination of outside water supply

PROCEDURE:

In the event of water distribution system failure, notify all affected areas.

Containment:

If breakage or disruption of main water line into medical center:

- Begin distribution of reserve water supplies
- Notify Administration that the reserve water supply is in use and that water rationing must be placed into effect
- Get estimate of length of time medical center will be without water from water company
- Secure boilers and follow procedures under "Failure of Boiler System"

If the breakage or disruption of water line is inside the building:

- Isolate and locate the point of breakage or disruption
- Notify all affected areas of disruption and estimated time of disruption
- Make necessary repairs or call for emergency assistance from outside plumbing contractor
- Notify affected areas upon restoration of service

If the water supply has been contaminated:

- Turn off the main domestic entry water valve
- Instruct all personnel and visitors through the Communications Department public address system not

to drink the water or flush toilets

- Contact Administration or the House Supervisor to notify the Department of Health immediately about the water supply contamination

Resolution:

- Request delivery of additional potable water in accordance with the outside vendor's agreement
- Under guidance of Department of Health and Water Company, sanitize water lines
- Notify all affected areas upon completion of sanitizing and approval from Department of Health
- Notify the City of Porterville Public Works (559) 782-7518.

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and take immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Water Distribution System include:

- Maintenance Engineers on all shifts

SUBJECT: FAILURE OF PLUMBING SYSTEM

Utility system operational plans are written to help assure reliability, control risk, reduce failures, and train users and operators of the systems.

POLICY:

The plumbing system serves all areas of the medical center. Warning signs or indicators of failure include:

- Overflowing of toilets
- Slow drainage in sinks
- Call from user staff
- Back-up in sinks and floor drains

Reasons for water distribution system failure:

- Blockage of the main sewer line
- Blockage of internal waste lines and mains
- Failure of sewage ejectors or sump pumps
- Breakage of internal sewer line

PROCEDURE:

In the event of plumbing system failure, notify all affected areas.

Containment:

In the event of failure of the external sewer main line:

- If failure is significant, notify Department of Public Health
- Limit available bathrooms for public and staff to compensate for flow of waste water in affected areas
- Post restriction signs or lock bathrooms as necessary
- Instruct Housekeeping Services to place red plastic liners in available bathrooms
- If failure results in flooding, Housekeeping Services will remove water with wet vacuums
- If major flooding caused by storm drain overflow, request emergency pumping by the City of Porterville

If the breakage or disruption of water line is inside the building:

- Notify affected areas by public address system or, if isolated area of failure, by telephone
- Isolate and locate the point of breakage or disruption

- Make necessary repairs or call for emergency assistance from outside plumbing contractor

Resolution:

- Limit available bathrooms for public and staff to compensate for flow of waste water in affected areas
- Post restriction signs or lock bathrooms as necessary
- Instruct Housekeeping Services to place red plastic liners in available bathrooms
- If failure results in flooding, Housekeeping Services will remove water with wet vacuums
- Notify affected areas upon restoration of service

Evaluation:

- Record incident on the Utility Disruption Form.
- Determine cause of failure and take immediate steps to eliminate.
- Revise as necessary any policies, procedures, inspections, tests, or changes in preventive maintenance to systems.
- Provide additional training as needed.

Employee Training:

Employees who require specific and/or specialized training in responding to, containing, and resolving the Failure of the Plumbing System include:

- Maintenance Engineers on all shifts

AFFECTED PERSONNEL/AREAS:

GOVERNING BOARD, MEDICAL STAFF, ALL HOSPITAL EMPLOYEES, VOLUNTEERS, VENDORS

REFERENCES:

- The Joint Commission (2023). Hospital Accreditation Standards. EC.02.05.01. EP10. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **WORKPLACE VIOLENCE PREVENTION PLAN**	SECTION: ***Security Management*** **Page 1 of 15**

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

PURPOSE:

Violence is occurring all throughout the world and over time has filtered into the workplace. Overall, violent assaults remain fairly rare, although healthcare workers may be at higher risk for attacks compared to other professions. With this in mind, Sierra View Medical Center (SVMC) is committed to providing a work environment that is safe, and every effort is made to reduce or eliminate threats or acts of workplace violence.

In late 2016, the Cal/OSHA Standards Board adopted SB 1299, a new health care workplace violence prevention regulation. The first phase of the regulation went into effect on April 1, 2017 related to reporting requirements and recordkeeping, followed by the final phase that became fully effective April 1, 2018. The Workplace Violence Prevention Plan, assessments of the workplace, hazards identified, corrective measures put into place, and staff training was implemented by the 2018 due date.

The Workplace Violence Prevention Plan (WVPP) is part of the organization's Injury and Illness Prevention Plan (IIPP). The WVPP is in effect at all times in every unit (including Outpatient areas), services and operations.

Key Elements of the WVPP include:

1. Identifying management positions with the responsibility for administering the WVPP
2. Coordination with other employers of employees (contractors, registries, vendors) regularly working at SVMC
3. Identifying and evaluating safety and security risks
4. Investigating acts of violence/violent incidents
5. Hazards corrections/mitigations
6. Communication plan with employees and others
7. Designing, coordinating and implementing the training
8. Incident reporting by employees, contracted labor, registries, and regularly on-site vendors
9. Incident reporting to Cal/OSHA, Law Enforcement and the California Department of Public Health (CDPH)
10. Recordkeeping/Incident Log
11. Annual Program Review

A. DEFINITIONS:

1. Workplace Violence: Any act of violence, threat of violence or aggressive behavior that occurs in the work setting. The term workplace violence shall not include lawful acts of self-defense or defense of others. Workplace violence includes the following:

   a. The threat or use of physical force against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury;

   b. An incident involving the threat or use of a firearm or other dangerous weapon, including the use of common objects as weapons, regardless of whether the employee sustains an injury;

   c. Examples of violent acts may include, but are not limited to, assault, battery, beatings, stabbings, shooting, rape, psychological traumas, threatening or obscene phone calls, stalking, being sworn or shouted at, intimidation, or harassment of any kind

   d. Threat of violence means a statement or conduct that causes a person to fear for his or her safety because there is a reasonable possibility the person might be physically injured, and that serves no legitimate purpose.

2. Four workplace violence types:

   a. "Type 1 violence" means workplace violence committed by a person who has no legitimate business in the worksite, and includes violent acts by anyone who enters the workplace with the intent to commit a crime

   b. "Type 2 violence" means workplace violence directed at employees by customers, clients, patients, students, inmates, or any other for whom an organization provides services

   c. "Type 3 violence" means workplace violence against an employee by a present or former employee, supervisor, or manager

   d. "Type 4 violence" means workplace violence committed in the workplace by someone who does not work there, but has, or is known to have had, a personal relationship with an employee

3. Risk Factors:

   a. Environmental risk factors in the facility or area in which health care services or operations are conducted may contribute to the likelihood or severity of a Workplace Violence incident. Environmental risk factors include risk factors associated with the specific task being performed.

   b. Patient specific risk factors are specific to a patient that may increase the likelihood or severity of a Workplace Violence incident, such as the use of drugs or alcohol, psychiatric condition or diagnosis associated with increased violence, and condition or disease process that would cause confusion and/or disorientation, or history of violence.

4. Work Practice Controls: Procedures, rules and staffing that are used to effectively reduce Workplace Violence hazards. Work practice controls include, as applicable, but are not limited to:

   a. Appropriate staffing levels.

   b. Provisions of dedicated safety personnel (e.g., Security Officers).

   c. Employee training on Workplace Violence prevention methods.

   d. Employee training on procedures to follow in the event of a Workplace Violence incident.

POLICY:

B. **RESPONSIBILITIES**

1. The Safety Officer is responsible to initiate, implement, maintain and administer the WVPP. The Safety Officer may delegate duties, tasks and assignments via the Environmental Safety Committee.

2. The Director of Quality & Patient Safety or designee is responsible to initiate, implement, maintain and administer the IIPP.

3. Each Department Director/Manager/Supervisor and Employers (On-site Contractors/Vendors) of other employees is responsible for implementing, complying and supporting the WVPP.

4. Each employee and other employees (contractors/vendors) are responsible for

implementing, complying and supporting the WVPP.

C. **PLAN DEVELOPMENT**

1. WVPP development requires a multidisciplinary team approach, which includes Leadership and Management, along with employees and their representatives in developing, implementing, and reviewing the plan.

2. The development, implementation, and annual review of the plan will be coordinated through the Environmental Safety Committee in conjunction with active involvement of employees and their representatives.

D. **COMMUNICATION**

WVPP information and updates are communicated through the following means:

1. Annual WVPP evaluation and review

2. Annual training (type of training is dependent on the roles, departments and specific risks associated with the job duties or environment)

3. Department Specific Training (example: CPI Non-Violent Crisis Intervention)

4. E-Learning self-learning module

5. Department Staff Meetings

6. SVMC will document and communicate to other employees, employers and between shift and units, information that may increase the potential for Workplace Violence incidents.

Employees are encouraged to report safety concerns to the Safety Officer, Security, Risk Management, Employee Health and their Director, Manager or Supervisor.

Attempts will be made throughout the year to solicit active participation of employees and their representatives in the review, creation, design and implementation of the WVPP and all training materials and sessions. The following methods will be used to solicit active participation:

1. E-Learning modules

2. Training session debriefings

3. Staff meetings

E. **TRAINING**

All employees working in the facility, units, service lines, or operations shall be provided initial

training, that includes an online module in E-Learning which covers the types of Workplace Violence, personal safety and reporting, followed by annual refresher training on the WVPP.

Initial employee training will address the workplace violence risks that the employees are reasonably anticipated to encounter in their jobs, the workplace violence hazards identified in the facility, unit, service or operation, and the corrective measures SVMC has implemented. The initial training was provided when the Workplace Violence Prevention Plan was first established and when an employee is newly hired, assigned to perform duties for which required training was not previously required, and new or reassigned employees.

Initial training includes:

1. An explanation of the Workplace Violence Prevention Plan, including the hazard identification and evaluation procedures, general and personal safety measures implemented, how the employee may communicate concerns about workplace violence without fear of reprisal, how workplace violence incidents will be addressed, and how employees can participate in reviewing and revising the plan.

2. How to recognize potential violence, factors contributing to the escalation of violence and how to counteract them, and when and how to seek assistance to prevent or respond to violence.

3. Strategies to avoid physical harm.

4. How to recognize alerts, alarms, or other warnings about emergency conditions and how to use identified escape routes or locations for shelters, as applicable.

5. The role of private security personnel, if any.

6. How to report violent incidents to law enforcement.

7. Resources available to employees for coping with incidents of violence, including but not limited to, critical incident stress debriefing or employee assistance program.

8. An opportunity for interactive questions and answers with a person on knowledge about the Workplace Violence Prevention Plan.

In addition to District employees, WVPP training is required for:

- Contracted/Contingent Workforce
- On-Site Contractors that conduct regular business on SVMC property (i.e., On-Site Security, Renovo)
- Licensed Independent Professionals not employed by the District and volunteers are not required to be trained by Cal/OSHA, but are highly encouraged to be familiar with the WVPP

The level of training on WVPP depends on the workplace or job position risk level:

- Low risk: E-Learning self-learning module
- High risk: Non-violent crisis intervention training

Employees performing patient care contact activities in higher-risk areas (example: Emergency Department), and those employees' supervisors are required to attend annual formal Non-Violent Crisis Intervention training. Non-Violent Crisis Intervention training (CPI) is a focused training on de-escalation techniques as well as restrictive and non-restrictive interventions. The training reviews the topics included in the initial training and the results of the annual Workplace Violence Prevention Plan review and/or any review conducted due to new procedures or new information.

Employees assigned to respond to alarms or other notifications of violent incidents or whose assignments involve confronting or controlling persons exhibiting aggressive or violent behavior (i.e., Security Officers) shall be provided training prior to initial assignment and at least annually thereafter that will include.

1. General and personal safety measures.

2. Aggression and violence predicting factors.

3. The assault cycle.

4. Characteristics of aggressive and violent patients and victims.

5. Verbal interventions and de-escalation techniques and physical maneuvers to defuse and prevent violent behavior.

6. Strategies to prevent physical harm.

7. Appropriate and inappropriate use of restraining techniques in accordance with Title 22.

8. Appropriate and inappropriate use of medication as chemical restraints in accordance with Title 22.

9. An opportunity to practice the maneuvers and techniques included in the training with other employees, including a meeting to debrief the practice session. Problems found are corrected.

SVMC provides additional training when new equipment, work practices or hazards are introduced, or when a new, or previously unrecognized, workplace violence hazard has been identified.

F. RISK ASSESSMENTS

1. A risk assessment is required for all departments, units, service lines, (including outpatient areas), and services that include:

   - Environmental risk factors;
   - Community-based risk factors;
   - Operation area surrounding the facility such as employee parking areas and other outdoor surroundings;

2. Include a review of workplace violence incidents that have occurred in each facility, department, unit, operations, (including outpatient areas), and services within the previous year, whether or not an injury occurred;

3. Risk assessments will be conducted annually or whenever conditions change that could affect safety;

4. The risk assessment shall be used to identify locations and situations where violent incidents are more likely to occur;

5. Active engagement of employees and their representatives.

Patient-Specific Risk Factors:

Create procedures to identify and evaluate factors specific to patients that may increase the likelihood or severity of violence or the threat of violence (e.g. alcohol, psychiatric condition or diagnosis associated with increased risk of violence, any condition or disease process that would cause confusion and/or disorientation, or history of violence.

1. Procedures for paramedics/emergency medical services to communicate with receiving facility to identify risk factors associated with patients being transported to the receiving facility

2. Procedures for receiving facilities to communicate with law enforcement and paramedics/emergency medical services to identify risk factors associated with patients being transported to the receiving facility.

Risk factors must include, but not limited to:

1. Patient's mental status and condition that may cause the patient to be non-responsive to instruction or to behave unpredictably, disruptively, uncooperatively, or aggressively;

2. A patient's treatment and medication status, type, and dosage, as is known to the health facility and employees;

3. A patient's history of violence;

4. Any disruptive or threatening behavior displayed by the patient.

Visitors or Other Persons Who Are Not Employees

Create procedures to assess visitors or other persons who are not employees who display disruptive behavior or otherwise demonstrate a risk of committing workplace violence.

1. Policies outlining the circumstances under which a person will not be permitted to enter or remain in the facility. Hospital should train staff on what to do if such a person comes into the facility or becomes angry when asked to leave.

2. Develop criteria for discontinuing the flagging of a visitor for risk of violence potential if the risk is due to a temporary situation.

3. Develop process to credential and manage vendors.

4. Develop a plan to communicate the violence potential of a visitor to staff.

G. HAZARD CORRECTION

1. Engineering and work practice controls shall be used to eliminate or minimize employee exposure to the identified hazards to the extent feasible.

2. SVMC shall take measures to protect employees from imminent hazards immediately, and shall take measures to protect employees from identified serious hazards within seven business days of the discovery of the hazard.

3. When an identified corrective measure cannot be implemented within the seven business day timeframe, such as a project that requires OSHPD approval, SVMC shall take interim measures to abate the imminent or serious nature of the hazard while completing the permanent control measures.

4. Active engagement of employees and their representatives will be included in the hazard corrective measures whenever feasible. Employees will be informed of the results and corrective actions taken.

5. Examples of Hazard Corrections include, but are not limited to, the following:

   a. Emergency Department:

a. Electronic access control
b. Closed Circuit Television (CCTV) cameras
c. Security Officer Station – Posted 24 hours per day

b. Maternal Child Health Unit:

a. Electronic access control
b. Access Control System
c. CCTV
d. Department policy in place for identifying visitors
e. Department procedure for uniquely identifying mother-infants
f. Security Officer Station – Posted 24 hours per day

c. Pharmacy Department:

a. Electronic access control
b. CCTV

d. Human Resources department:

a. Access Control System
b. CCTV

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

PROCEDURE:

H. VIOLENT INCIDENT REPORTING (Internal and External to Cal/OSHA)

A. Internal reporting of workplace violence incidents may be accomplished by several means:

1. During normal business hours Monday – Friday, employees may contact Employee Health Services (EHS) by dialing ext. 6174 or visiting the EHS office. They may also contact the Environment of Care/Safety and Security Manager at ext. 6008.

2. After hours and weekends, incidents may be reported by using the electronic Incident Reporting System.

3. For serious incidents, such as a death or injury requiring hospitalization, the employees' supervisor, manager or director shall be contacted and that individual will immediately contact the administrator on-call and the Environment of Care/Safety and Security Manager or Safety Officer.

4. External reporting of workplace violence incidents to Cal/OSHA shall be completed for incidents involving any of the following:

   - The use of physical force against a hospital employee by a patient or a person accompanying a patient that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury.
   - An incident involving the use of a firearm or other dangerous weapon, regardless of whether the employee sustains an injury.
   - An incident involving the death of an employee, hospitalization greater than 24 hours, one or more days away from work (which includes the day of the incident), restricted work or transfer to another job, medical treatment beyond "First Aid", loss of consciousness, significant injury, or psychological trauma or stress as a result of the workplace violence incident.

5. Timeframes for reporting to Cal/OSHA:

   1) Shall be reported online to Cal/OSHA within 24 hours if the incident involves:

      a. A fatality or an injury that requires inpatient hospitalization for a period in excess of 24 hours.
      b. Any incidents involving a firearm, dangerous weapon, loss of limb, or serious degree of permanent disfigurement.
      c. An urgent or emergent threat to the welfare, health, or safety of hospital personnel (potential exposure to death or serious physical harm)

   2) Shall be reported online to Cal/OSHA within 72 hours if the incident involves:

      a. All other incidents not listed above in section 3.a. b. c.

      b. The hospital shall submit an initial report with all information available within the allotted timeframe. There are no obligations by Cal/OSHA for the hospital to update the report online if additional information is made available at a later date.

   3) Reports to Law Enforcement

      a. Within 72 hours of an incident, the employer must report acts of assault or battery against on-duty hospital personnel to the local law enforcement agency if the incident results in injury or

involves the use of a firearm or other dangerous weapon, even if there is no injury.

4) Reports to the California Department of Public Health (CDPH)

a. The death or significant injury of a staff member resulting from a physical assault that occurs within or on the grounds of a facility is an adverse event that must be reported to CDPH no later than five days after the adverse event has been detected. If the event is an ongoing urgent or emergent threat to the welfare, health or safety of patients, personnel or visitors, the report must be made not later than 24 hours after the adverse event has been detected.

6. Telephone reports to Cal/OSHA

The Cal/OSHA WVP regulations states that employers must continue to report immediately by telephone to the nearest District Office of the Division of Occupational Safety & Health any serious work-connected injury, illness or death as required by Title 8, California Code of Regulations, Section 342(a).

A. Local District Office:

Fresno District Office
2550 Mariposa St. Room 4000
Fresno, CA. 93721
Telephone: 559-445-5302

B. Cal/OSHA does not accept telephone reporting in place of the online reporting noted in 3.a.b. The telephone reporting is a separate requirement for incidents involving death or serious work-connected injury.

C. "Immediately" means as soon as practically possible, but no longer than 8 hours after the hospital knows of the death or serious injury. In extreme exigent circumstances, the timeframe for reporting to Cal/OSHA may be extended up to 24 hours maximum.

D. Information required when completing a telephone report:

1. Time and date of accident/event
2. Employer's name, address and telephone number
3. Name and job title of the person reporting the accident
4. Address of accident/event site
5. Name of person to contact at accident/event site
6. Name and address of injured employee(s)

KH

7. Nature of injuries
8. Location where injured employee(s) was/were taken for medical treatment
9. List and identity of other law enforcement agencies present at the accident/event site
10. Description of accident/event and whether the accident scene or instrumentality has been altered.

B. VIOLENT INCIDENT LOG/RECORD KEEPING

1. Records of workplace violence hazards identification, evaluation, and correction shall be created and maintained in accordance with Title 8, California Code of Regulations, Section 3203(b) & 5120(e)(1)(B).

2. Training records shall be created and maintained for a minimum of 1 year. Per Title 8, California Code of Regulations, Section 3203(b). The records must include details with date of training, contents or summary of the training sessions, names and qualifications of persons conducting the training, and the names and job titles of all the persons attending the training sessions. In addition, Title 22, California Code of Regulations, Section 70214 states that orientation and competency validation must be documented in the employee's file for the duration of their employment.

3. Violent Incident Logs must be maintained for a minimum of five years, per Title 8, California Code of Regulations, Section 3342(h)(3). The Violent Incident Logs shall include:

1) The date, time, specific location and department of the incident.

2) A detailed description of the incident.

3) A classification of who committed the violence, including whether the perpetrator was a patient/client/customer, family/friend of a patient/client/customer, stranger with criminal intent, coworker, supervisor/manager, partner/spouse, parent/relative, or other perpetrator.

4) A classification of circumstances at the time of the incident, including whether the employee was completing usual job duties, working in poorly lit areas, rushed, working during a low staffing level, in a high-crime area, isolated or alone, unable to get help or assistance, working in a community setting, working in an unfamiliar or new location, or other circumstances.

5) A classification of where the incident occurred, including whether it was in a patient or client room, emergency room or urgent care, hallway, waiting room, rest room or bathroom, parking lot or other area outside the building, personal residence, break room, cafeteria, or other area.

6) The type of incident, including whether it involved:

a. Physical attack, including biting, choking, grabbing, hair pulling, kicking, punching, slapping, pushing, pulling, scratching or spitting;

b. Attack with a weapon or object, including a knife, gun, or other object;
c. Threat of physical force or threat of the use of a weapon or other object;

d. Sexual assault or threat, including rape/attempted rape, physical display, or unwanted verbal/physical sexual contact;

e. Animal attack;

f. Other

7) Consequences of the incident, including:

a. Whether medical treatment was provided to the employee;

b. Who, if anyone, provided necessary assistance to conclude the incident;

c. Whether security was contacted and whether law enforcement was contacted;

d. Amount of lost time from work, if any; and

e. Actions taken to protect employees from continuing threat, if any.

8) Information about the person completing the Log, including the person's name, job title, phone number, email address, and the date completed.
4.

5. All records required by this subsection shall be made available upon request to the Chief of the Division of Occupational Safety and Health or his/her representative (Cal/OSHA Investigators) for examination and copying.

6. All records required by this section shall be made available to employees and their representatives, on request, for examination and copying (at no charge to the employee).

C. **VIOLENT INCIDENT INVESTIGATION**

A. A post-incident response and investigation shall be completed for any employee, contractor, or other individuals that are covered by the WVPP, and have been involved in an act of violence or threat of violence. Steps that shall be taken in the event of an incident of violence (include, but not limited to):

1. Provide immediate medical care or first aid to employees or covered individuals who have been injured in the incident;

2. Identify all employees involved in the incident.

3. Making available individual trauma counseling to all employees affected by the incident.

4. Reviewing any patient-specific risk factors and any risk reduction measure that were specified for that patient.

5. Reviewing whether appropriate corrective measures developed under the Workplace Violence Prevention Plan were – such as adequate staffing, provisions and use of alarms or other means of summoning assistance, and response by staff or law enforcement were effectively implemented.

7. Soliciting from the injured employee and other personnel involved in the incident their opinions regarding the cause of the incident, and whether any measure would have prevented the injury.

8. Conduct a post-incident debriefing as soon as possible after the incident with all employees, supervisors, and security involved in the incident.

9. Completion of the Workplace Violent Incident Report form.

4. The Security Department will conduct a Security Incident Report for any incidents that cause injury or have a high probability of causing injury, psychological trauma or stress.

5. All violent incidents will be reviewed through the Environmental Safety Committee and reported to Senior Leadership, and finally up to the Board of Directors (annually).

D. ANNUAL REVIEW OF THE WVPP

A. An annual review of the WVPP must be completed at the end of each fiscal year. The goal of the annual evaluation is to evaluate the effectiveness of the plan and any actions implemented throughout the plan year. The annual review of the WVPP shall include:

1. Staffing, including staffing patterns and patient classification systems that contribute to, or are insufficient to address, the risk of violence;

2. Sufficiency of security systems, including alarms, emergency response, and security personnel availability;

3. Job design, equipment, and facilities;

4. Security risk associated with specific units, areas of the facility with uncontrolled access, late-night or early morning shifts, and employee security in areas surrounding the facility such as employee parking areas and other outdoor areas;

5. Review of the Violent Incident Log.

6. Additional limited review may be required following new procedures, processes

or information. An updated review of the plan shall be completed whenever necessary, as follows:

- To reflect new or modified tasks and procedures, changes in staffing, engineering controls, construction or modifications of the facilities, evacuation procedures, alarm systems and emergency responses;
- To include newly recognized workplace violence hazards;
- To review and evaluate workplace violence incidents that result in a serious injury or fatality; or
- To review and respond to information indicating that the WVPP is deficient in any area.

REFERENCES:

- The Joint Commission (2023). Hospital accreditation standards. EC.02.01.01, EC.04.01.01, HR.01.05.03, LD.03.01.01 Joint Commission Resources. Oak Brook, IL.
- Cal/OSHA Workplace Violence Prevention in Healthcare (2019).
- Title 8, California Code of Regulations, Section 3203(b); 5120(e)(1)(B); 3342(h)(3). (2019) Retrieved from https://www.dir.ca.gov/samples/search/query.htm.
- Title 22, California Code of Regulations, Section 70214 (2019). Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.
- California Hospital Association. (January 2017). Healthcare Workplace Violence Prevention: How to comply with the Cal/OSHA regulations. Retrieved from https://www.calhospital.org/sites/main/files/file-attachments/workplaceviolenceprevention_preview_0.pdf.

CROSS REFERENCES:

- SECURITY MANAGEMENT PLAN
- INJURY AND ILLNESS PREVENTION PROGRAM

Date of Requisition_____ Admitting Physician_____

Patient Name_____ Patient Date of Birth_____

Pt Diagnosis_____

(Circle one) INPT or OBS (Circle one) Med/Surg Med/Tele Telemetry (ICU is not an option for DA)

Where will the pt. be waiting until admission_____

Contact name and number to call when bed is assigned_____

Most Recent Vital Signs: Time taken _____HR _____BP_____ Resp. rate_____

O2 Sat_____O2 Delivery Mechanism _____

NOTE** (if physician states patient is unstable then patient should be sent directly to the ED)

COVID Test Date/results_____ Isolation Y/N _____

Code Status_____ Advanced Directives in place Y/N_____

Mental Status _____Family Decisions Maker/Proxy identified_____

Decision makers contact info_____

Initial when completed below:

_____ Is the patient stable enough to wait for bed and travel to SVMC?

_____ Acuity of Patient is appropriate for SVMC as approved by Resident/Hospitalist/Charge Nurse/Nursing House Supervisor (Clinical and Specialty/Consult is available and can be provided by SVMC)

_____ Staffing on desired unit is available (Approved by Charge Nurse and/or Nursing House Supervisor)

_____ Resident/Hospitalist/Intensivist is aware and in agreeance (Validate Doc to Doc report has occurred)

_____Accepting Physician (if other than Community Physician)_____

_____Orders are written and with Registration (Y/N)

_____Specialty Consult needed, must be approved in same manner as Hospitalists and/or the Intensivists have done on previous page

_____Accepting Specialty Physician (if needed)_____

_____CM/SS Manager has been notified and provided a verbal report of the patient "clinical picture"

_____Utilization Management Director has been notified (skip this step if after hours)

_____If after hours, was AOC/House Supervisor notified (Y/N)

Bed Assigned: _____RN assigned to receive report/ext #_____

Date Bed Assigned_____ Time pt is expected to arrive_____

Date and Time Patient was Received by SVMC_____

Notes:

_____

_____

_____

_____

_____

_____

Form Completed By:

Initials	Printed Name
_____	_____
_____	_____
_____	_____
_____	_____

PATIENT'S LABEL

Date of Requisition_____ Transferring Facility _____

Transferring Facility Staff initiating transfer_____Ph#_____

Transferring Physician_____

Patient Name_____ Patient Date of Birth _____

Pt Original SV Account#_____ Pt Original admit date_____

Pt transfer out from SVMC date_____ Reason for original transfer from SVMC _____

_____

What was done at transfer facility to our patient _____

_____

Most Recent Vital Signs: Time taken _____HR _____BP_____ Resp rate_____

O2 Sat_____O2 Delivery Mechanism _____

COVID Test Date/results_____ Isolation?_____ GCS of: _____

Code Status_____ Advanced Directives in place Y/N _____

Family Decisions Maker/Proxy identified _____

Decision makers contact info _____

Initial when completed below:

_____ Is the patient stable for transfer?

_____ Acuity of Patient is appropriate for SVMC (Clinical and Specialty/Consult is available and can be provided by SVMC)

_____ Staffing on desired unit is available (Approved by Charge Nurse and/or Nursing Supervisor)

_____ Resident/Hospitalist/Intensivist is aware and in agreeance (ensure they see and read entire clinical picture from Medical Chart provided from transferring facility, and a Doc to Doc conversation has happened)

_____Accepting Physician _____

_____Orders are written and with Registration (Y/N)

_____Specialty Consult needed, must be approved in same manner as Hospitalists and/or the Intensivists have done on previous page

_____Accepting Specialty Physician_____

_____CM/SS Manager has been notified and provided a copy of the patient packet

_____Utilization Management Director has been notified

_____If after hours, was AOC notified (Y/N)

Bed Assigned: _____RN assigned to receive report/ext #_____

Date Bed Assigned_____ Date being transported to us_____ Time_____

Date and Time Patient was Received by SVMC_____

Notes:

_____

_____

_____

_____

_____

_____

Form Completed By:

Initials	Printed Name
_____	_____
_____	_____
_____	_____
_____	_____

Sierra View Medical Center is a service of the Sierra View Local Health Care District.

PATIENT'S LABEL

SIERRA VIEW MEDICAL CENTER

SVMC RECIPROCAL INTERFACILITY TRANSFER AGREEMENT

Transferring Facility:_____ Date of Transfer:_____

Referring Physician: _____ Phone: _____

Contact Person: _____ Phone:_____ Fax:_____

Patient Name:_____

Receiving Physician:_____ Phone: _____

1. This is to confirm that Sierra View Medical Center has received a request to accept the above patient as a transfer from your facility.
2. The transferring facility will provide a transfer summary, a copy of the appropriate portions of the medical record, diagnostic test results and all requested/appropriate diagnostic films to accompany the patient.
3. The transferring facility will not transfer the patient until the receiving physician has consented to accept the patient, a room assigned and the transfer has been cleared by Care Integration/Clinical Operations.
4. The transferring facility will ensure that the patient is medically stable and SVMC is aware of services required at the time of transfer.
5. Transferring facility and referring physician agrees to accept the patient in return transfer, upon reasonable notice to do so.
6. Please specify an alternate accepting physician with phone number if the referring physician is unavailable to accept the patient back

   _____.
7. Please specify transferring facility contact person if other than the original contact person:

   Name: _____ Phone Number: _____

Under no circumstances will Sierra View Medical Center assume financial responsibility for the cost of transferring or transporting any patient to or from Sierra View Medical Center.

_____ _____

Hospital Administrator or Designee Date/Time

_____ _____

Title Contact #

This is a binding agreement. Breach of this agreement may impact future transfers.

SIERRA VIEW MEDICAL CENTER

Porterville, California 93257

SVMC RECIPROCAL INTERFACILITY TRANSFER AGREEMENT

Form # 025140 REV 01/23

Sierra View Medical Center is a service of the Sierra View Local Health Care District.

PATIENT'S LABEL

150

Patient Name_____ Patient Date of Birth_____

Reason for transfer_____

Diagnosis_____Level of Care:_____Intubated Y/N_____

Most Recent Vital Signs: Time taken _____HR _____BP_____ Resp rate_____

O2 Sat_____O2 Delivery Mechanism _____

COVID Test Date/results_____ Isolation?_____ GCS of: _____

Code Status_____ Advanced Directives in place Y/N_____

Family Decisions Maker/Proxy identified_____

Decision makers contact info_____

Date of Requisition_____ Transferring Facility_____

Transferring Facility Staff initiating transfer_____Ph#_____

Transferring Physician_____

Transferring Patient's needs not provided at current facility:

_____

Initial when completed below:

_____ Is the patient stable for transfer? Ground or Air?_____

_____ Acuity of Patient is appropriate for SVMC (Clinical and Specialty/Consult is available and can be provided by SVMC)

_____ Staffing on desired unit is available (Approved by Charge Nurse and/or Nursing House Supervisor)

_____ Resident/Hospitalist/Intensivist is aware and in agreeance (ensure they see and read entire clinical picture from Medical Chart provided from transferring facility, and a Doc to Doc conversation has happened)

_____ Accepting Physician _____

PATIENT'S LABEL

Sierra View Medical Center is a service of the Sierra View Local Health Care District.

_____Specialty Consult needed, must be approved in same manner as Hospitalists and/or the Intensivists have done above

_____ Accepting Specialty Physician_____

_____ Orders are written and with Registration (Y/N)

_____ Financial department has patient Demographics and insurance coverage information and given financial clearance M-F 8-5. (this step is bypassed for Emergent cases)

_____ CM/SS Manager has been notified and provided a copy of the patient packet (this step is bypassed for Emergent cases)

_____ Utilization Management Director has been notified (this step is bypassed for Emergent cases)

_____ If after hours was AOC notified (Y/N)

_____ Transfer Back Agreement signed by transferring facility and received

Bed Assigned: _____RN assigned to receive report/ext #_____

Date Bed Assigned_____ Date being transported to us_____ Time_____

Date and Time Patient was Received by SVMC_____

Notes:

_____

_____

_____

_____

_____

Form Completed By:

Initials	Printed Name
_____	_____
_____	_____
_____	_____

PATIENT'S LABEL

Sierra View Medical Center is a service of the Sierra View Local Health Care District.

Patient Name_____ Patient Date of Birth_____

Reason for transfer_____

Diagnosis_____Level of Care:_____Intubated Y/N_____

Most Recent Vital Signs: Time taken _____HR _____BP_____ Resp rate_____

O2 Sat_____O2 Delivery Mechanism _____

COVID Test Date/results_____ Isolation?_____ GCS of: _____

Code Status_____ Advanced Directives in place Y/N_____

Family Decisions Maker/Proxy identified_____

Decision makers contact info_____

Date of Requisition_____ Transferring Facility_____

Transferring Facility Staff initiating transfer_____Ph#_____

Transferring Physician_____

Transferring Patient's needs not provided at current facility:

_____

Initial when completed below:

_____ Is the patient stable for transfer? Ground or Air?_____

_____ Acuity of Patient is appropriate for SVMC (Clinical and Specialty/Consult is available and can be provided by SVMC)

_____ Staffing on desired unit is available (Approved by Charge Nurse and/or Nursing House Supervisor)

_____ Resident/Hospitalist/Intensivist is aware and in agreeance (ensure they see and read entire clinical picture from Medical Chart provided from transferring facility, and a Doc to Doc conversation has happened)

_____ Accepting Physician _____

PATIENT'S LABEL

Sierra View Medical Center is a service of the Sierra View Local Health Care District.

_____Specialty Consult needed, must be approved in same manner as Hospitalists and/or the Intensivists have done above

_____ Accepting Specialty Physician_____

_____ Orders are written and with Registration (Y/N)

_____ Financial department has patient Demographics and insurance coverage information and given financial clearance M-F 8-5. (this step is bypassed for Emergent cases)

_____ CM/SS Manager has been notified and provided a copy of the patient packet (this step is bypassed for Emergent cases)

_____ Utilization Management Director has been notified (this step is bypassed for Emergent cases)

_____ If after hours was AOC notified (Y/N)

_____ Transfer Back Agreement signed by transferring facility and received

Bed Assigned: _____RN assigned to receive report/ext #_____

Date Bed Assigned_____ Date being transported to us_____ Time_____

Date and Time Patient was Received by SVMC_____

Notes:

_____

_____

_____

_____

_____

Form Completed By:

Initials	Printed Name
_____	_____
_____	_____
_____	_____

Sierra View Medical Center is a service of the Sierra View Local Health Care District.

PATIENT'S LABEL

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MEDICAL EXECUTIVE COMMITTEE	04/05/2023
BOARD OF DIRECTORS APPROVAL	
	04/25/2023
BINDUSAGAR REDDY, MD, CHAIRMAN	DATE

SIERRA VIEW MEDICAL CENTER
CONSENT AGENDA REPORT FOR
April 25, 2023 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 ↓
• 24 Hour Urine Collection	1-2	
• 1799 Holds in the Emergency Department	3-5	
• Authorizations for Volunteer Caregivers During Disasters	6-9	
• Central Venous Catheters, Care and Maintenance of	10-18	
• DNR Physician Order – Guidelines for Use	19-20	
• Dialysate Mixing	21-22	
• Employee Education Assistance	23-31	
• Fluid Restrictions	32-34	
• Guidelines for the Prevention and Control of Infectious Disease Transmission Related to Hospital Construction	35-38	
• Medication Administration	39-47	
• Medication Administration Times	48-52	
• Medication Allergies and Adverse Reactions	53-59	
• Medication Procurement, Storage, Distribution and Control	60-70	
• Medications Restricted to Areas or Personnel	71-76	
• Non-Sterile Compounding	77-80	
• Patient's Own Medications	81-85	
• Pharmacy and Therapeutics Committee	86-87	
• Positive Expiratory Pressure (PEP) Therapy	88-90	
• Storage of Flammable Materials	91	
• Therapeutic Drug Substitution Protocol	92-101	
• Thrombolysis with TNKase for Acute Myocardial Infarction	102-110	
• Transfer of Patient to Higher Level of Care for Neurological Services	111-112	
• Transfusion Reaction Procedure	113-119	
• Treatment of Pediatric Patient with Shortness of Breath	120-122	
• Vancomycin Protocol per Clinical Pharmacist	123-127	
• Vascular Access Device – Blood Draw	128-130	
• Vascular Access Device – Bolus Injections	131-132	
II. Forms		
• Community Physician Direct Admit to SVMC Checklist	133-134	
• Repatriation Back to SVMC Checklist	135-136	
• SVMC Reciprocal Interfacility Transfer Agreement	137	
• Transfer Into SVMC Checklist	138-139	

SUBJECT: **24 HOUR URINE COLLECTION**	SECTION:

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

POLICY:

A complete and accurate urine collection will be done to ensure proper evaluation of tests on a 24 hour urine sample.

AFFECTED AREAS/PERSONNEL: *LABORATORY STAFF, NURSING, PHYSICIANS*

PROCEDURE:

- Have patient empty bladder first thing in the morning and discard this specimen, note time and date.
- After the first morning specimen is discarded, collect all urine passed during the next 24 hour period in a clean container.
- The final collection is when the patient empties his or her bladder the next morning at the same hour. Note time and date.
- Keep the collected urine refrigerated, or on ice, and send to the laboratory as soon as possible after the 24 hour collection is complete.

NOTES:

- Twenty four hour urine tests should be ordered in the computer.
- Urine containers for the collection of 24 hours specimens may be obtained from the laboratory.
- If 24 hour urine collections are to be made, they should be made before administration of dyes for intravenous pyelograms (IVPs) and other X-ray contrasts.

24 HOUR URINE COLLECTION GUIDE #11008

TEST	**COLLECTION INSTRUCTIONS**	
FOOTNOTE	**START**	**AFTER**
1. Calcium	None	None
2. Catecholamines, Frac.	None	Freeze
3. Citric Acid	None	Freeze 5 ml aliquot
4. Creatinine	None	None
5. Hydroxycorticosteroids,17	None	Freeze
6. Hydroxyindoleacetic Acid,5 (5-HIAA)	None	Freeze
7. Ketosteroids,17	None	Freeze
8. Magnesium	None	Freeze

9. Metanephrines	None	Freeze
10. Oxalate	None	Freeze
11. Phosphorus	None	Freeze
12. Potassium	None	None
13. Protein	None	None
14. Sodium	None	None
15. Uric Acid	None	None
16. Vanillylmandelic Acid (VMA)	None	Freeze

REFERENCES:

- Siemens CA document number 11110115_01_CA_ACH_EN
- Quest Diagnostics.com, Test Menu, 2021
- Siemens CREA document number 11110159_08_Crea_2_ACH_EN
- Siemens MG document number 11110175_01_Mg_ACH_EN
- Siemens PHOS document number 11110174_02_IP_ACH_EN
- Siemens A-Lyte Integrated Multisensor document number 11109447_01_IMT_NaKCl_ACH_EN
- Siemens UCFP document number 11111705_01_UCFP_ACH_EN
- Siemens URCA document number 11110187_01_URCA_ACH_EN

SUBJECT: **1799 HOLDS IN THE EMERGENCY DEPARTMENT**	SECTION: ***[Enter manual section here]*** **Page 1 of 3**

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

PURPOSE:

To define what a CA Health & Safety Code Section 1799.111(1799) hold is how to apply one in the emergency room, and how to determine if a patient meets criteria.

DEFINITIONS:

A 1799 can be used in a licensed general acute care hospital (within the Emergency Department only), as defined in a *subdivision of 1250. A physician of this facility shall not be held civilly or criminally liable* for detaining a person if all of the following conditions exist during the detention:

1. The person cannot be safely discharged from the hospital because, in the opinion of the treating physician and surgeon, or a clinical psychologist with the medical staff privileges, clinical privileges, or professional responsibilities provided in Section 1316.5, the person, as a result of a mental disorder, presents a danger to himself or herself, or others, or is gravely disabled. For purposes of this paragraph, "gravely disabled" means an inability to provide for his or her basic personal needs for food, clothing, or shelter.

2. The hospital staff, treating physician and surgeon, or appropriate licensed mental health professional, have made, and documented, repeated unsuccessful efforts to find appropriate mental health treatment for the person.

    a. Telephone calls or other contacts required pursuant to this paragraph shall commence as the earliest possible time when the treating physician and surgeon has determined the time at which the person will be medically stable for transfer.

3. The person is not detained beyond 24 hours.

4. There is probable cause for the detention.

    a. If the person is detained pursuant to subdivision beyond eight hours, but less than 24 hours, both of the following conditions shall be met:

        - A discharge or transfer for appropriate evaluation or treatment for the person has been delayed because of the need for continuous and ongoing care, observation, or treatment that the hospital is providing.

        - In the opinion of the treating physician and surgeon, or a clinical psychologist with medical staff privileges or professional responsibilities provided for in Section 1316.5, the person, as a result of a mental disorder, is still a danger to himself or herself, or others, or is gravely disabled, as defined in paragraph 1.

- In addition to the immunities set forth in subdivision (a), a licensed general acute care hospital, as defined in subdivision (a) of Section 1250 that is not a county-designated facility pursuant to Section 5150 of the Welfare and Institutions Code, licensed professional staff of those hospitals, or any physician and surgeon, providing emergency medical services in any department of those hospitals to a person at the hospital shall not be civilly or criminally liable for the actions of a person detained up to 24 hours in those hospitals who is subject to detention pursuant to subdivision (a) after that person's release from the detention at the hospital, if all of the following conditions exist during the detention:

    - The person has not been admitted to a licensed general acute care hospital or a licensed acute psychiatric hospital for evaluation and treatment pursuant to Section 5150 of the Welfare and Institutions Code.

    - The release from the licensed general acute care hospital or the licensed acute psychiatric hospital is authorized by a physician and surgeon or a clinical psychologist with the medical staff privileges or professional responsibilities provided for in Section 1316.5, who determines, based on a face to face examination of the person detained, that the person does not present a danger to himself /herself or others and is not gravely disabled, as defined in paragraph (1) of subdivision (a). In order for this paragraph to apply to a clinical psychologist, the clinical psychologist shall have a collaborative treatment relationship with the physician and surgeon. The clinical psychologist may authorize the release of the person from the detention, but only after he or she has consulted with the physician and surgeon. In the event of a clinical or professional disagreement regarding the release of a person subject to the detention, the detention shall be maintained unless the hospital's medical director overrules the decision of the physician and surgeon opposing the release. Both the physician and surgeon and clinical psychologist shall enter their findings, concerns, or objections in the person's medical record.

b. Nothing in this section shall affect the responsibility of a general acute care hospital or an acute psychiatric hospital to comply with all state laws and regulations pertaining to the use of seclusion and restraint and psychiatric medication for psychiatric patients. Persons detained under this section shall retain their legal rights regarding consent for medical treatment.

c. A person detained under this section shall be credited for the time detained, up to 24 hours, in the event he or she is placed on a subsequent 72 hour hold pursuant to Section 5150 of the Welfare and Institutions Code.

d. The amendments to this section made by the act adding this subdivision shall not be construed to limit any existing duties for psychotherapist contained in Section 43.92 of the Civil Code.

e. Nothing in this section is intended to expand the scope of licensure of clinical psychologists.

POLICY:

When a patient presents as meeting criteria for a 5150 hold (danger to self, danger to others, or gravely disabled, due to a mental illness) a 1799 shall be ordered and a psychiatric evaluation is to be completed by Tulare County CRISIS team, to evaluate for criteria. The 1799 allows a patient to be held for up to 24 hours to ensure their immediate safety while the evaluation can be completed.

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

PROCEDURE:

If a patient presents to the emergency room and appears to meet the above criteria (danger to self, danger to others, or gravely disabled) by means of a mental disorder, the physician shall place that patient on a 1799 hold. To place a patient on a 1799 hold, MD shall go into the ED order section of Meditech and select "1799 hold." This will time and date stamp the time of the hold. The Tulare County CRISIS team is to be called at the time the patient is medically clear and ready for discharge.

For patients presenting as suicidal, suicide precautions shall be initiated and the "Suicidal Patient Assessment & Management" policy shall be followed. If at any time the patients attempts to leave, SVMC staff will not impede their movement, unless they are an imminent danger to themselves or others or do not have the capacity to understand the risks and benefits of leaving placing them in harm's way. If the patient elopes, a code greed is to be initiated and documented.

REFERENCES:

- Welfare and Institutions Code 5150; 5152; CA Health & Safety Code Section 1799.111
- The Joint Commission. (2023). Comprehensive Accreditation Manual. (NPSG 15.01.01) Oakbrook Terrace, IL.

CROSS REFERENCES:

- Suicidal Patient Assessment and Management Policy
- Code Green Policy – Missing patient or Resident

SUBJECT: **AUTHORIZATION FOR VOLUNTEER CAREGIVERS DURING DISASTERS**	SECTION: ***Response and Assignment of Personnel*** **Page 1 of 4**

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

PURPOSE:

To establish guidelines for authorization of volunteer caregivers during disasters.

POLICY:

Upon activation of the Disaster Plan, the Incident Commander is empowered to authorize the use of volunteer caregivers to assist hospital staff in the event that the organization is unable to fully meet immediate patient needs without such volunteers. Such authorization may be given on a case-by-case basis.

Occupations considered volunteer caregivers are listed below. Occupations that fall under Licensed Independent Practitioner (LIP) and Allied Health Professional (AHP) are covered under the Medical Staff Bylaws Article 5.6 covering disaster privileges.

LIP	AHP
Physician (MD or DO)	Nurse Practitioner/Physician Asst.
Dentist	Certified RN Anesthetist
Psychologist	Certified Nurse Midwife
Podiatrist	

Clinical staff in these specialties:

- Lab sciences
- Pharmacy
- Imaging and diagnostics
- Dietitian
- Rehab services
- Behavioral health services

Volunteer Caregivers:

- Registered Nurse

- LVN
- CNA

PROCEDURE:

Once the volunteer caregiver has been authorized to assist, he/she will be under the direct supervision of the department manager or his/her designee to whom the volunteer caregiver has been assigned. The department manager or his/her designee must oversee the "just in time orientation" and professional performance of the volunteer care-giver who has been assigned disaster responsibilities through direct observation, mentoring, and/or clinical record review. Based on situation and need, consider assigning volunteer physicians in a "buddy" situation until competency is clearly evaluated. When possible, utilize volunteers in a secondary triage, and handling family of injured patients, phone advice and other useful, but low risk, assignments.

At a minimum, volunteer caregivers must present a valid government-issued photo identification issued by the state or federal agency (example, a driver's license or passport) and at least one of the following:

- A current hospital picture identification card that clearly identifies professional designation.
- A current license, certification, or registration.
- Primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession).
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) or other recognized state or federal emergency response organizations or groups.
- Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).
- Identification by current organization member(s) who possesses personal knowledge regarding the volunteer practitioner's qualifications.

The Human Resources and/or the Medical Staff departments will begin the verification process within 72 hours from the time the volunteer caregiver presents him/herself to the organization and has been authorized to provide care by the incident commander or designee. In the extraordinary circumstances that primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession) cannot be completed within 72 hours (e.g. no means of communication or lack of resources), it is expected to be completed as soon as possible.
The following must be documented:

- Why primary source verification could not be performed in the required time frame.
- Evidence of a demonstrated ability to continue to provide adequate care, treatment, and services.
- An attempt to rectify the situation as soon as possible.

The hospital makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours from the start of the assignment of the volunteer caregiver if the services of the volunteer caregiver are still needed.

Authorized volunteer caregivers will be provided with an identification badge indicating their name, professional degree, and specialty. The volunteer caregiver's assignment and authorization to provide patient care will be automatically terminated when the incident commander determines the hospital's emergency plan is no longer in effect or when the immediate needs of the patients can be met by the hospital without the volunteer caregiver's assistance.

Sierra View Medical Center Temporary Disaster Privileges Application			
Name of Non-physician Practitioner:			
Name of Agency Represented ☐DMAT ☐MRC ☐ESAR-VHP ☐Other			
Credential	**Photocopy Obtained**	**Verified Date/Time Verified By**	**Comment**
License			
Hospital Photo ID identifying professional designation			
Identification indication authorization to render patient care, treatment, and services in disaster circumstances.			
Identification by current organization member(s) who possesses personal knowledge regarding			

volunteer's qualifications.			
Name of hospital where practitioner actively practices:			
Other Information		**Completed**	**Comment**
Current CPR certification			
Verification/Approval Signatures and Dates			
Human Resource/Medical Staff Representative: **Date:**	**Incident Commander/ Designee:** **Date:**	**Comments:**	
Assignment:			
Acting Supervisor/Manager:			
Security Badge issued:			

DMAT: Disaster Medical Assistance Team

MRC: Medical Reserve Corps

ESAR-VHP: Emergency System for Advance Registration of Volunteer Health Professionals

REFERENCE:

- The Joint Commission (2023). Hospital accreditation standards. EM.12.02.03 Joint Commission Resources. Oak Brook, IL.

SUBJECT: **CENTRAL VENOUS CATHETERS, CARE AND MAINTENANCE OF**	SECTION: *Nursing Procedures (NR)* **Page 1 of 9**

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

PURPOSE:

To provide standardized guidelines for continuous and intermittent central venous therapy, to minimize the incidence of catheter-related complications and to provide guidelines for removal of central venous catheters.

POLICY:

1. Insertion of a central venous catheter requires signed informed consent.
2. The patient and, as appropriate, the family, will be educated on infection prevention strategies to help reduce central line-associated blood stream infection (CLABSI).
3. The Central Line Insertion Checklist must be completed on the Electronic Medical Record (EMR).
4. No central line is to be used until the catheter tip placement at the juncture of the right atrium and superior vena cava is verified by chest X-ray. **EXCEPTION**: *In an extreme emergency (i.e. code blue, trauma), a central line may be used without X-ray confirmation. However, free-flowing blood return must be present prior to use.*
5. If the physician places injection ports on the end of the central line upon insertion of a central venous catheter, the registered nurse (RN) will immediately replace ports with V-link (silver) valves.
6. Central venous catheters will be clamped at all times when not in use.
7. Flush unused lumens of the central line with 10 ml normal saline every 8 hours and before and after each use.
8. All central venous catheters will be dressed with a sterile, semi-permeable dressing. This dressing will be changed every 7 days or when damp, loose or soiled.
9. V-link valves will be changed every 7 days with sterile dressing change.
10. Central venous catheter V-link valves will be swabbed with an ***alcohol wipe*** and allowed to dry prior to accessing. Only a syringe is to be used for accessing valves. Do not use any device to pierce the valves (i.e. needle).
11. An infusion pump will be used on all central line infusions except in extreme emergencies.
12. Laboratory specimens may be drawn from central venous catheters unless a physician orders otherwise. *Exception: Blood cultures will be drawn from peripheral sites unless otherwise specified by the physician. If the line is used for TPN, stop TPN infusion, flush with 10 mL of normal saline and wait for 5 minutes; then specimen may be drawn.*

13. If a multilumen catheter is used to administer peripheral nutrition, designate one port for hyperalimentation, preferably the medial port. DO NOT use the designated hyperalimentation port for other purposes (e.g. administration of fluids, blood, or blood products.)

14. All central venous catheters established for the acute management of the patient may be removed by a registered nurse with a physician's orders. If any resistance is felt, the RN is to stop the procedure and notify the physician.

INDICATIONS FOR USE

- Fluids
- Blood Products
- Medications
- Dialysis
- Parenteral Nutrition
- Hemodynamic Monitoring
- Lack of Peripheral access
- Other

TRAINING AND COMPETENCY

NURSING

1. All RNs will be educated on central line management, including prevention of central line-associated bloodstream infections upon hire.

2. RN competency on central line management and infection prevention will be validated initially on hire and annually thereafter.

3. Nurses will be responsible for ensuring that the physician central line continuation orders are placed in the chart on a daily basis.

PHYSICIAN

1. Physicians will perform a daily evaluation of the need to continue a central line and document indications for continued use.

2. All physicians who are involved in central line insertion and management will complete a self-learning module on the prevention of central line-associated bloodstream infections initially.

3. Thereafter, education on the prevention of central line-associated bloodstream infections will be provided to physicians annually during medical staff meetings.

AFFECTED AREAS/PERSONNEL: *ALL NURSING UNITS*

PROCEDURE:

Flushing

1. Equipment
   a. Alcohol wipes
   b. Gloves
   c. Prefilled normal saline 10 mL syringe
2. Procedure
   a. Explain procedure to patient.
   b. Wash hands.
   c. Apply gloves.
   d. Cleanse V-Link valve with alcohol wipe. Allow to dry.
   e. Aspirate to verify patency of line before injecting recommended amount of flush solution. *No medication or solution should be infused unless a free-flowing blood return is obtained.*
   f. Flush each unused lumen with 10 mL normal saline
   g. After flushing the catheter, maintain positive pressure by keeping your thumb on the plunger of the syringe while clamping catheter. Remove syringe. This prevents blood backflow and potential clotting of the line.
   h. If the catheter does not flush freely or you meet resistance, change the patient's body position (i.e. raise arm on side of catheter insertion, etc.). If you are still unable to flush the line, notify the physician.
3. Documentation
   a. Chart time of the central line flush and line patency on the MAR. Prior to flush, aspirate for free-flowing blood return. Flush all unused lumens every 8 hours and before and after each use. If multiple lumens are being flushed, indicate line and amount of flush.

Example: 0600

Patency checked
Prox: 10 mL
Med 10 mL
Distal 10 mL
Sideport 5 mL

Dressing Changes:

1. Equipment
   a. Clear semi-permeable dressing
   b. Bio-patch
   c. Gauze, sterile
   d. Chlora-prep applicator 1
   e. Sterile gloves, non-sterile gloves
   f. Mask
2. Procedure
   a. Explain procedure to patient
   b. Assemble equipment
   c. Wash hands.
   d. Ask patient to turn head away from the insertion site or wear a mask
   e. Don gloves and mask
   f. Remove existing dressing and discard
   g. Assess insertion site
   h. Wash hands
   i. Prepare kit and/or supplies
   j. Put on sterile gloves

k. Clean insertion site with chlora-prep applicator in a side to side motion "scrubbing" for 30 seconds. Allow to air dry for 30 seconds

l. Apply Biopatch at catheter site

m. Apply clear semipermeable dressing. Care should be taken not to kink, pinch, or compress the catheter with the dressing

n. Loop the tubing and secure with tape

o. Label dressing with date, time and initials

p. Instruct patient that skin may turn orange temporarily

q. Discard used supplies in appropriate receptacle

r. Wash hands

3. Documentation

a. Record dressing change on nursing notes noting the date and time of the dressing change and a description of the catheter site and skin condition.

b. Document appearance of the insertion site every shift.

Injection Port Changes:

1. Equipment

a. V-Link (silver) valves

b. Gloves

c. Mask

d. Alcohol prep

e. Prefilled 10 mL normal saline syringes

2. Procedure

a. Explain procedure to patient

b. Assemble equipment

c. Wash hands

d. Don mask

e. Clamp the catheter

f. Ask patient to turn head away from insertion site or wear a mask

g. Remove old V-link valve and discard

h. Connect new V-link valve. Note: Remove air prior to flushing, either by flushing valve with normal saline prior to attaching or by aspirating air after attaching to the catheter

i. Flush each valve with a prefilled 10 mL normal saline syringe

j. Discard used supplies in appropriate receptacle

k. Wash hands

Blood Draws:

1. Equipment

   a. Non-sterile gloves

   b. Alcohol swabs

   c. Prefilled 5 mL normal saline syringe

   d. Prefilled 10 mL normal saline syringe

   e. 10 mL syringe for blood draw

   f. Specimen tubes

2. Procedure

   a. Wash hands

   b. Explain procedure to patient

   c. Apply gloves

   d. Cleanse V-link valve with alcohol wipe. Allow to dry.

   e. Flush with 5 mL normal saline

   f. Withdraw 5 mL blood and discard

g. Withdraw blood for specimens

h. Flush with 10 mL Normal Saline

i. Transfer blood into specimen tubes

j. Label specimen tubes with patient identification

SPECIAL CONSIDERATIONS FOR BLOOD BANK SPECIMENS

All blood specimens drawn from a **central line** for the purpose of blood bank testing will be obtained and labeled by an RN and/or physician in the presence of certified/licensed lab personnel or licensed personnel with each initialing the specimen labels and/or additional forms as required, and both confirming that the BBK# has been transcribed correctly from the patient's wrist band to the specimen label.

Removal:

NOTE: RNs may only remove non-tunneled central venous catheters

1. Equipment

   a. Goggles or face shield optional

   b. Mask

   c. Sterile and non-sterile gloves

   d. Chlora-prep applicator

   e. Suture removal kit

   f. Sterile 4 X 4 gauze pads

   g. 2 inch paper or foam tape

   h. Culture container optional if culturing tip

2. Procedure

   a. Wash hands

   b. Explain procedure to patient

   c. Apply personal protective equipment (non sterile gloves, goggles/face shield)

d. Place patient in supine or low semi-fowlers position

e. Don mask

f. Ask patient to turn head away from insertion site or wear a mask

g. Remove catheter dressing and discard

h. Cleanse site with chloraprep and allow to dry (30 seconds)

i. Apply sterile gloves

j. Cut sutures and remove

k. Instruct patient on Valsalva maneuver to decrease the risk of air embolism during removal. Instruct patient to take a deep breath and hold it, "bear down" for 10 seconds, then exhale. *NOTE: Valsalva maneuver is contraindicated in patients with increased intracranial pressure or if intubated.* If patient is on a ventilator, remove catheter at mid-exhalation.

l. Slowly remove catheter while patient is holding breath, bearing down, or exhaling and apply immediate pressure to exit site with a 4 X 4 gauze dressing, holding until hemostasis occurs. Apply pressure for 5 min and check for bleeding, if bleeding or oozing continues, apply pressure for another 5 minutes. Repeat until bleeding stops. If line is removed from a jugular site, apply gentle pressure.

m. Apply occlusive dressing. Dressing should be left in place for 24 hours.

n. Keep patient in supine position for 30 minutes, monitoring every 15 minutes for bleeding.

o. Following removal of a femoral line, the patient must be monitored for 60 minutes. After 30 minutes, if there is no bleeding or oozing, patient may flex hip and ambulate.

p. Document the following:

- Date and time of catheter removal
- Site assessment
- Culture specimen sent (if appropriate)
- Ease of catheter removal
- Inspection of intact catheter
- Length of time pressure applied to obtain hemostasis

- Application of occlusive dressing
- Patient tolerance of the procedure
- Patient and family education
- Any unexpected outcomes and interventions

SPECIAL CONSIDERATIONS

Caution should be taken when removing lines in patients with coagulation disorders and/or patients on anticoagulation therapy. Prior to removal, coagulation labs and platelets should be checked to ensure normal levels. If labs are not within normal limits, the physician should be notified for further orders.

REFERENCES:

- Nettina, S. M. (2019). Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health. (11th ed).
- Wiegand, D. L. (2017). AACN Procedure Manual for High Acuity, Progressive, and Critical Care. Missouri: Elsevier, Inc. (7th ed).

SUBJECT: **DNR PHYSICIAN ORDER –GUIDELINES FOR USE**	SECTION: ***Patient Rights & Organizational Ethics (RI)*** **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 identifying "Code Status" on all patients if other than "Full Code".
- To respect the patient's right to self-determination of care and their wishes regarding their Code Status.

POLICY:

Upon admission, all patients admitted to Sierra View Medical Center (SVMC) are considered to be of "Full Code" status unless otherwise stated. Those patients identified as either "No Code" or "Limited Code" status will have their code status identified by the initiation and completion of the Code Status Order Form. For the purposes of this policy, the following definitions will apply:

Do Not Resuscitate (DNR): In the event of a cardiac, pulmonary or cardiopulmonary arrest, no automatic initiation of new medication, cardiopulmonary resuscitation (CPR), intubation, defibrillation, or other mechanical support will take place.

Limited Code: In the event of a cardiac, pulmonary or cardiopulmonary arrest, specific limitations should be taken per the request of the patient/family.

1. Specific Limitations:
   a. No Chest Compressions
   b. No Intubation
   c. No Electrical Defibrillation or Cardioversion
   d. No Medication Intervention
   e. No Enteral Tube Feedings
   f. Other (as indicated by the physician)
2. Treatment limitation may also induce orders to withdraw or discontinue measures as indicated on the Physician Order Sheet.

NOTE: The term DNR or No Code refers only to the suspension of the otherwise automatic initiation of Cardiopulmonary Resuscitation (CPR).

AFFECTED AREAS/PERSONNEL: *NURSING; MEDICAL STAFF*

PROCEDURE:

1. Any limitation of life-sustaining treatment must be identified on the Physician Code Status Order Form *(see ATTACHMENT A)*.

2. The status of the patient's Advance Directive is to be noted on the Code Status Order Form. This is to be done by Nursing.

PHYSICIAN RESPONSIBILITY

1. If other than FULL CODE STATUS is required, document in the progress notes, at the time of writing orders, the rationale for the order and the relevant discussions held with the patient and family.

2. Review and complete the Code Status Order

3. If a decision has been made to attempt resuscitation in the event of an arrest but to limit the resuscitative measures used (LIMITED CODE), this limitation should be specified on the order form and the rationale detailed in the progress notes.

4. The Code Status Order must be signed by the attending physician or within 24 hours. A telephone order will be taken by 2 RNs as per policy. Verbal orders are not valid.

To change a code status order, a new order must be entered.

NOTE: If the order is being renewed or changed in any way, a new order sheet must be completed with the current code status and a note made in the progress notes.

NURSING RESPONSIBILITY

1. The registered nurse will acknowledge the physician's order by acknowledging the order.

2. Make the appropriate changes in the Patient Care Plan.

REFERENCES:

- California Code of Regulations. Title XXII Section 70203 (2019). Retrieved from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

- The Joint Commission (2019). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

SUBJECT: **Dialysate Mixing**	SECTION: ***Renal Services*** **Page 1 of 2**

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

PURPOSE:

To ensure safe practices for mixing of dialysate for patient care use.

POLICY:

- Bicarbonate will be mixed if premixed solutions are not available.
- Manufacture guidelines will be followed

AFFECTED PERSONNEL/AREAS: *Renal Service staff*
EQUIPMENT:

- **Manufacture guidelines**
- **Dry Bicarbonate for Dialysis**
- **Mixing containers**
- **Phoenix meter**
- **Bicarbonate pH strips for testing**
- **Goggles/face shield**
- **Gloves**
- **Gown**

PROCEDURE:

Bicarbonate Concentrations:

1. Proper personal protective gear should be wore when mixing and handling any chemicals. This will include but is not limited to eye protections such as googles or face shield, gown, and gloves.
2. Water used to mix bicarbonate concentrations must meet the AAMI standards for quality of water
3. Manufacture instructions will be followed for concentration mixing.
4. Manufacture instructions will be kept on the unit during preparation to use for guidelines
5. Final mixed dialysate will be tested for pH and conductivity using appropriate test methods per manufacture instructions. If the pH and /or conductivity readings are not within range the concentration will be discarded and the process will be restarted with a new mixture.
6. The pH and conductivity of bicarbonate will be documented per individual container.
7. Bicarbonate mixture will be used within 24 hours. After 24 hours the mix will be discarded.
8. Containers used for mixing will be rinsed daily and stored inverted to drain overnight. Containers will also be disinfected weekly. A log of disinfection will be kept.

REFERENCES:

Water Quality Standard for Hemodialysis American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI) 13959:2014.

Quality of Dialysis Fluid for Hemodialysis and Related therapies, ANSI/AAMI/ISO 11663:2009.

Guidance for the Preparation and Quality Management of Fluids for Hemodialysis and Related Therapies ANSI/AAMI/ISO 23500:2011.

SUBJECT: **EMPLOYEE EDUCATION ASSISTANCE**	SECTION: **Page 1 of 9**

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

PURPOSE:

To define the process by which eligible employees may receive education assistance or reimbursement for tuition for approved academic programs or courses and to encourage employee self-development.

To provide employees with support for outside education and/or certification that will enhance competency within an employee's present Sierra View Medical Center (SVMC) position or offer growth toward a SVMC position to which an employee may transfer or progress in the future.

POLICY:

A. Sierra View Medical Center (SVMC) encourages the development of an educated, highly skilled workforce. Each fiscal year, funds will be budgeted for Education Assistance purposes. SVMC reserves the right of fund discretion.

B. Education Assistance should be considered as a privilege rather than a right of a staff member. If Educational Assistance is approved, it will be considered as an interest-free loan and will be forgiven when the staff member has met the required work time payback and/or other criteria as outlined in this policy.

C. Approved courses: Courses must be academic courses toward an undergraduate degree or higher level and not continuing education units (CEU), workshops, or general education classes.

D. Approved certifications are awarded by a national, professional organization. The certification awarded denotes that the participant possesses a minimum educational level, licensure and experience, plus additional knowledge, skills, or competencies.

DEFINITIONS:

1. Academic courses: Courses taught by education institutions for which credit may be given towards a degree, or approved certificate.

2. Professional certifications: Certifications address a professional body of knowledge, which typically has been defined in a scope and standards of practice. Professional certification is a voluntary process by which a non-governmental body grants time-limited recognition and use of a credential to individuals who have demonstrated that they have met predetermined and standardized criteria for required knowledge, skill, or competencies. The certification is available at a national level (i.e., it is not a state-based or system-based certification). Skill-based and technical certificates or provider cards such as Advanced Cardiac Life Support (ACLS), Basic Life Support (BLS), Pediatric Advanced Life Support (PALS), Neonatal Resuscitation Program (NRP), etc., do not meet this requirement.

AFFECTED AREAS/PERSONNEL: *ALL ELIGIBLE SVMC PERSONNEL*
(RESIDENTS: REFER TO YOUR SPECIFIC GME RESIDENCY POLICIES.)

PROCEDURE:

A. Academic Course Selection, Approved Schools & Professional Organizations

1. Education institutions approved for this program may include any accredited public or private secondary school, university, scientific or technical institute, vocational, correspondence, extension, or business school. Online programs offered by these institutions are also acceptable.

2. Correspondence courses given by an accredited school may be included.

3. Recognized professional organizations offering concentrated courses of instruction are acceptable. Conference or conventional activities are NOT included.

4. Employees receiving college credit by challenge exam for a course that would have been approved for tuition assistance may submit proof of credit and receive reimbursement for the challenge examination fee with the same limits as applied to regular course work.

5. Certifications must be attained from a professional certification program.

6. Courses and Certifications must meet one or more of the following criteria:

   a. Provide/demonstrate particular knowledge, skills, or competencies directly applicable to present position

   b. Prepare an individual for career advancement at SVMC

   c. Be a required part of a degree program which is directly applicable to present position or area of work

   d. Prepare an individual for another position within SVMC

B. Eligibility

1. All regularly scheduled full-time SVMC employees are eligible to apply for education assistance based on their course of study. Staff must have successfully (no corrective actions in file) completed a full year of active employment prior to applying to the employee education assistance program.

2. All regularly scheduled full-time SVMC employees are eligible to apply for education assistance (reimbursement) for a first-time (one time only) completion of a qualified professional certification. Staff must have successfully (no corrective actions in file) completed a full year of active employment prior to applying.

3. Employees must remain in full time status throughout the time taking courses and during the work payback period.

4. Employees will be disqualified from the Education Assistance Program and any monies paid in assistance by SVMC must be repaid by the employee if any of the following occur:

   a. Grade below "C" or "Fail" if "Pass/Fail" for any course work or a withdrawal from a course

   b. A grade of "incomplete" will be considered a "Fail" if not corrected within 60 days of the end of the course

   c. An overall rating below 2% of eligible points on their most recent work performance evaluation

   d. Is within the Disciplinary Action Process and has received a written warning or higher

   e. Any type of Personal Leave of Absence (PLOA) from SVMC during the school term

   f. Termination of employment prior to completion of the course work and/or prior to submitting grades and receipts

   g. Changes to less than full time employment status.
   h.

5. If the employee terminates employment and/or is disqualified from the Education Assistance Program for any reason, he/she will be required to repay the prorated amount of costs reimbursed based on the amount of time left in the work payback period as defined below in Section C.2.

6. SVMC has the right to select applicants based on the course of study and their tenure with SVMC. (See Education Assistance Programs available on page 7-8.)

7. SVMC Nursing School with Unitek: Per Diem and Full-Time employees are eligible for sponsorship after 6 months of hire, at the time of application ($10,000 per year, up to 3 years if attend all three years towards a BSN degree, OR, Per Diem and Full-Time employees after 6 months of hire, prior to submitting an application, of tuition reimbursement up to 3 years in the BSN program. Grades have to be consistently at the "C" level or better to receive sponsorship or tuition reimbursement. SVMC reserves the right to determine the number of sponsored and tuition reimbursement selected students for each cohort.

C. Application Process for Educational Assistance - Degree

1. Staff must apply for assistance and complete the *Education Assistance Application Form* available in Education Department.

2. Employees applying for the program must agree to a work payback period for SVMC for no less than 12 months for each year reimbursed but not more than 12 months after receiving reimbursement.

3. Applications will be accepted twice per year in the months of May and November.

4. Employees who terminate or are terminated from employment with SVMC for any reason before the required work payback time is completed will be required to repay the prorated amount of costs reimbursed based on the amount of time left in the payback period.

5. Employees who change employment status to less than full time before the required work payback time is completed will be required to repay a prorated amount of costs reimbursed based on the amount of time left in the payback period.

6. The *Contingent Repayment Authorization Form* must be signed by the employee at the time tuition reimbursement is distributed.

7. The Education Coordinator will forward copies of the *Contingent Repayment Authorization Form* as follows: one (1) copy to the employee; one (1) copy to the Education Department; one (1) copy to HR for the employee's personnel file; and one (1) copy for the employee's Department Director.

8. The *Employer Provided Educational Assistance Form* must be signed by the employee and Director upon application for Education Assistance. The Department Director is responsible for identifying the job-related or non-job-related areas. This form must be sent with the *Education Assistance Application Form* to the Education Department. Federal and Social Security taxes will be deducted from the reimbursed amount for those courses which are non-job related.

9. The *Education Assistance Application Form* must be completed and signed by the staff member's Department Director with a letter of recommendation and forwarded to the respective Vice President (VP) for signature before routing to the Education Assistance Committee for final approval and processing.

10. Applicants will be required to indicate their education goals.

11. The Director and respective VP have the right to deny requests from staff members with performance problems and/or attendance problems. (See B. Eligibility)

12. Requests for tuition reimbursement will be considered for any coursework completed within the last six months of the application deadlines.

13. SVMC School of Nursing with Unitek – prospective student must register with Unitek College. Options for selecting sponsorship or tuition reimbursement is part of the registration process. The SVMC Education Department has additional templates and documents for prospective students to use in the application process to SVMC.

D. Approval Process for Professional Certification Reimbursement:

1. Staff planning on sitting for national professional certification must submit a request for reimbursement and receive approval from their Director and the Selection Committee. If staff have already taken a certification exam, they will still be considered for reimbursement if they have taken the exam within 6 months from submitting for reimbursement.

2. Only one time/first time certification will be reimbursed. Certification renewal fees are not reimbursable.

3. The Director and respective Vice President have the right to deny requests from staff members with performance problems and/or attendance problems. (See B. Eligibility)

4. Employees requesting reimbursement for a professional certification must agree to a work payback period for SVMC for not less than twelve (12) months.

5. Employees who terminate or are terminated for any reason before the required work time is completed will be required to repay the prorated amount of costs reimbursed based on the amount of time left in the payback period.

6. Employees who change employment status to less than full time before the required work payback time is completed will be required to repay a prorated amount of costs reimbursed based on the amount of time left in the payback period.

7. The *Contingent Repayment Authorization* must be signed by the employee at the time tuition reimbursement is distributed.

8. The Education Coordinator will forward copies of this form as follows: one (1) copy to the employee; one (1) copy to the Education Department; one (1) copy to HR for the employee's personnel file; and one (1) copy for the employee's Department Director.

9. SVMC School of Nursing with Unitek – SVMC will use a grading rubric, documents submitted from the student, along with a personal interview in the decision-making process for sponsored and tuition reimbursement. Sponsored and Tuition Reimbursement programs required a 1:1 year of payback working at SVMC full-time after graduation. Failure to finish the program and graduate, will be a required payback of any financial assistance/support to SVMC

E. Department Director Responsibility

1. In determining whether to approve a request for tuition/certification reimbursement, Department Directors and Vice Presidents will consider the necessity of the "Job Enhancement", the priority of the position to be achieved, as well as the length of service of the staff member (minimum of 12 months) and their job performance and/or attendance.

2. A letter of recommendation for degree completion (not certification reimbursement) written by the Department Director must accompany the employee's application when forwarded to the respective VP or Employee Education Assistance Committee (EEAC) for review.

3. Department Directors will notify staff that has been denied eligibility due to these factors.

F. Employee Education Assistance Committee (EEAC)

1. The EEAC shall consist of the following members:

   a. Vice President of Finance

   b. Vice President Patient Care Services

   c. Vice President of Human Resources

   d. Director of Nursing Education

2. The EEAC will be responsible for reviewing all applications presented looking at the following factors:

   a. Completeness of application packet

   b. The nature and purpose of the course of study

   c. The benefits to be derived by the staff member and by the District

3. Only those applications with all required information will be considered.

4. The EEAC will make the decision for final approval prior to processing.

   The Education Department will notify the employee and the employee's Department Director of the EEAC's decision.

G. Reimbursement

1. At successful completion of their course of study, and after receiving approval from the EEAC, staff members must submit receipts for approved expenses to the Education Department for reimbursement.

NOTE: Employees will only receive reimbursement upon successful completion of the course or first time approved certification.

2. The Education Department will then ensure that reimbursement is based upon actual receipts that are attached to the original form and forwarded for processing.

3. Costs excluded from the program are:

   a. Insurance

   b. Seminars and conventions

   c. Institutions/programs not approved by the District

   d. Report preparation

   e. Supplies (i.e., pens, pencils, calculators, recording devices, notebooks, etc.)

   f. Uniforms

   g. Transportation/mileage

   h. Parking expense

   i. Meals and lodging

   j. Skill-based and technical certificates or certification tuition such as ACLS

4. After successful completion of EACH grading period with a course grade, or passing a "pass-fail" course, or completion of a recognized professional certification, the staff member will submit the transcript of the grades received or copy of the certification and receipts to the Education Department.

   a. Future reimbursement will not be made until this information is received

   b. Anything lower than a grade of "C", "Fail", or "Incomplete" will not be reimbursed

5. To be eligible for reimbursement, the receipt must be turned in within thirty (30) days after completion of the course, or it will not be paid.

6. The Education Department will submit a Check Request to the Accounting Department along with the required supporting documents to have a check issued as follows:

   a. If the courses or certification exam taken were job-related, so that there are no payroll deductions, separate checks will be sent to the employee's Department Director for distribution to the employee

   b. If the courses or certification exam taken were not job-related, or otherwise subject to payroll deductions, the reimbursement money will be included in the employee's bi-weekly payroll check

Note: All checks will be processed according to current Accounts Payable and Payroll Policies and Procedures.

H. Miscellaneous

1. Class attendance, completion of study assignments, and certification exam preparation will be accomplished outside of the staff member's regularly scheduled working hours.

2. It is expected that educational activities/preparation will not interfere with the staff member's work. However, exceptions will be decided on a case-by-case basis by the respective Department Director and VP.

3. Any unsatisfactory job performance or attendance issues during enrollment may result in termination of education assistance, as well as affecting the individual's employment status, as it would for employees who are not receiving educational assistance.

4. Employees will be reimbursed for up to 2 years maximum for an undergraduate degree and up to 2 years maximum for a graduate degree and higher. However, in the SVMC School of Nursing with Unitek, the sponsorship or tuition reimbursement is for up to 3-years.

I. Education Assistance Programs Available:

ANNUAL TUITION REIMBURSEMENT	
Career Goals	**All Eligible Employees**
Bachelors, Masters, Post Graduate Certificate, Doctorate	Up to $3,000/fiscal year. Last day of course determines which year reimbursement will apply (max 2-years) SVMC School of Nursing with Unitek – Sponsored program for up to 3-years of

	$10,000 or up to 3-years for Tuition Reimbursement program. Requires at least 6 months of FT or PD status prior to application to the program.

ANNUAL TUITION REIMBURSEMENT	
Career Goals	**All Eligible Employees**
Professional Certification which addresses a professional body of knowledge, defined in a scope and standards of practice.	Up to $500 x one (1) time reimbursement of certification exam fee – First time only!

NOTE: Annual reimbursement of costs are based on a fiscal year and divided into two 6-month periods beginning on July 1st and January 1st.

J. Terms and Conditions

1. It is naturally expected that staff members who have received education assistance will remain with SVMC and will apply their acquired skills and knowledge to improve SVMC's overall performance.

2. A staff member who voluntarily leaves SVMC's employment or who is terminated for cause prior to completing the course or who does not complete their course will be expected to repay monies per contractual provisions.

K. Disclaimer

1. Nothing in this program represents an assurance of continued employment with SVMC.

2. Employment is at the mutual consent of the employee and SVMC and is entirely at will. No one is authorized to modify this Program without the consent of the Board of Directors.

SUBJECT: **FLUID RESTRICTIONS**	SECTION: ***Provision of Care, Treatment & Services (PC)*** **Page 1 of 3**

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

PURPOSE:

To ensure that patients with a fluid restriction receive the appropriate amount of fluid to meet the physician's orders.

POLICY:

Patients/residents requiring fluid restrictions will receive a determined amount of fluid from Food and Nutrition Service (FNS) on the meal trays and a determined amount from the nursing staff each day.

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

PROCEDURE:

1. Nursing will notify FNS of patients/residents requiring fluid restrictions via the electronic medical record (EMR). Fluid restrictions shall be ordered under diet modifications within the diet order, which will include the total daily amount of fluid to be given. *For example: 2 gram low sodium diet, 2000 cc fluid restriction.*

2. FNS will limit fluid on trays as specified by the guideline listed below.

3. Nursing limits the total fluid as specified by the guideline listed below, with extra fluid allowed if intake fluid from the trays is refused.

4. Nursing staff will record the amount of fluids taken in the electronic medical record (EMR) per policy.

5. The following items will be considered as fluids:

    a. Hot and cold beverages
    b. Soups
    c. Ice cream and sherbet
    d. Fruit ices
    e. Gelatin
    f. Water, juice
    g. Milk, coffee, tea
    h. Mighty shakes, Ensure, Glucerna, etc.

6. The following items will NOT be considered as fluids

    a. Custard, pudding
    b. Hot cereal
    c. Sauces, gravy, au jus
    d. Jelly

7. Fluid restriction schedule for FNS and Nursing in a 24 hour period:

FLUIDS RESTRICTION	NURSING	FNS	B	L	D
500 cc or less	500 cc	Dry Tray	0	0	0
1000 cc	600 cc	Dry Tray	0	0	0
1200 cc	700 cc	500 cc	240	120	120
1500 cc	900 cc	600 cc	240	180	180
1800 cc	900 cc	900 cc	360	300	240
2000 cc	1000 cc	1000 cc	400	300	300

8. Fluid amounts for standard containers and foods:

   a. Water Pitcher *(plastic insert filled to bottom of indentation)* – 900 cc
   b. Tumbler - 240 cc
   c. Thermal Cup - 180 cc
   d. Soup Bowl - 180 cc
   e. Milk - 8 oz. or 1 cup - 240 cc / 4 oz. or ½ cup –120 cc
   f. Carbonated Beverages - 12 oz. - 360 cc
   g. Ice Cream/Sherbet/Italian Ice 120cc, Popsicle - 90 cc
   h. Fruit Juice - 120 cc
   i. Ensure (1 carton) - 240 cc
   j. Gelatin - 120cc
   k. Fruited Gelatin – 60 cc
   l. Coffee - 8 oz. or 1 cup -240 cc / ½ cup Coffee – 120 cc

9. Standard Calculation for ounces to cc.

   a. 1 oz. = 30 cc
   b. 2 oz. = 60 cc
   c. 3 oz. = 90 cc
   d. 4 oz. = 120 cc
   e. 6 oz. = 180 cc
   f. 8 oz. = 240 cc

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- Centers for Medicare and Medicaid Services, Conditions of Participation (2023). Retrieved from https://www.cms.gov/Regulations-and-Guidance.

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SUBJECT: **GUIDELINES FOR THE PREVENTION AND CONTROL OF INFECTIOUS DISEASE TRANMISSION RELATED TO HOSPITAL CONSTRUCTION**	SECTION: **Page 1 of 4**

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

POLICY

PURPOSE:

To prevent transmission of infectious disease during construction or renovation either through exposed air-handling systems (e.g. *Aspergillus*) or water systems (e.g. *Legionella*).

BACKGROUND:

Since its formalization in 1996, the Infection Control Risk Assessment (ICRA) has been used to protect patients, staff, and others during construction and renovation projects within an existing facility. ICRA provided the evidence-based framework for a multidisciplinary team to evaluate and address potential infection risks created by construction in healthcare facilities

More recently, ICRA has been incorporated into the designing phase of health care facilities. As with any other relevant tool or guideline, ICRA has been evolving over the past few decades to keep up with key concepts of Infection Prevention and modern construction practices of health care facilities. In 2020, The American Society for Health Care Engineering (ASHE) assembled a group of health care organizations (such as APIC, AHA and others) and construction experts to clearly spell out what should be included in the next iteration of ICRA to update the guidelines. The result of these efforts, which is entitles ICRA 2.0, was published in the 2001 edition of the Guidelines, a product of the Facilities Guideline Institute (FGI). The ASHE ICRA 2.0 version focuses on the actual construction phase of projects. Among the key points made in ICRA 2.0 is that infection preventionists should be included with other stakeholders long before construction or renovation begins. Although the steps (briefly outlined below) remain the same, greater detail is provided to include non-invasive work and inspections (Class I), standing practice procedures (Class II), etc., to take the guesswork and interpretation out of the equation.

Below is a brief outline of the ICRA 2.0 steps:

Action	ICRA 2.0 Tables
1. Define the activity	**Table 1** Identification of Activity Type
2. Identify patient risk	**Table 2** Patient Risk Group
3. Define the class of precautions	**Table 3** Class of Precautions
4. Assess the surrounding areas	**Table 4** Surrounding Area Assessment
5. Establish the mitigation plan	**Table 5** Minimum Required Infection Control Precautions by Class (I – V) – Before and During Work Activity
6. Prepare for completion of work activity	**Table 6** Minimum Required Infection Control Precautions – Upon Completion of Work Activity

SUBJECT: **GUIDELINES FOR THE PREVENTION AND CONTROL OF INFECTIOUS DISEASE TRANMISSION RELATED TO HOSPITAL CONSTRUCTION**	SECTION: **Page 2 of 4**

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

PROCEDURE:

General Information

1. The Infection Prevention (IP) Manager and the Infection Prevention Council shall be informed of all construction and/or renovation projects prior to their initiation
2. An ICRA 2.0 will be conducted by a multidisciplinary team that includes the IP Manager and other identified stakeholders before any construction and/or renovation project begins
3. The IP Manager shall be involved in all aspects of construction and/or renovation projects from the planning stage to the final completion and preparation for use on an ongoing basis
4. The IP Manager will provide project updates to the Infection Prevention Council as needed
5. The IP Manager and the Infection Prevention Council shall provide evidence-based advice using the ASHE ICRA 2.0 Guidelines (See Appendix A)
6. Contracted construction companies and their on-site employees or representatives will comply with all safety and control measures as agreed upon by the contract

Conducting the ICRA 2.0

1. **Step 1 – Determine Activity Type:** using Table 1 of ICRA 2.0, identify the construction or renovation activity type. Indicate the type of activity (Type A through Type D) in the space provided in the upper left side of the document. The broad definition of activity types are:
    a. **Type A** – Inspection and non-invasive activities (see Table 1 for examples)
    b. **Type B** – Small-scale, short duration activates that create minimal dust and debris
    c. **Type C** – Large-scale, longer duration activities that create a moderate amount of dust and debris
    d. **Type D** – Major demolition and construction activates
2. **Step 2 – Identify the Patient Risk Group(s)**: Table 2 provides a breakout of 4 different patient risk groups. If more than one risk group will be affected, select the higher of the identified groups and record that on the space on the upper left side of the document. The risk groups include:
    a. **Low Risk**: Non-patient care areas
    b. **Medium Risk**: Patient care support areas
    c. **High Risk**: Patient care areas
    d. **Highest Risk**: Procedural, invasive, sterile support and highly compromised patient care areas
3. **Step 3 – Determine the Class of Precautions to Implement:** Table 3 is a matrix that includes Patient Risk Group versus Construction Project Type is provided to allow the selection of the

appropriate precautions for the construction/renovation project. Once Class Precautions have been identified (I, II, III, IV, or V), record the Class of Precautions in the space provided.

4. **Step 4 – Assessment of the Surrounding Areas**: Use Table 4 to conduct an assessment of the areas surrounding the construction or renovation project. What is the type of impact that will occur during the proposed activity? If more than one risk group will be affected, always select the higher risk group using Table 2. Table 4 includes information for the assessment of:
    a. The surrounding area(s)
    b. Noise and vibration mitigation strategies
    c. Ventilation and pressurization mitigation strategies, and
    d. Impact to other systems
5. **Step 5 – Selection of Precautions by Identified Class**: Table 5, *Minimum Required Infection Control Precautions by Class – Before and During Work Activity*, outlines the types of mitigation activities required by class. Use the outcome from the previous assessments using Tables 1 through 4, to identify the class of precautions to use for the proposed project. The categories run from Class I through Class V. Notice that the higher the class, the more precautions are described.
6. **Step 6 – Determine the Minimum Required Infection Control Precautions required during the Completion of Work Activity**: Table 6 has two major categories of mitigation activities. The first group includes Classes I, II and III, and provides information for cleaning and HVAC systems. The second broad group includes Classes III (Type C activities, only), IV and V. The second broad group includes mitigation information on cleaning of the work area, removal of critical barriers, negative air pressure requirements and HVAC system operations.
7. **Step 7 – Complete the ICRA 2.0 Infection Control Risk Assessment and Permit, Submit to the IP Department for Approval and ICRA Permit Number**. ICRA 2.0 Permit is a 2-page document that requires a better-defined description of the project and required mitigation activities to safely carry out the proposed project. The items that are required to complete the permit include
    a. **Project Information**. Note that if the scope of work changes, or additional toxic or biological substances are identified, *work must be stopped* and additional guidance and approval are required before proceeding.
    b. **Type of Activity** – includes space for explanation
    c. **Patient Risk Area** – includes space for description of key patient risks
    d. **Class of Precautions** – The assessment outcome is recorded here
    e. **Surrounding Area** – The pertinent information is summarized here
    f. **Detailed ICRA Control Plan** – Controls, specifications, materials and verification of method(s) and frequencies are recorded here

SUBJECT: **GUIDELINES FOR THE PREVENTION AND CONTROL OF INFECTIOUS DISEASE TRANMISSION RELATED TO HOSPITAL CONSTRUCTION**	SECTION: **Page 4 of 4**

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CROSS REFERENCES:

Appendix A - ICRA 2.0 Assessment Form

SUBJECT: **MEDICATION ADMINISTRATION**	SECTION:

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

PURPOSE:

To establish guidelines for safe medication administration.

POLICY:

1. Medications may be administered pursuant to a provider's order or an approved hospital protocol.

2. The following employees are authorized to administer medications per their scope of practice and departmental policy as appropriate:

   a. Registered Nurses (RN)
   b. Licensed Vocational Nurses (LVN)
   c. Respiratory Care Practitioners (RCP)
   d. Radiology Technologists (RT)

3. Nursing students and Registered Nurse Interim Permittees are allowed to administer medications under the supervision of an instructor/staff nurse as part of their educational experience.

4. Sierra View Medical Center (SVMC) recognizes the "Medication Rights" as desired outcomes of medication administration. Staff authorized to administer medications will follow all established processes to ensure the following:

   a. Right Patient
   b. Right Medication
   c. Right Dose
   d. Right Route
   e. Right Time
   f. Right Documentation
   g. Right Assessment
   h. Right Education
   i. Right Evaluation
   j. Right to Refuse Medication

5. Training and Competency

   a. Upon hire, all RNs and LVNs will receive training on medication management policies and procedures and be required to take and pass with an 85% or greater a medication math aptitude written test.

   b. Annually, all RNs and LVNs will take a math medication calculation test and be required to pass with an 85% or greater. Remediation will take place for those who do not pass.

   c. Upon hire all RCPs and RTs will receive training on medication management policies and procedures as determined by their departments management. Remediation will take place for those who do not pass.

AFFECTED PERSONNEL/AREAS: *REGISTERED NURSES (RN), LICENSED VOCATIONAL NURSES (LVN), RESPIRATORY CARE PRACTITIONERS (RCP), RADIOLOGY TECHNOLOGISTS (RT), PHARMACISTS (PHARM. D),*

PROCEDURE:

Rights of Medication Administration

Staff will adhere to established SVMC processes to ensure all "Rights" of medication administration.

Right Patient

1. Two identifiers will be used to verify the right patient. Verification of the right patient occurs at the patient's bedside.

    a. At the patient's bedside, the nurse will verify the right patient prior to administering medication by comparing patient's name and DOB on the identification band to the MAR or physician's order.

Right Medication

2. For each medication to be administered, the nurse must know the following information:

    a. Name and dose of the medication
    b. Reason for giving the medication to the patient
    c. Expected results/effects of the medication
    d. Side effects
    e. Toxic effects
    f. Incompatabilities
    g. Contraindications

3. The nurse will look up any medication that is unfamiliar to him/her by utilizing available resources.

4. The nurse will check the stability of medications by visually inspecting for particulates, discoloration and expiration date. If the medication is compromised in any way, the nurse will return the medication to the pharmacy immediately.

5. Labeling of medication will occur when any medication or solution is transferred from the original packaging to another container such as a plastic bag, syringe, bottle or box.

    a. Medication labels will include the name and strength of the medication or solution, the date, and the initials of the person preparing the medication.

b. All sterile IV products prepared outside of the pharmacy will have begun administration within one hour of preparation. No preparations shall be stored or prepared in anticipation of need.

c. Appropriate labeling is necessary in the following situations:

1. Any time one or more medications are prepared but are not administered immediately.

2. On and off the sterile field any time medication is being administered in the perioperative area or other procedural settings.

d. Any medication or solution found unlabeled will be immediately discarded.

6. The nurse will be careful to check the accuracy of a look alike, sound alike medication. See HIGH-ALERT MEDICATIONS AND LOOK ALIKE SOUND ALIKE MEDICATIONS .

7. Every 24 hours, the RN will perform a 24-hour chart check to ensure accuracy of the eMAR.

8. The RN or LVN will verify the right medication by rechecking the physician's order whenever necessary to resolve any discrepancies.

Right Dose

To determine or to double check a single medication dose, the basic formula below may be utilized:

$$\frac{\text{Dr.'s Order}}{\text{Quantity}} \times \text{Dose Have}$$

EXAMPLE: Dr.'s order 50mg Solu-Medrol. Have 125mg vial.

$$\frac{50\text{mg}}{125\text{mg}} \times 1\text{ ml} = 0.4\text{ml}$$ is the dose to be administered

1. Many medications come in varying concentrations. Prior to drawing up the ordered dose of medication, the nurse must verify that the correct concentration of the medication is being used.

2. The following medications require a second licensed person to verify the medications that are listed below. The second licensed person will check the medication order, the dosage calculation, the dose that is prepared, the smart pump library setting and starting dose, and then confirm that the spiked source container's IV line is in the proper pump channel and will then properly label the line with the name of the medication and place the label near the IV insertion site. Both licensed persons, one of which must be an RN, will cosign the eMAR.

a. Insulin
b. Heparin
c. Pediatric/neonatal medications that are High-Alert, IV and IM doses, excluding vitamin K and immunizations.

d. Narcotics used for Patient Controlled Analgesia (PCA)
e. Chemotherapy
f. Fentanyl and morphine continuous infusions
g. Midazolam and lorazepam continuous infusions
h. Propofol and precedex continuous infusions
i. Neuromuscular blocking continuous infusions

3. When calculating dosage, if there is any doubt or concern, the nurse will consult with another nurse and/or a pharmacist prior to preparing and administering the medication.

Right Route

1. A medication's rate of absorption and onset of action varies based upon what route the medication is administered. The nurse must check that the route of administration is correct and obtain clarification from the physician if there are any questions or concerns with the prescribed route.

Right Time

1. Routine medications will be administered per the SVMC Standardized Dosing Schedules for Non-IV and IV medications. See policy MEDICATION ADMINISTRATION TIMES.

2. When scheduling a new medication, the nurse will administer the initial dose as soon as possible. Subsequent doses will be administered per the standardized dosing schedule.

3. Routine medications, excluding initial dose, must be given no more than 1 hour before or after the actual scheduled time.

4. When a medication is not administered at a specific time (i.e. medication help for a procedure or medication not available, etc.), the nurse will administer the medications as soon as he/she is able to document the reason for the delay or change in administration time. The time the next dose is administered is determined by referring to the appropriate standardized dosing schedule.

5. Medications ordered "Stat" are to be administered within 30 minutes of the prescribed order.

6. All first dose intravenous antibiotics are to be administered within 4 hours of the prescribed order, or earlier if warranted, e.g., sepsis, etc.

7. Variations in medication administration times may occur based on nursing assessment and/or judgment. For example, if the patient is to receive 10 units of NPH insulin in the evening but the patient did not eat lunch or dinner and the patient's blood sugar is only 100mg/dl, the nurse may hold and notify the physician for further orders. In such cases, the nurse must document the variation in timing, the rationale for the change and the physician notification. (Example: "NPH insulin held due to patient's lack of adequate intake and BS of 100mg/dl. Notified Dr. Smith.")

Right Documentation

1. Medication administration is documented on the electronic medication administration record (eMAR).

2. The nurse will document medication administration on the eMAR according to the following guidelines:

   a. Medication
   b. Route
   c. Date
   d. Time
   e. Site of injection if necessary
   f. Assessment parameters
   g. Signature of caregiver that administered

3. In certain circumstances, administering medication outside of the scheduled timeframe may require the nurse to document a rationale in the patient's record. The following circumstances are some examples:

   a. Patient is having a procedure/test done and unavailable at the scheduled time.
   b. The medication is held due to established patient assessment parameters (i.e. digoxin held for heart rate <60bpm)
   c. Patient refused
   e. The site of intramuscular, intradermal, subcutaneous injections and medication topical transdermal patches must be documented.

4. Adverse drug reactions and allergies must be documented as per policy ADVERSE DRUG REACTIONS.

5. Special Areas for Documentation (when eMAR/EHR not used)

   a. Operating Room- The OR Anesthesiologist/Anesthetist documents the medications that he/she administers during surgery on the anesthesia record.
   b. Code Blue/White- The code form is a record of medication administration to the patient during the code process. In this instance, the notation is made under the medication section of the code form. The date, time, and notation shall serve as a reference for all medications administered during the code.

6. When the EHR/eMAR are unavailable, the downtime procedures shall be followed. See MEDITECH DOWNTIME - CLINICAL DOCUMENTATION.

7. Block Charting is defined as: A documentation method that can be used when a rapid titration of medication is necessary in specific urgent/emergent situations.

a. Emergent situations that are acceptable for block charting would include rapid responses, code blues, or a patient rapidly deteriorating with immediate life being threatened.
b. Block charting will not extend beyond a four hour timeframe, and if it needs to be continued, a new charting block will be started after the four hour limit.
c. There will be an order entered into the EMR for each medication administered during the block charting.
d. The following will be included in each block charting episode:
    a. Time of initiation of the charting block
    b. Name of the medications being administered
    c. Starting and ending rates of the titratable medications
    d. Maximum dose rate of the medications administered
    e. Time of completion of the charting block

8. Physiological parameters evaluated to determine the administration of titratable medications during the charting block

Right Assessment

1. Prior to medication administration, the nurse will assess the following patient information in order to ensure safe medication use:

    a. Age
    b. Allergies
    c. Height & Weight
    d. Diagnosis
    e. Co-Morbidities
    f. Pregnancy status
    g. Laboratory and diagnostic values
    h. Patient's previous experience with the medication
    i. Contraindications

2. Some medications require certain physiological parameters to be met before administration. The nurse must assess the specific patient indicator appropriate to the medication to be administered (i.e., heart rate, blood pressure, etc.). If the patient value is outside of the established ordered parameter, the medication is held.

Right Education

1. The nurse will provide the following information to the patient during medication administration:

    a. Name of the medication
    b. The expected response (i.e., will alleviate pain)
    c. Possible side effects/adverse reactions

2. If the patient requires additional information on a newly prescribed medication, the nurse may utilize Krames notes or Lexicomp to provide more comprehensive education.

3. If the patient will be discharged on a new medication, the nurse will provide the necessary education in order to help ensure medication safety at home.

   a. Medication education may be coordinated with and provided by other healthcare disciplines as necessary (dietician, pharmacist, respiratory therapy).
   b. The nurse will provide special instructions and demonstrations, as necessary, to assist the patient in learning specific skills required to administer medication safely at home (i.e., checking blood sugars and insulin injections).

Right Evaluation

1. Ensuring medication safety requires the nurse to monitor the patient for the effects of the medication after it has been administered. Following medication administration, the nurse will evaluate:

   a. Medication effectiveness (Did the medication have the desired response?)
   b. The presence of side effects, adverse reaction and/or allergic response
   c. Patient physiological parameters, as applicable, such as blood sugar, vital signs, urine lab values, etc.

Black Box Warnings:

The nurse will monitor the patient for any serious side effects associated with medications that have specific black box warnings. See BLACK BOX WARNING

Right to Refuse

1. Patients have the right to refuse medication. The nurse will ascertain the reason for the refusal and discuss consequences of not taking the medication, but the patient may still refuse. Patient refusal must be documented and, in some cases, the physician may need to be notified.

Medication Procedures

MEDICATION ORDERS

1. Licensed individuals allowed to prescribe may communicate medication orders over the telephone to a registered nurse or pharmacist for immediate notation into the EHR. (In emergency situations, orders may be given verbally in person).

2. Additionally, "PRN" medication orders need to include the indication for use. (i.e. PRN pain).

3. The nurse will clarify all incomplete and/or ambiguous orders with the physician prior to administration.

BEDSIDE MEDICATION VERIFICATION (BMV) / ELECTRONIC MEDICATION ADMINISTRATION RECORD (EMAR)

1. Obtain medication from automated dispensing unit.

2. Nurse will verify medication and patient with drug profile on the EMAR.

3. Scan the patient's identification band using the BMV.

4. Scan the medication using the BMV.

5. Nurse will confirm the five rights for accurate medication administration.

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CROSS REFERENCES:

- High-Alert Medications and Look Alike Sound Alike Medications
- Adverse Drug Reactions
- Meditech Downtime- Clinical Documentation
- Black Box Warning

SUBJECT: **MEDICATION ADMINISTRATION TIMES**	SECTION: ***Medication Management (MM)*** **Page 1 of 4**

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

PURPOSE:

To ensure that medications administered at Sierra View Medical Center (SVMC) are done so in accordance with a Medical Staff approved standardized administration time schedule, to provide consistent patient care.

POLICY:

Standardized medication administration times are approved by the Medical Staff through the Pharmacy & Therapeutics (P&T) Committee. Exceptions are specifically designated by administration time in accordance with published recommendations, due to interactions with food, and for patient comfort. This is a house-wide policy.

AFFECTED AREAS/PERSONNEL: *MEDICAL STAFF, NURSING, PHARMACY*

PROCEDURE:

1. Routine orders are those written for a specified schedule.

   Unless specifically stated otherwise in the medication order, all medications are eligible for the following standard routine order times:

DAILY, QDAY, QD	0900
HS	2100
BID	0900, 2100
Q12HR	0900, 2100
TID	0600, 1400, 2100
Q8HR	0600, 1400, 2200
QID	0600, 1200, 1700, 2100
Q3HR	0100, 0400, 0700, 1000, 1300, 1600, 1900, 2200
Q4HR	0200, 0600, 1000, 1400, 1800, 2200
Q6HR	0600, 1200, 1800, 2400

Medication-Specific Exceptions: (Below medications should not follow above scheduled dosing times)

1. Cholesterol lowering medications (i.e., "Statin" class, etc.)	2100
2. Potassium Chloride – given with meals (This applies to scheduled orders for daily administration as maintenance orders)	0800, 1200, 1730, 2100 (with snack)
4. Coumadin (Warfarin)	1200
6. Oral Hypoglycemics	0730, 1730

2. Non-routine administration times.

Medication orders for non-routine administration times will be administered as follows:

AC	Given ½ hour (30 minutes) before meals.
PC	Upon finishing the meal (or same as with meal).
STAT	To be filled by pharmacy immediately and administered within 30 minutes from the time of the order.
NOW	To be filled by pharmacy and administered within 60 minutes from the time of the order.
Pre-Op	Time designated.
One Time Only	Given once on the day the order is written.
PRN	Given only as needed by the patient. (Order must include dose, frequency and indication).

3. Critically Timed Medications

A. The majority of medications should be administered within 1 hour or their scheduling dosing time, but the following medications, due to pharmacokinetic considerations, should be administered within 30 minutes of their scheduled dosing time to ensure therapeutic effectiveness: effectiveness (See Table 1). Notification to provider should be done if Rx not administered within the designated time frame.
Any orders for medications due at or around mealtimes require nursing judgment for the exact scheduled time of administration that can change due to meal delivery time, patient status, and quantity of meal consumed.

Scheduled medication can be given a time critical designation by a provider by indication in the electronic medication administration record entry by placing a one-time STAT or NOW order.

Non-Time-Critical

Delayed or early administration within a specified range of either one or two hours should not cause harm or result in substantial sub-optimal therapy or pharmacological effect (see Table 2).

First or Loading Doses
Certain medications first doses are essential to be given in a timely manner. (See Table 3).

Table 1: Time Critical Medications

Time-Critical Scheduled Medications	Reason "Time-Critical"
Dosing scheduled more frequent than every 4 hours	Small dosing intervals require timely administration to avoid toxicity or sub-optimal therapy.
Opioids	Scheduled use for chronic pain or palliative care (not PRN); Inconsistencies with timely admin may result in unnecessary break-through pain
Immunosuppressants Tacrolimus (Prograf) Cyclosporine (SandIMMUNE) Sirolimus Mycophenolate	When used for prevention of organ transplant rejection.
Itraconazole Ketoconazole	Antacids may decrease serum concentrations. Itraconazole should be given 1 hr after or 2 hours before antacids and ketoconazole at least 2 hours before antacids.
Rapid Acting Insulin Lispro, Aspart, or glulisine	Administration required to occur within 15 minutes before a meal.
Levothyroxine	Administration is necessary on an empty stomach, at least 30 minutes before food.
Pyridostigmine Neostigmine	Short duration of action: When used for the treatment of Myasthenia gravis. The timely administration is required to maintain symptomatic benefit.

Table 2: Non-Time Critical Medications

Non- Time-Critical Scheduled Medications	Timing
Daily, weekly, monthly medications Notify Provider if medication not administered within the time designated in next column.	Administer within 2 hours before or after the scheduled time; to prevent accidental omission of doses that might be more easily forgotten if delayed more than 2 hours.
Medications prescribed more frequently than daily, but not more frequently than every 4 hours.	Administer within 1 hour before or after the scheduled time.

Table 3: First/Loading Doses

First/Loading doses	Targeted time frame of administration
Antiepileptic agents (IV)	Within 15 minutes of medication order.
Antibiotics (IV)	Indication of Sepsis – within 30 minutes of order.
Anticoagulation (IV)	tPA for PE or stroke – within 15 minutes of order post verification of no contraindications

The registered nurses' (RNs) electronic medication administration record (eMAR) will be updated to reflect the need to administer these medications within a 30-minute window of the dosing schedule.

If a medication is unable to be administered within the hour window (30 min window for critically timed meds) of the scheduled dosing time, then the RN should administer as soon as possible and provide note in the patient's chart explaining the circumstances that led to the delay in administration.

Pharmacy will perform random audits of medication administration times on a quarterly basis.

4. Administration Adjustment Chart (1st doses)

SIERRA VIEW DISTRICT HOSPITAL - STANDARDIZED MEDICATION TIMES (ADJUSTMENT CHART)

QD — SCHEDULE IS QD (DAILY): 0900 HOURS *(IF 1ST DOSE ORDERED BETWEEN 0400 & 1400 HOURS)*

24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
SEE DOSING SCHEDULE FOR 2100 HOURS				GIVE 1ST DOSE AND REPEAT THE FOLLOWING CALENDAR DAY											SEE DOSING SCHEDULE FOR 2100 HOURS								

* *Exception: H2 antagonists, i.e. Pepcid, Zantac, Tagamet, etc., give @ 1800 hours. Coumadin @ 1200 hours.*

Q3HR — SCHEDULE IS Q 3 H (EVERY 3 HOURS): 0100, 0400, 0700, 1000, 1300, 1900 & 2200 HOURS

24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
GIVE 1ST DOSE & REPEAT @ 0400			GIVE 1ST DOSE & REPEAT @ 0700			GIVE 1ST DOSE & REPEAT @ 1000			GIVE 1ST DOSE & REPEAT @ 1300			GIVE 1ST DOSE & REPEAT @ 1900				GIVE 1ST DOSE & REPEAT @ 2200					GIVE 1ST DOSE & REPEAT @ 0100	

Q4HR — SCHEDULE IS Q 4 H (EVERY 4 HOURS): 0200, 0600, 1000, 1400, 1800 & 2200 HOURS

24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
GIVE 1ST DOSE & REPEAT @ 0600				GIVE 1ST DOSE & REPEAT @ 1000				GIVE 1ST DOSE & REPEAT @ 1400				GIVE 1ST DOSE & REPEAT @ 1800				GIVE 1ST DOSE & REPEAT @ 2200				GIVE 1ST DOSE & REPEAT @ 0200		

Q6HR QID — SCHEDULE IS Q 6 H (EVERY 6 HOURS): 0600, 1200, 1800 & 2400 HOURS

24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
GIVE 1ST DOSE & REPEAT @ 0600						GIVE 1ST DOSE & REPEAT @ 1200						GIVE 1ST DOSE & REPEAT @ 1800						GIVE 1ST DOSE & REPEAT @ 2400					GIVE 1ST DOSE & REPEAT @ 0600

Q8HR TID — SCHEDULE IS Q 8 H (EVERY 8 HOURS): 0600, 1400 & 2200 HOURS

24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
GIVE 1ST DOSE & REPEAT @ 0600						GIVE 1ST DOSE & REPEAT @ 1400								GIVE 1ST DOSE & REPEAT @ 2200									GIVE 1ST DOSE & REPEAT @ 0600

Q12HR BID — SCHEDULE IS Q 12 H (EVERY 12 HOURS): 0900 & 2100 HOURS

24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
GIVE 1ST DOSE & REPEAT @ 0900											GIVE 1ST DOSE & REPEAT @ 2100 HOURS											GIVE 1ST DOSE & REPEAT @ 0900 HOURS	

* *Exception: Diuretics give @0600 & 1800 & Oral Hypoglycemic @0730 & 1730*

HS — SCHEDULE IS HS: 2100 HOURS

24	01	02	03	04	05	060	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
GIVE 1ST DOSE AND REPEAT THE FOLLOWING CALENDAR DAY				SEE DOSING SCHEDULE FOR 0900 HOURS												GIVE 1ST DOSE AND REPEAT THE FOLLOWING CALENDAR DAY							

* *Exception: H2 antagonists, i.e. Pepcid, Zantac, Tagamet, etc., give @ 1800 hours. Coumadin @ 1200 hours.*

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CROSS REFERENCES:

MEDICATION ORDERING

SUBJECT:	SECTION:
MEDICATION ALLERGIES AND ADVERSE REACTIONS	*Medication Management (MM)* **Page 1 of 7**

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

PURPOSE:

To promote the development of a robust patient medication allergy and adverse reaction record in the electronic medical record (EMR). As well as, to provide guidance to the interdisciplinary team responsible for administering a potential allergen or adverse reactant, and provide preparation to respond to potential anaphylaxis. Furthermore, this policy will describe optional objective testing for patients with potential allergies.

DEFINITIONS:

1. **Drug allergy** — A drug allergy is an adverse drug reaction that is caused by an immunologic reaction elicited by a drug. Immunologic drug reactions are divided into four categories according to the Gell and Coombs system.

Gell and Coombs classification of immunologic drug reactions

Type	Description	Mechanism	Clinical features
I Immediate reaction (within one hour)	IgE-mediated, immediate-type hypersensitivity	Antigen exposure causes IgE-mediated activation of mast cells and basophils, with release of vasoactive substances, such as histamine, prostaglandins, and leukotrienes.	Anaphylaxis Angioedema Bronchospasm Urticaria (hives) Hypotension
II	Antibody-dependent cytotoxicity	An antigen or hapten that is intimately associated with a cell binds to antibody, leading to cell or tissue injury.	Hemolytic anemia Thrombocytopenia Neutropenia
III	Immune complex disease	Damage is caused by formation or deposition of antigen-antibody complexes in vessels or tissue. Deposition of immune complexes causes complement activation and/or recruitment of neutrophils by interaction of immune complexes with Fc IgG receptors.	Serum sickness Arthus reaction
IV	Cell-mediated or delayed hypersensitivity	Antigen exposure activates T cells, which then mediate tissue injury. Depending upon the type of T cell activation and the other effector cells recruited, different subtypes can be differentiated (ie, types IVa to IVd).	Contact dermatitis, Some morbilliform reactions Severe exfoliative dermatoses (eg, SJS/TEN) AGEP DRESS/DiHS Interstitial nephritis Drug-induced hepatitis Other presentations

IgE: immunoglobulin E; Fc IgG: Fc portion of immunoglobulin G; SJS/TEN: Stevens-Johnson syndrome/toxic epidermal necrolysis; AGEP: acute-generalized exanthematous pustulosis; DRESS/DiHS: drug rash with eosinophilia and systemic symptoms/drug-induced hypersensitivity syndrome.

Adapted from: Weiss ME, Adkinson NF. Immediate hypersensitivity reactions to penicillin and related antibiotics. Clin Allergy 1988; 18:515.

2. The World Allergy Organization (WAO) has recommended dividing immunologic drug reactions into two types:

   - Immediate reactions, occurring within one hour of the first administered dose.

- Delayed reactions, occurring after one hour, but usually more than six hours and occasionally weeks to months after the start of administration.

POLICY:

A. Developing A Detailed Patient Allergy and Adverse Reaction History in the EMR:

1. In order to promote safe and judicious prescribing throughout the organization all direct patient care staff are encourage to consistently question new patients about their medication allergy and adverse reaction history. Furthermore, all direct patient care staff are encouraged to document all new information, in adequate detail, into the patient's EMR.

    a. The house wide procedure for this practice is outlined in the Patient Care Services Policy ALLERGY DOCUMENTATION/ COMMUNICATION

B. Providing the RN with Guidance When Asked to Administer a Medication That is a Potential Allergen or Adverse Reactant:

1. Multiple members of the interdisciplinary team, including but not limited to physicians, RNs and pharmacists are to discuss the potential benefits and harms of administering a potential allergen.

2. If the medication is determined to possess more benefit than harm, and then therefore will be administered, then the interdisciplinary staff will be prepared to respond to an adverse reaction.

C. Available Objective Testing for Potential Allergens:

1. Skin testing for drug-specific IgE:

    a. A limited number of medications can be used to perform prick and/or intradermal skin testing for the purpose of determining if the drug interacts with drug-specific IgE bound to cutaneous mast cells. This type of testing is only used to evaluate suspected type I allergic reactions. A positive wheal-and-flare response appearing within 15 to 20 minutes indicates the presence of drug-specific IgE on the patient's mast cells and supports the diagnosis of a type I reaction (see box above)

    b. Medications for which skin testing for immediate reactions with the native (unmetabolized) form has proven useful in identifying a subset of allergic patients include the following:

        i. Other beta-lactam antibiotics (cephalosporins and imipenem)

        ii. Neuromuscular blockers and dyes used to localize lymph nodes intraoperatively (ie, patent blue, isosulfan blue, methylene blue)

iii. Carboplatin and other platin drugs

iv. Pyrazolones, such as metamizole

v. Local anesthetics

vi. Thiobarbiturates

vii. Therapeutic monoclonal antibodies, even if fully humanized, can still elicit immune reactions. The majority of reactions involve immunoglobulin G (IgG) antibodies, some neutralizing the efficacy of the therapeutic antibody. IgE-mediated reactions do occur, but are rather rare.

AFFECTED PERSONNEL/AREAS: *ALL DIRECT PATIENT CARE PERSONNEL*

EQUIPMENT:

- MEDITECH
- Anaphylaxis Kit (Epinephrine 1mg/mL, Diphenhydramine 50mg/mL, Hydrocortisone 100mg/mL)

PROCEDURE:

A. Developing A Detailed Patient Allergy and Adverse Reaction History in the EMR:

1. Please refer to the Patient Care Services Policy ALLERGY DOCUMENTATION/ COMMUNICATION.

B. In the event that the RN is asked by the prescribing Physician to administer a medication in which the patient has a listed allergy or past adverse reaction:

1. The RN is to first call the Physician and alert them of the information regarding the allergy or adverse reaction in the EMR.

2. If the Physician would like to proceed with administration, a discussion with the Pharmacist regarding nature of the reaction, likelihood of adverse reaction, potential alternatives, and availability of skin testing for drug –specific IgE should first ensue.

3. If potential allergen is determined to possess more benefit than harm, then an anaphylaxis kit (Epinephrine 1mg/mL, Diphenhydramine 50mg/mL, Hydrocortisone 100mg/mL) should be on hand and ready for use if needed, and the prescribing physician should either

be present for the next 30 minutes or immediately available by telephone. Further treatment of Anaphylaxis will be determined by the patient's Physician.

C. Treatment of Anaphylaxis:

1. Patients with anaphylaxis should be assessed and treated as rapidly as possible, as respiratory or cardiac arrest and death can occur within minutes. Anaphylaxis appears to be most responsive to treatment in its early phases, before shock has developed, based on the observation that delayed epinephrine injection is associated with fatalities.

2. *Epinephrine is life-saving in anaphylaxis. It should be injected as early as possible in the episode in order to prevent progression of symptoms and signs*. There are no absolute contraindications to epinephrine use, and it is the treatment of choice for anaphylaxis of any severity. Epinephrine use is recommended for patients with apparently mild symptoms and signs (e.g., a few hives and mild wheezing) (Grade 1B), as well as for patients with moderate-to-severe symptoms and signs (Grade 1A).

3. The route of epinephrine administration depends upon the presenting symptoms. For patients who are not profoundly hypotensive or in shock or cardiorespiratory arrest, intramuscular (IM) injection into the mid-outer thigh as the initial route of administration is advised, in preference to subcutaneous administration or intravenous (IV) administration.

4. All adverse events when be documented in the organization's QAPI software by either the RN, Pharmacist, or Risk representative.

5. Immediate Management for Adults: (see graphic on page 5)

6. Immediate Management for Infants and Children: (see graphic on page 6)

D. Performing Objective Testing for Potential Allergens:

1. After a discussion between the physician and pharmacist regarding potential alternatives it is possible that the listed allergen is the best possible course of treatment. In certain situations, performing skin testing for drug specific IgE may be advisable (i.e. Penicillin and Cephalosporins)

2. The following chart lists the nonirritating concentrations of a select few drugs in which skin testing is applicable:

Nonirritating concentrations for skin testing with common antibiotics

Antimicrobial drug	Full-strength concentration	Nonirritating concentration
Cefotaxime	100 mg/mL	10^{-1}
Cefuroxime	100 mg/mL	10^{-1}
Cefazolin	330 mg/mL	10^{-1}
Ceftazidime	100 mg/mL	10^{-1}
Ceftriaxone	100 mg/mL	10^{-1}
Tobramycin	80 mg/2 mL	10^{-1}
Ticarcillin	200 mg/mL	10^{-1}
Clindamycin	150 mg/mL	10^{-1}
Gentamicin	40 mg/mL	10^{-1}
Cotrimoxazole	80 mg/mL	10^{-2}
Levofloxacin	25 mg/mL	10^{-3}
Erythromycin	50 mg/mL	10^{-3}
Azithromycin	100 mg/mL	10^{-4}
Nafcillin	250 mg/mL	10^{-4}
Vancomycin	50 mg/mL	10^{-4}

Nonirritating concentrations are expressed as dilutions from the full-strength intravenous preparation.

Reproduced from: Empedrad R, Darter A, Earl H, Gruchalla R. Letters to the Editor. Nonirritating intradermal skin test concentrations for commonly prescribed antibiotics. J Allergy Clin Immunol 2009; 112:629. Illustration used with the permission of Elsevier Inc. All rights reserved.

3. Clinical Pharmacists will aid physicians in the process of skin testing (order entry) as deemed necessary and to respond to potential adverse reactions, such as anaphylaxis.

   a. The results of skin testing with one of the above agents should be interpreted as follows:

      i. A positive result is indicative of allergy, provided nonirritating concentrations of the drug were used (see table in Procedure section)

      ii. A negative result does NOT exclude allergy, because the patient may be allergic to metabolites of the medication, or metabolite/protein complexes.

Rapid overview: Emergency management of anaphylaxis in adults

Diagnosis is made clinically:

The most common signs and symptoms are cutaneous (eg, sudden onset of generalized urticaria, angioedema, flushing, pruritus). However, 10 to 20% of patients have no skin findings.

Danger signs: Rapid progression of symptoms, respiratory distress (eg, stridor, wheezing, dyspnea, increased work of breathing, persistent cough, cyanosis), vomiting, abdominal pain, hypotension, dysrhythmia, chest pain, collapse.

Acute management:

The first and most important treatment in anaphylaxis is epinephrine. There are **NO absolute contraindications to epinephrine** in the setting of anaphylaxis.

Airway: Immediate intubation if evidence of impending airway obstruction from angioedema. Delay may lead to complete obstruction. Intubation can be difficult and should be performed by the most experienced clinician available. Cricothyrotomy may be necessary.

Promptly and simultaneously, give:

IM epinephrine (1 mg/mL preparation): Give epinephrine 0.3 to 0.5 mg intramuscularly, preferably in the mid-outer thigh. Can repeat every 5 to 15 minutes (or more frequently), as needed. If epinephrine is injected promptly IM, most patients respond to one, two, or at most, three doses. If symptoms are not responding to epinephrine injections, prepare IV epinephrine for infusion (see below).

Place patient in recumbent position, if tolerated, and elevate lower extremities.

Oxygen: Give 8 to 10 L/minute via facemask or up to 100% oxygen, as needed.

Normal saline rapid bolus: Treat hypotension with rapid infusion of 1 to 2 liters IV. Repeat, as needed. Massive fluid shifts with severe loss of intravascular volume can occur.

Albuterol (salbutamol): For bronchospasm resistant to IM epinephrine, give 2.5 to 5 mg in 3 mL saline via nebulizer. Repeat, as needed.

Adjunctive therapies:

H1 antihistamine*: Consider giving diphenhydramine 25 to 50 mg IV (for relief of urticaria and itching only).

H2 antihistamine*: Consider giving ranitidine 50 mg IV.

Glucocorticoid*: Consider giving methylprednisolone 125 mg IV.

Monitoring: Continuous noninvasive hemodynamic monitoring and pulse oximetry monitoring should be performed. Urine output should be monitored in patients receiving IV fluid resuscitation for severe hypotension or shock.

Treatment of refractory symptoms:

Epinephrine infusion¶: For patients with inadequate response to IM epinephrine and IV saline, give epinephrine continuous infusion, beginning at **0.1 mcg/kg/minute** by infusion pump$^{\Delta}$. Titrate the dose continuously according to blood pressure, cardiac rate and function, and oxygenation.

Vasopressors¶: Some patients may require a second vasopressor (in addition to epinephrine). All vasopressors should be given by infusion pump, with the doses titrated continuously according to blood pressure and cardiac rate/function and oxygenation monitored by pulse oximetry.

Glucagon: Patients on beta-blockers may not respond to epinephrine and can be given glucagon 1 to 5 mg IV over 5 minutes, followed by infusion of 5 to 15 mcg/minute. Rapid administration of glucagon can cause vomiting.

Rapid overview: Emergent management of anaphylaxis in infants and children*

Diagnosis is made clinically:

The most common signs and symptoms are cutaneous (eg, sudden onset of generalized urticaria, angioedema, flushing, pruritus). However, 10 to 20% of patients have no skin findings.

Danger signs: Rapid progression of symptoms, evidence of respiratory distress (eg, stridor, wheezing, dyspnea, increased work of breathing, retractions, persistent cough, cyanosis), signs of poor perfusion, abdominal pain, vomiting, dysrhythmia, hypotension, collapse.

Acute management:

The first and most important therapy in anaphylaxis is epinephrine. There are **NO absolute contraindications to epinephrine** in the setting of anaphylaxis.

Airway: Immediate intubation if evidence of impending airway obstruction from angioedema. Delay may lead to complete obstruction. Intubation can be difficult and should be performed by the most experienced clinician available. Cricothyrotomy may be necessary.

IM epinephrine (1 mg/mL preparation): Epinephrine 0.01 mg/kg should be injected intramuscularly in the mid-outer thigh. For large children (>50 kg), the maximum is 0.5 mg per dose. If there is no response or the response is inadequate, the injection can be repeated in 5 to 15 minutes (or more frequently). If epinephrine is injected promptly IM, patients respond to one, two, or at most, three injections. If signs of poor perfusion are present or symptoms are not responding to epinephrine injections, prepare IV epinephrine for infusion (see below).

Place patient in recumbent position, if tolerated, and elevate lower extremities.

Oxygen: Give 8 to 10 L/minute via facemask or up to 100% oxygen, as needed.

Normal saline rapid bolus: Treat poor perfusion with rapid infusion of 20 mL/kg. Re-evaluate and repeat fluid boluses (20 mL/kg), as needed. Massive fluid shifts with severe loss of intravascular volume can occur. Monitor urine output.

Albuterol: For bronchospasm resistant to IM epinephrine, give albuterol 0.15 mg/kg (minimum dose: 2.5 mg) in 3 mL saline inhaled via nebulizer. Repeat, as needed.

H1 antihistamine: Consider giving diphenhydramine 1 mg/kg (max 40 mg) IV.

H2 antihistamine: Consider giving ranitidine 1 mg/kg (max 50 mg) IV.

Glucocorticoid: Consider giving methylprednisolone 1 mg/kg (max 125 mg) IV.

Monitoring: Continuous noninvasive hemodynamic monitoring and pulse oximetry monitoring should be performed. Urine output should be monitored in patients receiving IV fluid resuscitation for severe hypotension or shock.

Treatment of refractory symptoms:

Epinephrine infusion¶: In patients with inadequate response to IM epinephrine and IV saline, give epinephrine continuous infusion at 0.1 to 1 mcg/kg/minute, titrated to effect.

Vasopressors¶: Patients may require large amounts of IV crystalloid to maintain blood pressure. Some patients may require a second vasopressor (in addition to epinephrine). All vasopressors should be given by infusion pump, with the doses titrated continuously according to blood pressure and cardiac rate/function monitored continuously and oxygenation monitored by pulse oximetry.

IM: intramuscular; IV: intravenous.

* A child is defined as a prepubertal patient weighing less than 40 kg.

¶ All patients receiving an infusion of epinephrine and/or another vasopressor require continuous noninvasive monitoring of blood pressure, heart rate and function, and oxygen saturation. We suggest that pediatric centers provide instructions for preparation of standard concentrations and also provide charts for established infusion rate for epinephrine and other vasopressors in infants and children.

REFERENCES:

- Pichler MD, Adkinson, MD, Felder MD. An Approach to the Patient with Drug Allergy. In: UpToDate, Waltham, MA. (Accessed on August 15, 2016).
- Solensky MD, Adkinson MD, Feldweg MD. Penicillin Skin Testing. In: UpToDate, Waltham, MA. (Accessed on August 18, 2016).

CROSS REFERENCES:

- SVMC Patient Care Services policy Allergy Documentation / Communication

SUBJECT: **MEDICATION PROCUREMENT, STORAGE, DISTRIBUTION AND CONTROL**	SECTION: ***Medication Management (MM)*** **Page 1 of 11**

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

PURPOSE:

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

POLICY:

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

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

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

AFFECTED AREAS/PERSONNEL:

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

PROCEDURE:

I. Procurement

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

Large and small volume intravenous solutions without additives.

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

C. Procedure:

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

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

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

4. Hazardous drugs will be received and stored at the cancer center location.

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

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

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

II. Storage and Control

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

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

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

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

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

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

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

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

4. Return to Storage

a. Nursing

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

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

b. Pharmacy

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

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

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

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

III. Control and Security/Accountability

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

B. Controlled Substances – All controlled substances of schedules C-II through C-V will be under a double lock system. A lockable door (i.e., outside door of a medication room or

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

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

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

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

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

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

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

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

IV. Inspection and Disposition

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

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

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

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

5. Drugs are stored at appropriate temperatures.

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

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

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

B. Return and Disposal of Medications:

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

1. Registered Pharmacist on staff.

2. Be a licensed DEA Registrant.

3. Be DEP/EPA registered large quantity hazardous waste generator.

4. Utilize a licensed hazardous waste transporter.

5. Utilize a licensed hazardous waste processing firm for incineration of disposable products.

6. Maintain general liability insurance.

7. Field Service Technicians are bonded and have Power of Attorney to handle narcotics.

8. Provide documentation or return and/or disposal in accordance with FDA and DEA guidelines.

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

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

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

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

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

- Credit Tracking Report – for all items being returned to manufacturers for credit by total Calculated Return Value.

- Manufacturer Return Report – details all items returned by NDC #, description, lot #, expiration date, price and quantity by manufacturer.

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

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

Waste Management and Accountability (On-site disposal)

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

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

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

V. Distribution of Medications

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

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

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

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

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

VI. Blood Derivatives

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

VII. Guidelines For Product Dating

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

General Guidelines:

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

Form Specific Guidelines:

1. Injectable:

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

   b. Single Dose Vials – Discard immediately after use.

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

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

2. IV Solutions – Admixed

   a. Mixed on the unit/patient care area – 24 hours after mixing.

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

3. IV Solutions – Unmixed

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

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

4. Irrigation Solutions

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

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

   a. Nasal solutions/sprays

   b. Ophthalmic

   c. Otic

6. Nitroglycerin

   a. Sublingual – 6 months after opening.

7. Oral Liquids & Solids

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

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

8. Topicals- 1 year after opening or manufacturers expiration date, whichever is first.

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

   b. Ointments, Creams

9. Non-sterile Compounded Medications

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

REFERENCES:

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

CROSS REFERENCES:

- Nursing Manual – "Controlled Substances – Procurement, Administration & Documentation."
- Pharmacy Manual – "Controlled Substances"
- Diagnostic Imaging Services – Nuclear Medicine Policy & Procedure Manual.

SUBJECT: **MEDICATIONS RESTRICTED TO AREAS OR PERSONNEL**	SECTION: ***Pharmaceutical Services*** **Page 1 of 6**

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

PURPOSE:

To provide guidelines for the safe administration of specific medications restricted to approved nursing units and patient care areas.

DEFINITIONS:

1. Approved areas: Areas as indicated in policy where medications may be administered.

2. Non-approved areas: Any unit where identified medications are not approved for administration.

POLICY:

It is the policy of Sierra View Medical Center (SVMC) that identified medications by nature of their pharmacology and indications require specific monitoring.

AFFECTED PERSONNEL/AREAS: *ALL NURSING AREAS AND PHARMACY*

PROCEDURE:

A. Administration of medications in approved nursing units

1. Restricted medications will be administered only in the approved units and with the requirements indicated in Addendum A of this policy and more specifically described in medication-specific policies, which may be referenced.

B. Administration of medications in non-approved nursing units

2. If the physician orders a medication listed in Addendum A for a patient located in an non-approved unit, and/or the requirements listed in Addendum A or medication specific policy, as referenced, cannot be met, the physician will:

a) Consider an alternative therapy.

b) Order the patient transferred to an appropriate unit.

c) Order the medication to be given using the criteria listed below:

i. The patient must have bedside monitoring to include continuous cardiac monitoring, pulse oximetry, and monitoring at least every 15 minutes or more frequently as indicated in Addendum A or in referenced medication specific policies. These vital signs will be documented as obtained.

ii. The medication must be administered under the direct supervision of the ordering physician.

iii. The ordering physician, nurse, or allied health professional administering the medication must have the appropriate credentials and meet the requirements listed in Addendum A or in medication-specific referenced policies.

iv. Pharmacy must be notified by telephone that the criteria listed above have been met before they will send the needed medication(s).

Addendum A

Generic Name	Trade Name	Approved Unit	Additional Requirements
Adenosine ~~Adenosine~~	Adenocard® ~~Adenocard®~~	OR, L&D-OR, ED, PACU, ICU	Every 5 min vitals and transfer to Critical Care
		ICU & Cath Lab Imaging (Stress tests) NICU	Physician administered only and patients must be on a cardiac monitor For NICU, RN can administer but Physician must be at bedside
Alteplase	Activase®	ICU, ED, Cath.Lab	For stroke, MI patients only
Amiodarone IV	Cordarone®	ICU, OR, ED, PACU, Cath.Lab, Tele	
Cisatracurium	Nimbex®	ICU, ED, OR L&D- OR, Cath Lab	.
Desflurane	Suprane®	L&D-OR, OR only	Anesthesia staff only
Diltiazem IV	Cardizem®	ICU, OR, ED, PACU, Cath.Lab, Tele	
Dobutamine	Dobutrex®	ICU, OR, L&D-OR, ED, PACU, Cath.Lab,	Vital signs every 15 min while on drip
Dopamine	Intropin®	ICU, OR, L&D-OR, ED, PACU, Cath.Lab, TELE	Vital signs every 15 min while on drip, TELE ok for non-titratable low dose renal perfusion.
Epinephrine Drip		ICU, ED, Cath Lab, OR, NICU	
Eptifibatide	Integrelin®	ICU, Tele, ED, Cath Lab	

Generic Name	Trade Name	Approved Unit	Additional Requirements
Esmolol	Brevibloc®	ICU, OR, L&D-OR, ED, PACU, Cath.Lab	
Etomidate	Amidate®		Anesthesia staff, physicians credentialed in Rapid Sequence Intubation, or RNs who have completed the RSI Learning Module, Vital signs every 5 min.
Fentanyl IV Push Fentanyl IV Drip		All Inpatient Units ED/ICU/Cath Lab *Tele/3rd floor	Pain or sedation for a procedure *must be a fixed dose and comfort care
Factor VII	NovoSeven®	ICU,ED, OR	.
Glycopyrrolate	Robinul®	L&D-OR, OR only	Anesthesia staff only
Haloperidol IV	Haldol®	All units	All IV administration at any dose amount must have cardiac monitoring.
Heparin IV		All Inpatient Units Clinics	
Hydralazine IV	Apresoline®	ICU, DOU, ED, OR, L&D-OR, L&D,NICU, MS. TELE, CDU, Cath Lab	
Insulin IV Drip (Regular Insulin only)		ICU, ED, Cath Lab	
Isofluorane	Forane®	L&D, OR only	Anesthesia staff only
Ketamine	Ketalar®	Bolus	Anesthesia staff, physicians credentialed in Rapid Sequence Intubation and Deep Procedural Sedation, and RNs who have completed RSI and Procedural Sedation Learning Modules, vital signs every 5 min during Deep Sedation
		Infusion: ICU/ED/Cath Lab	
Labetalol IV	Normodyne®, Trandate®	ICU, OR, L&D-OR, ED, PACU, Cath.Lab,TELE, CDU	*Cardiac Monitoring

Generic Name	Trade Name	Approved Unit	Additional Requirements
Lidocaine IV	Xylocaine®	ICU, OR, L&D, OR, ED, PACU, Cath Lab	Required vital signs every 15min.
Lorazepam IV Drip	Ativan®	ICU, ED, PACU	
Magnesium-Sulfate IV Drip (40 gram)		L&D, ICU, PACU	PACU or OB patients only.
Metoprolol IV	Lopressor®	ICU, OR, L&D-OR, ED, PACU, Cath.Lab, TELE	*Cardiac Monitoring: ECG, HR, BP
Midazolam IV Drip	Versed®	ICU, ED, PACU, Cath Lab	
Midazolam	Versed®	All Inpatient Units	
Nitroglycerin IV		ICU, OR, ED, PACU, Cath Lab	Vital signs every 15 min while on drip.
Nitroprusside	Nipride®	ICU, OR, ED, PACU, Cath.Lab	
Norepinephrine	Levophed®	ICU, OR, L&D-OR, ED, PACU, Cath.Lab	
Octreotide	Sandostatin®	ED, ICU, OR, PACU, MS, TELE, Cath Lab	
Phenylephrine	Neosynephrine ®	ICU, OR, L&D-OR, ED, PACU, Cath.Lab	
Physostigmine	Antilirium®	OR, L&D-OR, PACU	
Propofol	Diprivan®	ICU, ED, OR, L&D-OR, Cath Lab	If intended for Deep Procedural Sedation, vital signs every 5 min.
Propranolol IV	Inderal®	ICU, OR, L&D-OR, ED, PACU, Cath.Lab,	
Rocuronium	Zemuron	L&D-OR, OR Only, ED, ICU, Cath Lab	

Sevoflurane	Ultane	L and D OR, OR only	Anesthesia only.
Succinylcholine	Anectine®		Anesthesia staff, physicians credentialed in Rapid Sequence Intubation, or RNs who have completed the RSI Learning Module.
Tenecteplase	TNKase	ICU, ED, Cath lab	
Vasopressin	Pitressin®	ICU, OR, ED, PACU, Cath.Lab	
Vecuronium	Norcuron®	ICU, OR, L&D-OR, ED, PACU, Cath.Lab, NICU	Drips only for ICU & recommend preparation by pharmacy for NMBA drip.
Verapamil IV	Calan®	ICU, OR, L&D-OR, ED, PACU, Cath.Lab, TELE	*Cardiac Monitoring: BP, HR, ECG

SUBJECT: NON-STERILE COMPOUNDING	SECTION: Page 1 of 4

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

PURPOSE:

In compliance with state and federal laws, this policy defines the process to follow any time two or more ingredients are combined to produce a medication intended for patient use, except for admixing and reconstitution of medications and preparations that are products of sterile compounding.

DEFINITIONS:

1. **Beyond Use Date**- the date, or date and time, after which administration of a compounding drug preparation shall not begin, the preparation shall not be dispensed, and the preparation shall not be stored.

2. **Compounding (Non Sterile)**- the act of combining or altering ingredients by a pharmacist, or by a pharmacy technician under the direct supervision of a pharmacist, in response to a licensed practitioner's prescription, which produces a medication tailored to an individual patient's special medical needs. This definition does not include mixing or reconstituting commercial products in accordance with the manufacturer's instructions or the product's approved labeling, as these tasks are not considered compounding.

3. **Reconstitution**- the return, usually by adding liquid, of a drug previously altered for preservation and storage to its original state for administration to a patient.

4. **Integrity**- retention of potency until the expiration date noted on the label.

5. **Potency**- active ingredient strength within +/- 10% of the labeled amount.

6. **Quality**- absence of harmful contaminants, including filth, putrid, or decomposed substances, and absence of active ingredients other than those noted on the label.

7. **Strength**- amount of active ingredient per unit of a compounded drug product.

POLICY:

Sierra View Medical Center's Department of Pharmacy will follow USP 795 guidelines for nonsterile compounding outlined in this policy to produce safe and effective medications.

AFFECTED PERSONNEL/AREAS: *PHARMACY*

EQUIPMENT:

- Graduated cylinders, mortar and pestle, electronic scale, weighing paper, spatula, glass stir rod.

PROCEDURE:

A. A drug preparation shall not be compounded until the pharmacy has first prepared a written master formula. When the pharmacy does not routinely compound a particular drug preparation, the master formula may be written on the prescription itself.

B. Each master formula must contain at a minimum:

1. Active ingredient to be used.
2. Equipment to be used
3. The maximum allowable beyond use date.
4. Inactive ingredients to be used.
5. Process and/or procedure used to prepare the drug.
6. Quality reviews required at each step in the preparation of the drug.
7. Post-compounding process or procedures if required.

C. Assign each product or batch a unique compounding lot number or reference.

D. For non-sterile compounded drug preparation (s), the beyond use date shall not exceed any of the following:

1. The shortest expiration date or beyond use date of any ingredient in the preparation
2. The chemical stability of any one ingredient in the preparation
3. The chemical stability of the combination of all the ingredients in the preparation
4. For non-aqueous formulations, 180 days
5. For water containing oral formulations, 14 days
6. For water containing topical/dermal and mucosal liquid and semisolid formulations, 30 days
7. A pharmacist, using his or her professional judgment, may establish an extended date if the pharmacist researches literature and applies drug-specific and general stability documentation from the literature; Documentation of the pharmacist's research and analysis supporting an extension must be maintained in a readily retrievable format as part of the master formula.
8. Shorter dating may be used if it is deemed appropriate in the professional judgment of the responsible pharmacist.

E. Record Keeping

A record for each compounded drug product will be maintained and includes the following:

1. The master formula-document.
2. Name and strength of the compounded drug product.
3. The date the drug product was compounded
4. The identity of the pharmacy personnel who compounded the drug product
5. The identity of the pharmacist reviewing the final drug product
6. The quantity of each component used in compounding the drug product