7. The manufacturer or supplier, expiration date and lot number of each component
8. The pharmacy assigned reference or lot number for the compounded drug product
9. The quantity or amount of drug product compounded
10. The BUD of the final compounded drug product

The pharmacy shall maintain records of the proper acquisition, storage, and destruction of chemicals, bulk drug substances, drug products, and components used in compounding.

F. The pharmacy maintains and retains all records required in the pharmacy in a readily retrievable form for 3 years.

G. All non-sterile compounding will be:

1. Performed in a designated area
2. Prepared accurately and carefully using clean equipment in good working order, and certified if applicable.
3. The final product will be accurately labeled with the pharmacy name, the generic name(s) of the principle active ingredient(s) and strength, volume and weight of each ingredient, date, expiration date, lot number and initials of person preparing and checking the product. Drug products compounded into unit-dose containers that are too small or otherwise impractical for full compliance will be labeled with at least the name(s) of the active ingredient(s), concentration of strength, volume or weight, pharmacy reference or lot number, and expiration date.
4. The container or receipt contains a statement that the drug has been compounded by the pharmacy.
5. Appropriate auxiliary labels will be affixed.
6. In addition to checking the final product, the pharmacist will perform quality checks throughout the compounding procedure to verify accuracy.

H. Procurement:

1. Preferably, active pharmaceutical ingredients (API) that meet the USP-NF standards of strength, quality, purity and integrity and comply with FDA Good Manufacturing Practices will be used.
2. For all ingredients used a MSDS sheet will be readily available.

I. All equipment utilized to compound drug products are calibrated prior to use and will be stored, used, maintained and cleaned/disinfected in accordance to manufacturer recommendations. Equipment should be cleaned/disinfected prior to compounding of any product.

1. Staff, utilizing such equipment, will receive training to verify competency.
2. Date and time of each calibration is recorded, maintained and retained in the pharmacy records.

J. Drug Recalls: See Policy: SVMC DRUG RECALL POLICY

K. Training of Compounding Staff:

1. The pharmacy will maintain written documentation sufficient to demonstrate that pharmacy personnel have the skills and training required to properly and accurately perform assigned responsibilities relating to compounding.
2. All pharmacy personnel performing compounding will complete an initial assessment and an online module prior to performing non-sterile compounding.
3. Pharmacy leadership will notify and educate staff of any changes in process via email, meetings or written material.

L. Compounding Quality Assurance:

1. Pharmacy leadership will verify, monitor and review the adequacy of the compounding processes as well as documentation of review of those processes by qualified pharmacy personnel
2. Authorized pharmacy personnel shall perform quantitative testing as deemed appropriate by the pharmacist in charge (PIC).
3. Any quality reports generated will be retained by the pharmacy and collated with the compounding record and master formula
4. When a sample yields a significant variance from labeled strength, the pharmacist in charge shall be notified. Likewise appropriate follow up, corrective action and process improvement shall commence as deemed necessary based on the findings.

REFERENCES:

- California Pharmacy Lawbook Online-California Code of Regulations (2019), Division 17, Title 16, Section 1735-1735.8.
- USP. USP <795> Pharmaceutical compounding—Nonsterile preparations. Second supplement to USP 40–NF 35. December 29, 2022; 675–83.

CROSS REFERENCES:

- Drug Recall Procedure Policy

SUBJECT: **PATIENT'S OWN MEDICATIONS**	SECTION: **Page 1 of 5**

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

PURPOSE:

To define conditions under which patient's medications may be brought into the facility.

POLICY:

Patients are discouraged from bringing their own medications into Sierra View Medical Center (SVMC). Under limited and unusual circumstances, the patient may use their own medication (s) under the following circumstances:

1. Pharmacy cannot supply the medication.

2. When the patient insists.

Patient's own herbal remedies may not be used at Sierra View Medical Center due to the following reasons:

1. Herbal medications are categorized as a food (dietary supplement) under the Dietary Supplement Health and Education Act of 1994 by the Food and Drug Administration and are not held to the standards for the manufacturer of drugs.

2. These dietary supplements are not marked or identified with a stamp or number which does not satisfy the requirements for "positive identification" as stipulated in Title 22 § 70263 (m)(3).

~~2.~~

Sierra View Medical Center shall permit patient use of medical cannabis for terminally ill patient's (prognosis of life of one year or less, if the disease follows it's natural course) and shall do all of the following:

1. Prohibit smoking or vaping as methods to use medicinal cannabis
2. Include the use of medicinal cannabis within the patient's medical record. This will be done by following the process outlined in Patient's Own Medication policy & in adherence to the Controlled Substances Policy.
3. ~~1.~~ Patient is required to provide a copy of their medical marijuana card or written documentation that the use of medicinal cannabis is recommended by a physician prior to its use. This must be documented in the medical record. Patient's qualifying status as terminally ill by provider must also be documented into the medical record.
4. ~~2.~~ Require a patient or a primary caregiver, as defined in Section 11362.7, to be responsible for acquiring, retrieving, administering, and removing medicinal cannabis.
5. Medicinal cannabis is to be stored securely at all times in a locked container & with the patient's primary caregiver. Sierra View Medical Center also prohibits health care professionals and facility staff, including but not limited to physicians, nurses, and pharmacists from administering medicinal cannabis or retrieving medicinal cannabis from storage.

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6. Use is not permitted by a patient receiving emergency services and care, as defined in Section 1317.1, or to the emergency department of a health care facility, as specified in subdivision (a) of Section 1250, while the patient is receiving emergency services and care.
7. Medicinal cannabis will not be supplied by Sierra View Medical center.
8. Medicinal cannabis will be allowed to be brought in by the patient or by someone on the patient's behalf, for the patient's exclusive use. It is the personal property of the patient.
9. Only oral and topical forms of medical cannabis may be brought into Sierra View Medical Center for use under this policy.
10. Upon discharge, all remaining medicinal cannabis shall be removed by the patient or patient's primary caregiver. If a patient cannot remove the medicinal cannabis and does not have a primary caregiver that is available to remove the medicinal cannabis the product shall be disposed of in accordance with health facility policy and procedure for controlled substances.

Sierra View Medical Center will not prohibit patient use of medicinal cannabis due soley to that fact cannabis is a schedule I drug in the federal Uniform Controlled Substances Act, or other federal constraints on the use of medicinal cannabis that were in existence prior to January 1, 2022.
Sierra View Medical center reserves the right to suspend patient use of medicinal cannabis if a federal regulatory agency, the United States Department of Justice, or CMS does one of the following:

Initiates enforcement action against Sierra View Medical center related to the facility's compliance with the state-regulated mandate.

Issues a rule or otherwise provides the facility with notification that prohibits the use of medical marijuana in health care facilities or otherwise prohibits compliance with the state-regulated medical marijuana program.

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Home Medications not including Medicinal Cannabis

Medications meeting the conditions below, may be brought into the hospital under the following conditions:

1. Drugs have been ordered by a person lawfully authorized to give such an order, and the order is entered in the patient medical record.

   Orders shall meet the requirements of Medication Ordering Policy.

2. The medication container is clearly and properly labeled.

3. The contents of the containers have been examined and positively identified by the hospital's pharmacist.

a. The pharmacist will log the medication into the "Patient Own Medication Log Sheet." For medications which the pharmacy cannot supply or when the patient insists, the pharmacist will take appropriate measures to ensure provided medications match the ordered medication. They will use a pill identifier via Clinical Pharmacology or other drug identifier database, at minimum, to confirm the contents of patient's bottles/bags, etc. Once confirmation is achieved, the pharmacist will enter the order for Patient's Own Medication. The patient's pill bottle will then be sent to the patient's unit with a label from Pharmacy for scanning/administration to patient. The pharmacist will initial this label to show confirmation that the order was checked by pharmacy. Upon dispensing, the pharmacy will label the container stating "Return Patient's Own Medications To Patient Upon Discharge."

b. The pharmacist or pharmacy technician will then deliver Patient's Own Medications to the appropriate patient care area.

Drugs that are not to be used during the patient's stay at the hospital will be given to the patient's family to take home.

In the event that the medications cannot be sent home, the medications will be sent to the pharmacy. The pharmacist (or nursing supervisor, after normal pharmacy hours), will place the labeled bag of medications in a separate drawer/cabinet marked "patients own medications" away from all other pharmacy stock. Receipt of the medication will be documented on the "patient's medication log" to include the name of the patient, the date received and the disposition of the medications (i.e. date returned to the patient upon discharge or date destroyed as applicable).

AFFECTED AREAS/PERSONNEL: *PHARMACY, NURSING*

PROCEDURE:

A patient may utilize his/her medication on the written order of the attending physician when all of the following conditions are met:

1. Medications are ordered by the patient's physician and the order is entered on the patient's medication profile indicating:

   a. Patient's own medication may be used

   ~~b.~~ Name, strength, route, and dose schedule ~~of the drug~~

   ~~c. Strength of drug and route~~

   ~~d. Dose schedule~~

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2. Medications have been examined by the pharmacist for positive identification and correctly labeled.

3. In the event that a patient has an attached medication delivery device, (e.g., pump , etc.), the nurse will contact the pharmacist to come to the patient's bedside for a visual inspection of the device.

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MEDICATION INFUSION DEVICES

1. The pharmacist will contact the pharmacy that provided the pump and determine concentration, original volume, expiration of the drug and any other pertinent information deemed necessary at the time and enter that information into the medical record.

2. The pharmacist will also contact the prescriber to validate dose and delivery rate of the medication being infused as well as any parameters under which the infusion should be slowed or stopped and enter that information into the medication profile.

3. Instructions on how to stop the pump or change the rate will be obtained from the original prescriber or manufacturer and kept at the nursing station.

STORAGE AND DESTRUCTION OF PATIENT'S OWN MEDICATION:

1. Patient's own medication should be returned to the patient's family upon admission.

2. If the medication is unable to be returned to the family, it is to be sent to the pharmacy for storage.

3. If the medications are not claimed 30 days after discharge, they will be destroyed in the following manner:

   a. Drugs listed in Schedule II, III, or IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended, shall be destroyed in the presence of two pharmacists employed by the hospital. The name of the patient, the name and strength of the drug, the prescription number, the amount destroyed, the date of destruction and the signatures of the required witnesses shall be recorded in a separate log. Such a log shall be retained for at least 3 years. Medications may be sent to DEA disposal unit as required by DEA office.

   b. Drugs not listed under Schedule II, III, IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended, shall be destroyed in the presence of a pharmacist.

REFERENCES:

- The Joint Commission (2022~~19~~). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.
- Statutory Changes in Pharmacy Law. https://www.pharmacy.ca.gov/laws_regs/new_laws.pdf Accessed 1/10/2023.
- Pharmacy Law: California Edition.(2022~~19~~) San Clemente, California: Law Tech Publishing Group.
- Title 22 (n.d.).Retrieved on September 20, 2019, from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.
- SB 311, Hueso. Retrieved on February 9th, 2022. https://leginfo.legislature.ca.gov/faces/billTextClinet.xhtml?bill id=202120220SB311

SUBJECT: **PHARMACY AND THERAPEUTICS COMMITTEE**	SECTION: **Page 1 of 2**

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POLICY:

The Pharmacy and Therapeutics Committee is a policy recommending body to the medical staff governing body, hospital administration and, ultimately, the Board of Directors on matters related to the therapeutic use of drugs as well as pharmacy processes and procedures. The Committee will consist of at least two physicians, the Director of Pharmacy, the Chief Nurse Executive and the VP of Quality. The Committee will meet at least quarterly.

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

PROCEDURE:

The Committee is responsible for developing policies and procedures regarding the procurement, distribution, storage, dispensing and safe use of pharmaceuticals within the hospital. The Committee will also participate in quality assurance and performance improvement activities surrounding pharmaceutical care.

1. Any processes surrounding policies, procedures, or activities of pharmaceutical care should involve Pharmacy Services for review and/or development.
2. Upon approval by the subgroups involved, the policy, procedure or reports will be taken to the Pharmacy and Therapeutics Committee for approval and/or discussion.
3. All reports given to the Committee on studies performed report trends or results are strictly confidential. When deemed appropriate by the Pharmacy and Therapeutics Committee, request may be made to the individual medicine departments for their review of data.
4. When approved or reviewed, the policy, procedure, or result will be forwarded to all the organizational health-care staff affected by the process or policy change.
5. The Director or Manager of Pharmacy or his representative will participate in the implementation of all decisions made by the Pharmacy and Therapeutics Committee throughout the Hospital.
6. Developing and reviewing the formulary and Medication Error Reduction Plan (MERP) data.
7. Evaluating data on new drugs or preparations suggested by staff.
8. Reviewing performance improvement data from pharmacy department.
9. Review and approve clinical practice guidelines that involve pharmacotherapy.
10. Policies adopted by the Committee will be approved by the Executive Committee of the Medical Staff, and when appropriate, by Hospital Administration and the Board of Directors.

VOTING PRIVLIGES

1. The voting members shall consist of two physician representatives, the Director/Manager of Pharmacy or designee, Chief Nurse Executive or designee, and the VP of Quality or designee.

2. A quorum is needed to conduct business and shall consist of the members present and no less than two voting members.

REFERENCES:

- Title 22 (n.d.).Retrieved on September 20, 2019, from https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=ID7365A90D4BB11DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)&bhcp=1.

SUBJECT: **POSITIVE EXPIRATORY PRESSURE (PEP) THERAPY**	SECTION: **Page 1 of 3**

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

PURPOSE:

To standardize the use of Positive Expiratory Pressure (PEP) therapy, a bronchial hygiene technique used for secretion mobilization.

DEFINITIONS:

PEP = Positive Expiratory Pressure

POLICY:

Respiratory Care Services utilizes PEP therapy, per physician order, as a bronchial hygiene technique and in the treatment and prophylaxis of postoperative pulmonary atelectasis.

PEP therapy may be administered by a Respiratory Care Practitioner trained and checked off in the proper procedure with an understanding of age specific requirements of the patient population treated.

INDICATIONS:

- Patients with chronic pulmonary conditions, such as cystic fibrosis and chronic bronchitis, which predispose them to large volume sputum production.
- To reduce air trapping in asthma and chronic obstructive pulmonary disease (COPD).
- To optimize delivery of bronchodilators in patients receiving bronchial hygiene therapy.

CONTRAINDICATIONS:

- Patients who are uncooperative and will not comply with therapy
- Patients with a history of epistaxis
- Patients who are unable to tolerate the increased work of breathing
- Intracranial pressure (ICP) > 20 mm Hg
- Hemodynamic instability
- Acute sinusitis
- Recent facial, oral or skull surgery or trauma
- Esophageal surgery
- Active hemoptysis
- Nausea
- Untreated pneumothorax
- Known or suspected tympanic membrane rupture

POSSIBLE HAZARDS / COMPLICATIONS

- Increased work of breathing that may lead to hypoventilation and hypercapnia
- Increased intracranial pressure
- Cardiovascular compromise
- Myocardial ischemia
- Decreased venous return

- Air swallowing, with increased likelihood of vomiting and aspiration
- Claustrophobia
- Pulmonary barotrauma

AFFECTED PERSONNEL/AREAS: *RESPIRATORY CARE PRACTITIONERS*

EQUIPMENT:

- PEP device - acapella
- Clear mouthpiece
- Optional – hand held nebulizer with large tubing adaptor
- Optional - Nose clips

PROCEDURE:

1. Verify the physician order.
2. Wash hands.
3. Verify that you have the correct patient by using two patient identifiers.
4. Collect and assemble equipment. Attach a one-way valve on the inspiratory end, and a resistor on the expiratory end. Select the largest expiratory resistor setting when initiating therapy.
5. Explain the procedure to the patient. Have patient sit up straight, preferably at a table, with their elbows resting on the table.
6. Instruct the patient to place the mouthpiece in their mouth.
7. Instruct the patient to take in a breath larger than a normal tidal volume, but not up to Total Lung Capacity.
8. Instruct the patient to perform 10-20 breaths as above.
9. Cough to expectorate raised sputum. Quantify estimated sputum in milliliters.
10. This sequence of 10-20 PEP breaths and expectoration will be repeated 4-8 times, for a total PEP session not to exceed 20 minutes.

If a patient is on nebulized bronchodilators, they will be given in conjunction with the PEP treatment. Connect the nebulizer directly to the inspiratory end of the PEP assembly, using a larger bore adapter. Attempts will be made to administer the combined therapy via a mouthpiece (with nose clips), if tolerated by the patient. NOTE: Patients using MDI bronchodilators will be instructed to administer the MDI puffs just prior to PEP therapy.

INFECTION CONTROL:

- Standard Precautions

REFERENCES:

- Acapella DM & DH Vibratory PEP Therapy System. Product guide. Retrieved from https://www.smiths-medical.com/en-us/products/respiratory/bronchial-hygiene/acapella-vibratory-pep-therapy-system

- Bottrell, J. (2021). What are flutter valves and acapellas? COPD.net. Retrieved from https://copd.net/clinical/flutter-valves-acapellas

SUBJECT: **STORAGE OF FLAMMABLE MATERIALS**	SECTION: **Page 1 of 1**

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

PURPOSE:

To ensure all flammable materials are stored in an area that complies with all state and federal regulations.

POLICY:

All flammable materials must be stored in an area that complies with all state and federal regulations.

AFFECTED AREAS/PERSONNEL: *PHARMACY, NURSING*

PROCEDURE:

1. Flammable drugs in pharmacy will be stored in the flammable lockers, which are labeled FLAMMABLE.

2. Flammable drugs include, but are not limited to:

    a. Alcohol (in a quantity greater than 100ml and/or in a concentration in water greater than 70% concentration.

    b. Flexible Collodion

    c. Phenol

    d. Ethyl Chloride (spray)

    e. Tincture of Benzoin (spray)

REFERENCES

- Lexicomp Drug Reference Handbook (27st Edition). (2022). Hudson, Ohio. Lexicomp Information Management Service.

SUBJECT: **THERAPEUTIC DRUG SUBSTITUTION PROTOCOL**	SECTION: ***Clinical Pharmacy Drug Protocols*** **Page 1 of 10**

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

PURPOSE:

To promote cost effective, rational drug therapy by controlling the number of similar medications within a given therapeutic class that will be available on formulary.

POLICY:

A therapeutically equivalent drug may be dispensed following the development of objective interchange guidelines by the medical and pharmacy staff through the Pharmacy and Therapeutic Committee.

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

PROCEDURE:

The Pharmacy and Therapeutics Committee will identify potential therapeutic classes of medications, which may provide an opportunity for therapeutic interchange. Upon identification, experts in the area of therapeutic classification will be changed with selecting an appropriate therapeutic class representative drug. In making this selection, the following factors should be considered: mechanism of action, adverse effect profile, dosing schedule, monitoring parameters, potential drug interactions, and cost. Following the agent selection, objective interchange guidelines will be established and will be reviewed with other members of the medical staff.

The P&T Committee will review these guidelines. Following approval by P&T, the Medical Executive Committee of the institution will review and approve.

Medications with a DAW or dispense as written designation will be reviewed through the non-formulary process.

DEFINITIONS:

1. Therapeutic Substitutions- Is the replacement of the originally prescribed drug with an alternative molecule with assumed equivalent therapeutic effect. The alternative drug may be within the same class or from another class with assumed therapeutic equivalence.

2. Biosimilar- FDA approved medication that is highly similar to the reference product. For approval, the structure and function of an approved biosimilar were compared to reference product and shown to have no clinically meaningful differences in safety, purity, or potency (safety and effectiveness) compared to the reference product.

Appendix A: Proton Pump Inhibitor

Pantoprazole (Protonix®) will be the preferred (medication substituted to) proton pump inhibitor at Sierra View Medical Center. Lansoprazole (Prevacid®) 30mg Solutabs may be used if PPI needed to be delivered via G-tube. Orders written for oral dexlansoprazole (Dexilant®), esomeprazole (Nexium®), lansoprazole (Prevacid®), omeprazole (Prilosec®) or rabeprazole (Aciphex®) are autosubstituetd by Pharmacy per the table below.

Preferred Agent					
Pantoprazole (Protonix®)	**Omeprazole (Prilosec®)**	**Esomeprazole (Nexium®)**	**Rabeprazole (Aciphex®)**	**Lansoprazole (Prevacid®**	**Dexlansoprazole (Dexilant®)**
20mg daily	10mg daily	20mg daily	20mg daily	15mg daily	30mg daily
40mg daily	20mg daily	20mg daily	20mg daily	30mg daily	60mg daily
40mg BID	20mg bid or 40mg daily	40mg daily	20mg BID	30mg BID	30mg BID
80mg BID	40mg bid	80mg daily	40mg BID	60mg BID	60mg BID

Note: In the event of a drug shortage for Pantoprazole; Esomeprazole will be the substitute agent.

Appendix B: Nasal Corticosteroid Products

Substitutive Agent-Therapeutic Interchange	Non-Form
Fluticasone Nasal 1 spray each nostril daily	Beclomethasone Nasal, 1-2 spray each nostril BID
Fluticasone Nasal 1 spray each nostril daily	Budesonide Nasal, 1-2 spray each nostril BID
Fluticasone Nasal 1 spray each nostril daily	Flunisolide Nasal, 2 sprays each nostril BID
Fluticasone Nasal 1 spray each nostril daily	Mometasone Nasal, 2 sprays each nostril daily
Fluticasone Nasal 2 spray each nostril daily	Triamcinolone Nasal, 2 sprays each nostril daily

Note: In the event of a drug shortage for Fluticasone nasal, Triamcinolone Nasal will be the substitute agent.

Appendix C: Inhaled Combination Medication Therapeutic Interchange

Substitutive Agent- Therapeutic Interchange	Non-Form
Fluticasone/Salmetrol (Advair) 100/50 mcg 1 puff BID 250/50 mcg 1 puff BID	Budesonide/Formoterol (Symbicort) 80/4.5 mcg 2 puffs BID 160/4.5 mcg 2 puffs BID
Fluticasone/Salmetrol (Advair) 100/50 mcg 1 puff BID 250/50 mcg 1 puff BID 500/50 mcg 1 puff BID	Fluticasone/Salmeterol(Advair HFA) 45/21 mcg 2 puffs BID 115/21 mcg 2 puffs BID 230/21 mcg 2 puffs BID
Fluticasone/Salmetrol (Advair) 100/50 mcg 1 puff BID 250/50 mcg 1 puff BID	Fluticasone/Vilanterol (Breo) 100/25 mcg daily 200/25 mcg daily
Albuterol MDI same dose and frequency plus Tiotropium (Spiriva Respimat) 2 INH daily	Ipratropium/Albuterol (Combivent)
Fluticasone/Salmeterol (Advair) 250/50 mcg 1 puff BID 250/50 mcg 1 puff BID	Mometasone/Formoterol (Dulera) 100/5 mcg 2 puffs BID 200/5 mcg 2 puffs BID
Tiotropium (Spiriva Respimat) 2 inhalations (2.5mcg) daily	Tiotropoium (Spiriva Handihaler) Inhale contents of one capsule daily

Appendix D: Insulin Therapeutic Interchange

Substitutive Agent- Therapeutic Interchange	Non-Form
Insulin Lispro (Humalog) 1:1 conversion	Insulin Aspart (Novolog)
Insulin glargine 1:1 conversion	Insulin degludec (Tresiba)
Insulin glargine 1:1 conversion	Insulin detemir (Levemir)

Note biosimilar's for substitutive therapeutic interchange may be used.

Appendix E: Antihistamine agents

Substitutive Agent- Therapeutic Interchange	Non-Form
Loratadine (Claritin) 10mg daily	Cetirizine (Zyrtec) Oral 5mg or 10mg daily
Loratadine (Claritin) 10mg daily plus Equivalent Pseudoephedrine up to 60mg po QID	Cetirizine/Pseudoephedrine (Zyrtec-D) All doses
Loratadine (Claritin) 10mg daily	Desloratidine (Clarinex) Oral 5mg daily
Loratadine (Claritin) 10mg daily	Fexofenadine (Allegra) Oral all doses
Loratadine (Claritin) 10mg daily Equivalent Pseudoephedrine up to 60mg po QID	Fexofenadine/Pseudoephedrine (Allegra-D) All doses
Loratadine (Claritin) 10mg daily	Levocetirizine (Xyxal) Oral 2.5 to 5mg daily
Loratadine (Claritin) 10mg daily Equivalent Pseudoephedrine up to 60mg po QID	Loratidine/Pseduoephedrine (Claritin D)

Appendix F: Biosimilar Medications

Note- Preferred agents should be utilized for inpatient and outpatient use. If a patient's payer requires use of a non-preferred agent, the non-preferred biosimilar may be used.

Therapeutic Interchange (Preferred agent)	Reference Product	Comments
Alymsys (Bevacizumab- maly) Mvasi (Bevacizumab- awwb)	Avastin (Bevacizumab)	
Kanjinti (Trastuzumab-anns)	Herceptin (Trastuzumab)	
Ziextenzo (pegfilgrastim-bmez)	Pegfilgrastim (Neulasta)	As insurance allows Pegfilgrastim biosimilar and products is NON-FORMULARY for inpatients. Filgrastim should be used for inpatients
Releuko (Filgrastim-ayow)- preferred Zarxio (Filgrastim-sndz)	Neupogen (Filgrastim)	As required by payor
Renflexis (infliximab-abda)- preferred Inflectra (infliximab-dyyb)	Remicade (Infliximab)	As required by payor
Retacrit- epoetin alpa-epbx	Procrit/Epogen- epoetin alpha	
Truxima (rituximab-abbs)- preferred Riabni (rituximan-arrx)	Rituxan-rituximab	

Cancer Treatment Center Procedure:

If it is discovered that a patient's insurance rejects said biosimilar as part of the patient's treatment, the patient's care plan will be adjusted by the CTC pharmacist to reflect the approved agent. Example: Mvasi is rejected but insurance will cover Avastin→Pharmacist will be allowed by physician to make the adjustment in the patient's care plan.

1. Upon receipt of new care plan, CTC pharmacist will confirm with said list and if necessary, adjust the medication within the care plan to reflect the current approved medication from Addendum A if necessary to conform to insurance authorized and physician requested care plan.

2. After pharmacist adjustment in care plan, they will forward to insurance authorizer for approval. Once approved, Pharmacy will order as needed.

Dose Rounding for Continuous Infusion of Oncology Medications

1. Upon receipt of new orders for chemotherapy or biotherapy, the pharmacist will verify all calculations for dosage of agents ordered by the MD.
2. The pharmacist will evaluate the availability of the medications ordered. If the medication is available as a single use vial, the pharmacist shall calculate the difference in the dose ordered and the dose rounded to vial size.
3. For all single use vials of chemotherapy the pharmacist shall round the dose to a vial size within a 10% range of the dose ordered.
4. For all single use vials of monoclonal agents, the pharmacist shall round the dose to vial size within a 10% range of the dose ordered.
5. The provider will not be notified for dose changes of up to 5% for either chemotherapy or monoclonal agents.
6. The provider will be notified for dose changes greater than 5% and up to 10% for either chemotherapy or monoclonal agents.
7. Patients enrolled in clinical trials are excluded from the policy (unless dose rounding is specifically allowed in the investigational protocol)
8. If the physician does not wish to have the rounding policy applied, they will document on the order "no dose rounding" within the treatment plan within the administration instructions section.

Duplicate Orders

- Pharmacists may delete duplicate orders of the same medication, dose, and route with varying schedules. It will be assumed the new order with updated schedule is intended to replace the previous order (update frequency, dose, etc). E.g. Acetaminophen 650mg PO Q4HRS prn pain and Acetaminophen 650mg po Q6hrs prn pain. Pharmacist can authorize to delete the old order, and verify the new order while adding additional comments not to exceed 4gm/day as they see necessary.

Interchange between liquid and solid dosage forms

Pharmacists may automatically interchange between liquid and solid forms and route. EG patient is receiving medication and/or feedings via NG,OG,PEG; Pharmacist after discussion with patient's nurse will switch from oral to liquid form if available. Exception-Phenytoin with consult to patient practioner.

Therapeutic Duplications

- Duplicate orders for the same indication are only appropriate if clear instructions around the circumstances each order applies to are indicated by the ordering practitioner. Any duplicative order without clear distinction will be assessed and addressed by the reviewing pharmacist.
- Any parenteral (IV, IM, SQ) or rectal (PR) medication ordered as needed (PRN), will have direction added by pharmacist to "use when unable to tolerate oral" if another order for an oral alternative is ordered for the same as needed indication.

Example: Order written for Ondansetron 4mg IV q8h prn Nausea/vomiting with an existing Ondansetron 4mg PO q8h prn Nausea/vomiting. Pharmacist to clarify in the comment field of the IV order: Ondansetron 4mg IV q8h prn Nausea/vomiting, use when unable to tolerate oral

Example: Order written for Oxycodone 5mg PO q4h prn pain scale 4-7 with an existing Hydromorphone 0.4mg IV q4h prn pain scale 4-7. Pharmacist to clarify in the comment field: Hydromorphone 0.4mg IV q4h prn pain scale 4-7, use when unable to tolerate oral

- Any order for a parenteral (IV, IM, SQ) as needed (i.e., PRN) opioid will be discontinued when a subsequent order for a parenteral PRN opioid is placed unless there is clear criteria included on the order for when to administer one opioid over the other (e.g. breakthrough pain).

Example: Order written for HYDROmorphone (Dilaudid®) 0.5 mg IV q4h PRN pain 8-10 ordered on a patient with an existing order for Morphine 2 mg IV q4h PRN pain 8-10. Pharmacist will discontinue the existing Morphine order and validated the new HYDROmorphone (Dilaudid®) order.

- Any order for a short-acting PRN oral opioid will be discontinued when a subsequent order for a short-acting oral PRN opioid is placed unless there is clear criteria included on the order for when to administer one opioid over the other (e.g. Breakthrough pain).

Example: Order written for Oxycodone Immediate Release (IR) 5 mg PO q4h prn pain 8-10 ordered on a patient with an existing order for Tramadol (Ultram) 50 mg PO q4h prn pain 8-10. Pharmacist will discontinue the existing Tramadol order and validate the new Oxycodone order.

• Any orders for parenteral or oral as needed (i.e. PRN) opioids will discontinued when a subsequent order for a PCA or epidural is placed unless a clear indication that both can be administered concurrently via an order clarified with the provider.

• Any orders for parenteral or oral as needed (i.e. PRN) opioids will be left unvalidated if ordered at the same time as a PCA or epidural unless a clear indication that both can be administered concurrently via an order clarified with the provider. Upon PCA or epidural discontinuation, parenteral or oral as needed opioids will be validated.

• Any orders with overlapping pain scales ordered at the same time will be clarified that the higher dose of medication is clarified to the higher pain scale as long as no medication is indicated for that pain scale.

Example: Orders written for Oxycodone Immediate Release 2.5mg PO q4h prn pain 4-7 and Oxycodone Immediate Release 5mg PO q4h prn pain 4-7. Pharmacist will adjust the Oxycodone Immediate Release 5mg PO q4hr prn pain 4-7 to a pain scale of 8-10 upon validation.

• Any orders with pain scales of 1-3 or 4-7 and no order or information that include the higher pain scales will be clarified to include the higher pain scale as long as no medication is indicated for that pain scale.

Example: Order written for Tramadol 50mg PO q4hr prn pain 4-7. Pharmacist will adjust the Tramadol 50mg PO q4hr prn pain 4-7 to a pain scale of 4-10 upon validation.

Appendix: IV to PO Subsection

PURPOSE: To provide a process for changing parenteral medications to the oral/enteral route when medically appropriate.

The advantages of this program are to provide an oral/enteral dosage form with comparable bioavailability to the intravenous form, which has been shown to decrease length of hospitalization.

To reduce the added risks associated with continued intravenous therapy.

To lower overall medication and associated costs to the patient and the hospital.

Additional benefits include greater patient comfort, decreased nursing needs, & easier ambulation. Orders for approved intravenous (IV) medications are automatically changed to PO (by mouth) administration form when medical staff approved conditions and guidelines are met, and the switch is appropriate.

PROCEDURE: Patients must meet the following criteria in order to be considered for automatic IV to PO conversion of the selected medications. If the patient does not meet all criteria listed below, they will not be considered for automatic IV to PO conversion.

Inclusion Criteria

- The patient must be on IV therapy for at least 24 hours before IV to PO conversion consideration.
- The patient is tolerating scheduled medications and diet (orally, or via NG or G tube).
- The patient is not on a pre-operative or -procedure or post-operative or -procedure fast.
- The patient has not experienced any recurrent nausea, vomiting or diarrhea for at least 24 hours.
- The patient does not have documented esophophageal sphincter incompetence.
- The patient does not have an active gastrointestinal bleed.
- The patient does not have documented problems with oral absorption (i.e., ileus, short bowel syndrome, celiac sprue, and inflammatory bowel disease or malabsorption syndrome).
- The patient is not at risk for aspiration (e.g., decreased consciousness, seizures, etc.).

Additional criteria for antibiotic/antifungal agents

- The patient is afebrile for at least 24 hours (temp < 100.4° F).
- The patient is clinically improving (white blood cell count decreasing, bands decreasing, improved signs and symptoms as documented in prescriber progress notes).
- The infection is at a site where an oral agent will achieve an adequate level (not endocarditis, meningitis, brain abscess, orbital cellulitis, other CNS infections, osteomyelitis, and endophthalmitis).
- The patient is not septic, and is hemodynamically stable (heart rate ≤ 100 beats/minute, respiratory rate ≤ 24 breaths/minute, and systolic blood pressure > 90 mm Hg without vasopressor support).
- For documented fungemia, fluconazole will continue IV for 7 days before PO switch.

The pharmacist may automatically switch the following medications to the oral dosage form, if the conditions under section 1 of this policy are met:

Antimicrobials

Medication	Intravenous Dose	Oral Equivalent
Azithromycin	250 mg IV daily 500 mg IV daily	250 mg PO daily 500 mg PO daily
Ciprofloxacin	200 mg IV every 12 hours 400 mg IV every 12 hours 400 mg IV every 8 hours	250 mg PO every 12 hours 500 mg PO every 12 hour 750 mg PO every 12 hours
Clindamycin	600mg-900mg IV every 8 hours	300mg-450 mg PO every 8 hours
Doxycycline	100 mg IV every 12 hours	100 mg PO every 12 hours
Levofloxacin	250 mg IV daily 500 mg IV daily 750 mg IV daily	250 mg PO daily 500 mg PO daily 750 mg PO daily
Fluconazole	100 mg IV daily 200 mg IV daily 400 mg IV daily	100 mg PO daily 200 mg PO daily 400 mg PO daily
Linezolid	600 mg IV every 12 hour	600 mg PO every 12 hours
Metronidazole	500 mg IV every 8 hours	500 mg PO every 8 hours
Rifampin	600 mg IV daily	600 mg PO daily
Trimethoprim / Sulfamethoxazole (TMP/SMX)	5-20 mg TMP/kg/day in 3-4 divided doses IV	As close to 1:1 conversion of TMP as possible: 1 double strength = 160 mg TMP 1 single strength = 80 mg TMP
Voriconazole	3-4 mg/kg IV every 12 hours (maintenance dose)	<40 kg: 100 mg PO every 12 hours ≥40 kg: 200 mg PO every 12 hours

Others

Medication	Intravenous Dose	Oral Equivalent
Acetaminophen IV (Ofirmev) (restricted only for those with strict NPO)	IV to PO is equivalent	Same dose regimen and frequency. May need to adjust in multiples of 325mg. IV acetaminophen doses limited to 2 doses for PRN orders and 4 doses for scheduled orders.
Famotidine	20 mg IV every 12 hrs.	20 mg PO every 12 hours
Ranitidine	50 mg IV every 6 or 8 hrs.	150 mg PO every 12 hours
Pantoprazole	40 mg IV daily	40 mg PO daily (lansoprazole 30mg NG daily)
Folic Acid	1mg IV daily	1mg PO daily
Levetiracetam	500 mg IV every 12 hours	500 mg PO every 12 hours
Metoclopramide	10 mg IV every 6 hours PRN	10 mg PO Q6H every 6 hours PRN
Thiamine	100 mg IV daily	100 mg PO daily
Multivitamin	10 ml IV daily	1 tablet PO daily

The pharmacist will review the criteria and effect the change when appropriate. He/She will enter an order in the patient's chart under "Physician Orders" as "Change I.V. (*insert drug name*) to P.O. per protocol". The notation "Per SVMC Policy" will be entered or written adjacent to the pharmacist's signature.

REFERENCES:

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SUBJECT: **THROMBOLYSIS with TNKase for ACUTE MYOCARDIAL INFARCTION**	SECTION: **Page 1 of 9**

PURPOSE:

The intent of this procedure is to outline the recommended nursing and physician management for use of TNK in a patient presenting with an Acute Myocardial Infarction (MI).

DEFINITIONS:

1. STEMI: ST-segment Elevation Myocardial Infarction
2. PCI: Percutaneous coronary intervention
3. TNK or TNKase (Tenecteplase): Medication (tissue plasminogen activator) that causes thrombolysis, a second generation derivative of tPA.

AFFECTED AREAS/STAFF: *EMERGENCY DEPARTMENT, INTENSIVE CARE UNIT STAFF*

POLICY:

Although primary percutaneous coronary intervention is the preferred method of treatment for acute MI patients, STEMI patients presenting to SVMC without reasonable chance of emergency **primary PCI within 90 minutes of presentation** should undergo thrombolysis **within 30 minutes unless contraindicated** (based on AHA/ACC Class I evidence). For all patients presenting to the Emergency Department with complaints of chest pain or other signs and symptoms of an acute MI who meet this criteria, the following evaluation and interventions are considered.

PROCEDURE:

A. Perform initial assessment and interventions:

1. Obtain vital sign including $SaPO_2$ and 12-lead ECG within five (5) minutes of arrival
2. Place on continuous Pulse Oximetry monitor
3. Place on continuous cardiac monitor
   a. Assess the cardiac rhythm
   b. Place initial strip in medical record
4. Obtain patient's height, weight and allergies

5. Insert a large bore (18 gauge) IV Saline Lock

6. Complete cardiac and neurological assessment

B. Perform screening to identify inclusion and exclusion criteria for thrombolysis as indicated:

1. **Inclusion criteria:** Consider thrombolytic therapy if **ALL** the following are **present**:

   a. Symptoms started less than three (3) hours ago

   b. Clear ST elevation in two (2) or more contiguous leads, greater than 1mm, or a new symptomatic left bundle branch block (LBBB) or after consultation and agreement with Cardiologist.

   c. Confirm patient has no absolute contraindications to thrombolytics (listed in B.2. below)

   d. Patient stable without signs of cardiogenic shock or severe heart failure (PCI is preferred)

2. **Confirm Absolutely No Contraindications**: **Avoid thrombolytics** if **ANY** of the following are **present**, or the patient has a **history** of:

   a. Active internal bleeding

   b. History of cerebrovascular accident

   c. Intracranial or intra-spinal surgery or trauma within 2 months

   d. Intracranial neoplasm, arteriovenous malformation, or aneurysm

   e. Known bleeding diathesis

   f. Severe uncontrolled hypertension

   Additional Absolute contraindications per (ACC/AHA)

   g. Ischemic stroke within 3 months

h. Prior intracranial hemorrhage

i. Active bleeding (excluding meses)

j. Suspected aortic dissection

k. Significant closed head or facial trauma within 3 months.

3. **Relative Contraindications**: Benefit of PCI may be greater than giving thrombolytics, particularly if multiple factors are present. Reasonably assess and document combined factors:

a. Uncertain diagnosis of STEMI (consult cardiology immediately & document findings and review of Cardiology consultation discussion)

b. Hypertension: systolic BP $\geq$ 180 mmHg and/or diastolic BP $\geq$ 110 mmHg

c. History of ischemic stroke within three (3) months ago

d. Dementia or other intracranial pathology

e. Recent, vigorous CPR for greater than 10 minutes (risk vs. benefit)

f. Internal bleeding within two (2) to four (4) weeks,

g. Non-compressible vascular punctures

h. Pregnancy

i. Active peptic ulcer

j. Age over 80 (age alone is NOT a contraindication to thrombolytics)

k. Current use of anticoagulants (increased risk of bleeding, use with caution)

l. Increased risk of ICH. It has been suggested that fibrinolysis has a greater potential for harm than benefit if the risk of ICH exceeds 4%.

m. Recent administration of GP IIb/IIIa inhibitors (within the previous 12 hours)

n. Recent (within six (6) weeks) major trauma or surgery (including laser eye surgery)

o. Severe hepatic dysfunction

p. Subacute bacterial endocarditis

q. Acute pericarditis

r. Suspected Aortic dissection

s. High likelihood of left heart thrombus (e.g., mitral stenosis with atrial fibrillation)

C. Consent:

1. Physician will communicate with patient/family regarding treatment options, including use of TNKase and its potential risks, side effects, complications, and benefits.

2. Physician to document patient's consent or refusal of the use of TNK and note in the patient's medical record.

3. If unable to obtain consent, physician to document necessity and urgency of TNK and administer, if deemed appropriate.

D. BP management for the pre-treatment of patients who are otherwise eligible for TNK: If for two (2) readings five (5) minutes apart, the systolic blood pressure is greater than 180 mmHg, or the diastolic blood pressure is greater than 110 mmHg:

1. With the Physicians order, give Labetalol 20 mg intravenously over 1 to 2 minutes. May repeat dose x 1, if BP is still elevated after 15 minutes (hold if heart rate (HR) less than 60) as ordered by physician.

2. Notify physician if BP remains elevated past 2nd dose of labetalol.

3. Alternatively, nitroglycerin (NTG) may be used if there is no evidence of right ventricular involvement in Inferior Wall STEMI.

4. Monitor blood pressure every 10-15 minutes during and after TNK administration. Observe for hypotension.

5. If systolic BP is not lowered to less than 180 mmHg and if diastolic BP is not lowered to less than 110 mmHg, TNK should NOT be given.

E. TNK Administration:

1. Remember, Time = Muscle! Door to needle goal <30 minutes.

2. TNK is a single bolus injection only.

3. TNK dosing is ideal weight based. Follow the parameters on the table (see below):

PATEINT'S WEIGHT (Kg)	TNK DOSE	TNK VOLUME
< 60 kg	30 mg	6 mL
≥60 to <70 kg	35 mg	7 mL
≥70 to <80 kg	40 mg	8 mL
≥80 to <90 kg	45 mg	9 mL
≥ 90 kg	50 mg	10 mL
Concentration is 5 mg/mL.	****Maximum dose is 50 mg, or 10mL**	

4. Preparation of the patient

   a. When the decision is made to administer TNK, the patient should have an IV of Normal Saline. *Note:* ***Dextrose solutions are not compatible with TNK***

   b. When the decision to give TNK is made, Heparin should be administered before or concurrently with TNK

5. Preparation of TNK medication when a pharmacist is not present (requires completion of *RN House Supervisor Admixture Competency*)

a. Remove "shield assembly" from 10mL syringe. Note: do not discard the shield assembly – it is needed to administer the medication.

b. Withdraw 10 mL of sterile water (not bacteriostatic water) from the provided vial using "red hub" device

c. Gently inject sterile water into vial containing TNK powder

d. Gently swirl contents; do not shake or agitate

i. It should be colorless to clear - pale yellow

ii. Slight foaming is normal

6. Administration

a. Withdraw appropriate weight-based patient dose from TNK vial

b. Stand "shield assembly" vertically on countertop (green cap down) and recap red hub

c. Remove entire shield assembly including red hub

d. TNK is ready to inject as a bolus through a needleless hub into a saline solution IV line

e. Dextrose containing lines must be flushed with a saline solution before and after administration

f. Inject TNK as an IV bolus over 5 seconds

g. Avoid IM injections

h. Discard into pharmaceutical waste bin, remaining TNK if physician concurs

i. Remember to consult provider to give Heparin (or lovenox) in addition to TNK

F. Ongoing Assessment:

1. The patient who has received TNK is at high risk for reperfusion arrhythmia's and should be monitored frequently.

2. Assess and monitor the following after starting TNK infusion:

   a. VS, cardiac/neurological check and $SaPO_2$ every 15 minutes for 2 hours

   b. VS, cardiac/neurological check and $SaPO_2$ every 30 min. for 6 hours

   c. VS cardiac/neurological check and $SaPO_2$ every hour for 18 hours

3. Monitor Cardiac rhythm and obtain strip for medical records per unit standards

4. Monitor for signs of bleeding and neurological deterioration:

   a. New headache

   b. Acute hypertension or acute hypotension

   c. Bleeding of gums, mouth or venipuncture sites

   d. Nausea or stomach pain

   Recommendations for BP management of patients who have just received TNK:

5. Check BP every 15-20 minutes during treatment and subsequent 2 hours, followed by every 30-40 minutes for 6 hours, then hourly for 16 hours.

6. If SBP is 180 - 230 mmHg or DBP is 105 - 120 mmHg:

   a. Consult provider for appropriate intervention

   b. Consider one of the following:
      i. Administer labetalol 20mg over 1-2 minutes. May repeat every 10-20 minutes up to maximum dose of 300mg
      ii. If SBP is greater than 230mmHg or DBP is greater than 120mmHg, may consider Nicardipine Protocol at provider discretion.

G. Complication Management:

1. Monitor for cardiac arrhythmias; notify physician immediately for any change in cardiac rhythms.

2. Monitor for any signs of bleeding or intracranial hemorrhage:

   a. Changes in mental status/level of consciousness

   b. Complaints of new onset headache

   c. Acute hypertension

3. If any of these occur:

   a. Notify MD

   b. Obtain CT scan without contrast stat

H. Documentation:

1. Nurses and Physicians will record assessment findings, timing of TNK administration, pre-treatment interventions, and response to treatment in the patient medical record.

REFERENCES:

- American College of Emergency Physicians (2006). Clinical policy: indications for reperfusion therapy in Emergency Department patients with suspected acute myocardial infarction. *Ann Emerg Med.*;*48*:358-383. Retrieved on 07/01/2014 from: http://www.acep.org/clinicalpolicies/?pg=2

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- San Joaquin Community Hospital Chest Pain Center (2013). Thrombolysis with TNK for acute myocardial infarction. *Shared protocol.* Received on 05/21/2014 from SJCH CPC Education Department.

- Dalal, J., Sahoo, P.K., et al (2013). Role of thrombolysis in reperfusion therapy for management of AMI: Indian scenario. *Indian Heart J. 65*(5): 566-585. Retrieved on 07/02/2014 from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3861063/

SUBJECT: **TRANSFER OF PATIENT TO HIGHER LEVEL OF CARE FOR NEUROLOGICAL SERVICES**	SECTION: **Page 1 of 2**

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

PURPOSE:

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

POLICY:

Patients treated at SVMC who require a higher level of care due to their diagnosis or when needed medical services are not offered at SVMC will be transferred to the accepting hospital for further medical treatment.

Examples – Intracranial bleed or mechanical thrombectomy

AFFECTED PERSONNEL/AREAS: *ALL PATIENT CARE AREAS, RESPIRATORY THERAPY, HOUSE SUPERVISORS, SOCIAL SERVICES, CASE MANAGEMENT.*

EQUIPMENT:

- Portable ventilator
- Infusion pumps

PROCEDURE:

A. Emergency Transfer

1. Immediately notify the charge nurse of need for transfer; also notify Case Management for transfers in inpatient areas.

    a. Transfer happens as soon as possible, preferably within two (2) hours

2. Obtain order from attending provider to transfer patient to desired hospital.

3. Charge nurse or case management will contact facilities that offer the needed level of care and obtain acceptance from the facility and receiving physician.

4. Call accepting facility and give report to assigned clinician.

5. Contact Emergency Medical Services (EMS) or air transfer dispatch of need for emergency transfers from patient's unit (ED, ICU, Med Surg, CDU, Telemetry, or other patient care area) to accepting facility.

6. Stabilize and prepare patient for transfer.

7. Obtain the following documentation:

a. Physician Transfer Certification Form (pink) completed by RN and MD (copy goes with patient)
b. Physician certification statement (white copy stays at SVMC, yellow copy goes with ambulance)
c. CD of any relevant images
d. Copy of lab results
e. Copy of patient's face sheet
f. List of medications – both home and medications received at SVMC
g. Copy of patient's history and physical, if inpatient. If in the ED, copy of the ED physician note
h. Copies of radiology reports (along with CD of images)

8. Notify patient's family if physician has not already done so

9. Patients with infusing titratable medications will be accompanied by an SVMC Registered Nurse

10. Patients requiring a portable ventilator will be accompanied by a Respiratory Care Practitioner (RCP).

REFERENCES:

- The Joint Commission (2020). Comprehensive Certification Manual for Disease-Specific Care. Oakbrook Terrace, IL

CROSS REFERENCES:

- EMTALA- Interfacility Transfers, MSE, Emergency Care and Stabilization

SUBJECT: **TRANSFUSION REACTION PROCEDURE**	SECTION: ***Provision of Care, Treatment & Services (PC)*** **Page 1 of 7**

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

PURPOSE:

To establish guidelines for the handling, determining and reporting of adverse transfusion reactions.

POLICY:

1. In the event of a suspected transfusion reaction, the nursing personnel shall report patient symptoms to the physician. If the physician elects to stop transfusion:

   a. The Registered Nurse shall discontinue the transfusion and notify the blood bank personnel. The transfusion reaction workup will reflex order from the data entered into the Transfusion Administration Record (TAR) in Meditech. If the department is not using TAR or it is a delayed transfusion reaction, the nurse will order the transfusion reaction workup in Meditech.

   b. The Registered Nurse will call the lab to draw blood sample.

   c. Prepare the blood component bag and blood tubing and return to Blood Bank.

   d. Return the "Report of Suspected Transfusion Reaction" form (Addendum A) with blood component bag and tubing.

   e. The registered nurse will verify patient identification and document as indicated on the Reaction form.

   f. The Registered Nurse will obtain physician order, and collect the urine specimen for a post transfusion urinalysis and send it to the lab.

   g. The Laboratory will collect a new, properly labeled, blood sample (avoiding hemolysis) from the patient.

2. The Laboratory will perform the following "Partial Transfusion Reaction" work-up:

   a. Urine check for Hgb. If positive, check for RBC.

   b. The label on the blood containers, pre and post patient sample tubes, requisitions and computer records will be checked to detect whether there has been a clerical error made in identifying the patient or the blood.

   c. The patient's post-reaction serum shall be inspected for evidence of hemolysis, using a pre-reaction sample for comparison if available.

d. A blood type, Rh, and DAT will be performed on the patient's post-reaction transfusion specimen.

e. The results of these above mentioned procedures shall be documented in the appropriate spaces on the "Transfusion Reaction Form" with the Clinical Laboratory Scientist (CLS) performing the work-up signing, dating and timing the form.

f. The CLS will make copies of all reports and keep one copy in Blood Bank file under Transfusion Reactions, and send original to Pathologist. Preliminary documentation of the findings will be entered into Meditech.

g. The CLS will immediately contact the Pathologist informing him / her if any of the findings are positive and then perform full workup. The CLS will order the extended transfusion reaction workup in Meditech.

h. The transfusion reaction form will be submitted to the Pathologist for his/her signature and interpretation. The Pathologist will submit a progress report. A copy of this report will be filed in blood bank and another submitted to the Risk Manager. The Risk Manager will forward the Progress Report to Medical Records and keep the Report to document the incident.

i. In the event a hemolytic transfusion reaction is suspected the testing protocol shall include (but not be limited to) the following procedures:

- Retesting of the patient's pre and post-transfusion specimen for ABO, Rh, and antibody screen.
- Compatibility retesting of the donor specimen in question using patient's pre and post-reaction specimen samples.
- The CLS will culture the donor blood bag if temperature rise of >4° F.
- Bilirubin determinations on the patient.
- Hemoglobin determinations will be performed on the patient.
- If reaction is suggestive of a hemolytic reaction or bacterial contamination the attending physician shall be notified immediately.
- All transfusion reactions are to be reported to the Rad/Path Committee for review.

DEFINITION OF POSSIBLE ADVERSE BLOOD TRANSFUSION REACTIONS:

1. Hemolytic Transfusion Reaction:

   a. Cause:

   Antibodies in the recipient's plasma react with antigens in donor red blood cells. This leads to donor cell agglutination and capillary occlusion, blocking blood flow and oxygen to vital organs. Eventually, the red blood cells break down and release free hemoglobin into plasma and urine. This free hemoglobin may block the renal tubules, resulting in renal failure.

   b. Signs and Symptoms:

   Chills, fever, backache, leg pain, rigors, chest pain, tachycardia, hypotension, cyanosis, hemoglobinemia, hemoglobinuria, oliguria, anuria, hematuria, jaundice, shock, vascular collapse, nausea, vomiting, restlessness, anxiety, pallor, pulmonary edema, precordial distress.

   c. Definitive Laboratory Testing:

   - Positive Direct Coombs test post-transfusion.
   - Gross hemolysis of serum post-transfusion.
   - Occult blood positive test in post-transfusion urine analysis.
   - Elevated Bilirubin post-transfusion.

2. Significant Hemolytic Transfusion Reactions:

   a. All verified hemolytic transfusion reactions are considered and reported as significant.

   b. All suspected hemolytic transfusion reactions will have a repeat type Rh of both the recipient and the donor blood.

3. Allergic Transfusion Reaction:

   a. Cause:

      Probable mechanism of reaction due to allergens in donor blood with antibodies in recipient blood.

   b. Signs and Symptoms:

      Urticaria, pruritus, chills, nausea, vomiting, headache, nasal congestion, wheezing, bronchospasm, dyspnea, laryngeal edema, circulatory collapse, fever, diaphoresis, anxiety, restlessness, headache, pallor, erythema.

   c. Definitive Laboratory Testing:

      All suspected allergic reactions will have direct Coombs testing performed by laboratory to determine type of reaction. If direct Coombs testing are within normal limits, the Pathologist will be notified to determine if further testing is required.

   d. Significant Allergic Reactions:

      Significant Allergic reactions are defined as: bronchospasm, laryngeal edema, severe dyspnea, circulatory collapse, pulmonary edema, skin sloughing as a result of severe pruritus and/or erythema.

4. Febrile Transfusion Reaction:

   a. Cause:

      Recipient sensitivity to donor leukocytes or platelets.

      A febrile transfusion is defined as an increase of 2° F above baseline temperature.

   b. Signs and Symptoms:

      Fever, chills, flushing, back pain, malaise, tachycardia, headache, confusion, nausea and vomiting.

   c. Definitive Laboratory Testing:

      The same procedure is followed as with allergic reactions.

d. Significant Allergic Febrile Reactions:

A significant febrile transfusion reaction is defined as: A rise in temperature greater than two (2) degrees from pre-transfusion temperature.

5. TRALI – Another possible adverse effect of transfusion is Transfusion Associated Acute Lung Injury (TRALI). This is a rare but potentially life-threating reaction to plasma containing blood components. As it is most common in donations from multiparous women, Central California Blood Center (CCBC) has instituted a policy of only collecting plasma from male donors. Platelet transfusion reactions should be monitored for fever, chills, dyspnea, cyanosis and hypotension. The Medical Director and CCBC should be notified of any suspected cases of TRALI.

6. All possible transfusion reactions are reported to the Pathology Department, Quality Improvement Committee, Transfusion Committee, Medical Executive Committee, and the Governing Body at least on a quarterly basis.

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

REFERENCES:

- Association for the Advancement of Blood and Biotherapies (AABB) Standards, 33rd edition, pp 94-96, 7.5 - 7.5.3; , 2022
- Association for the Advancement of Blood and Biotherapies (AABB) Technical Manual, 20th edition, pp 634 - 648, 2020.
- The Joint Commission (2023). Hospital accreditation standards (QSA.05.18.01, QSA.05.19.01, QSA.05.19.03, QSA.05.19.05). Joint Commission Resources. Oak Brook, IL.

ADDENDUM A

SIERRA VIEW DISTRICT HOSPITAL — **REPORT OF SUSPECTED TRANSFUSION REACTION**

NURSING

Steps: Discontinue transfusion, flush line with saline, monitor vs, notify physician & lab, transport blood product to lab, collect U/A & blood specimen

Date _____ *Room #* _____ *BBK#* _____ *Unit ID #* _____ Blood Unit Label matches Patient ID band and Transfusion Issue Card YES NO (Circle)

Product: ❑ PC ❑ FFP ❑ PLAT

Diagnosis _____

Patient History

Previous transfusions ❑ Yes ❑ No Date of previous tranfusions _____

Number of pregnancies ❑ N/A # _____ Number of deliveries

Tranfusion Date	Time Started	Temperature	Discontinued	Temperature	Amount Given

Concurrent administration of other intravenous fluids or drugs? ❑ NO ❑ YES (please specify)

Reactions Noted

❑ Chills	❑ Nausea	❑ Anxiety	❑ Pallor	❑ Erythema	❑ Anuria	❑ Shock	❑ Pain_____ (where)
❑ Fever	❑ Vomiting	❑ Restlessness	❑ Urticaria	❑ Hematuria	❑ Jaundice	❑ Cyanosis	❑ Pulmonary Edema
❑ Sweating	❑ Rigor	❑ Headache	❑ Bronchospasm	❑ Oliguria	❑ Dyspnea	❑ Pruritis	❑ Precordial Distress

Time of Onset _____ Signature _____ RN/LVN

LABORATORY

Unit ID# _____ Exp. date _____ Amount of blood returned to lab _____

POST-TRANSFUSION FINDINGS (LAB)

Check for identification errors: OK? YES NO (Circle)

Serum appearance: Pre-transfusion: Hemolysis? YES NO (Circle)

Post-transfusion: Hemolysis? YES NO (Circle)

DIRECT COOMBS on post-transfusion blood
AHG _____
TYPE _____
Rh _____

Urine Check: Post-transfusion: Hemglobin? POS NEG (Circle) Note: If positive spin down specimen and check for RBCs.
Compare pre-transfusion urine HBG if available.

CONCLUSION: IF ALL FINDINGS ARE NEGATIVE, NO ADVERSE REACTION.

NOTE: If all findings are negative at this point, notify floor and submit report to pathologist. CLS Signature: _____
If findings are questionable complete the remainder of workup and notify pathologist and patient physician of findings.

RECHECK OF TYPINGS, ANTIBODY SCREEN, AND CROSSMATCH

	ABO Typing DIRECT ANTI			BACK CELLS		Rho (D) Typing		
	A	B	A,B	A	B	ANTI D	Du	CONCLUSION:
Pt's pre-transfusion blood								TYPE Rh
Pt's post-transfusion blood								TYPE Rh
Donor blood								TYPE Rh

MAJOR CROSSMATCH							ANTIBODY SCREEN						
SALINE				ALBUMIN			SALINE				ALBUMIN		
I.S.	R.T.	37	AHG	I.S.	R.T.	AHG	I.S.	R.T.	37	AHG	I.S.	R.T.	AHG

Donor unit gram stain _____ Culture to follow _____

Medical Director's Signature _____ Date _____

Comment: _____

SIERRA VIEW District Hospital Porterville, California 93257
REPORT OF SUSPECTED TRANSFUSION REACTION

Form # 013979 REV. 1/13 CVBF

PATIENT'S LABEL

SUBJECT:	SECTION:
TREATMENT OF PEDIATRIC PATIENT WITH SHORTNESS OF BREATH	**Page 1 of 3**

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

POLICY:

A. **Function:** To provide immediate diagnostic procedures and treatment to pediatric patients with shortness of breath, when the Emergency Department Physician is not readily available.

B. **Circumstance:**

1. **Setting:** Pediatric patients presenting to the Emergency Department with complaint of shortness of breath (dyspnea).
2. **Supervision**: Emergency Department Physician
3. **Patient Condition/Contraindications**: As indicated by patient triage and history of co-morbidities. Allergies to be assessed.

PROCEDURE:

A. **Definition:** To provide immediate diagnostic procedures and treatment to pediatric patients with shortness of breath, and related co-morbidities when the Emergency Department Physician is not readily available. Patients who present with a medical history of or one or more of the following signs and symptoms.

1. Asthma
2. Wheezing
3. Pallor/cyanosis (If patient is exhibiting cyanosis, contact MD immediately)
4. Restlessness
5. Retractions
6. Respiratory distress

B. **Data Base:**

1. **Subjective:** Documentation of patient statement of chief complaints.
2. **Objective**: Documentation of nursing assessment of patient.

C. **Diagnosis:** Documentation of physician findings.

D. **Plan:** For patients that meet emergent criteria which includes:

1. Abnormal vital signs
2. Wheezing
3. Pulse ox less than 93%
4. History of bronchitis or asthma

E. **Interventions:**

1. Full set of vital signs
2. Page respiratory care
3. Pulse ox, O_2 to keep pulse ox greater than 93%
   cardiac monitor
4. Establish intravenous lock
5. If patient has wheezing lung sounds, give respiratory treatment of albuterol 0.5ml in 3ml NS nebulized
6. Have bag-valve mask and intubation kit available
7. Order the following:
   a. CXR 2-view
   b. IVL
   c. CBC, CMP, MAG
   d. RSV Ag EIA if during RSV season and only if the patient is under age of 6
   e. Flu A & B Rapid Panel, if indicated
   f. Blood Cultures X 1
   g. Pulse-oximetry
   h. O_2 - titrate to keep SpO_2 greater than 93%
   i. Cardiac monitor

If patient is wheezing give:

Pediatric

Albuterol 0.3mg in 3 ml NS nebulized

If suspected Croup

Cool Mist 8L O_2 per min

Consultation Required: As requested.

F. **Patient Education:** Inform patient of plan of care.

G. **Follow-up:** Reassess as appropriate for patient condition. Notify ED Physician if patient's condition changes or if additional immediate intervention is required.

H. **Documentation:** All orders to be performed by Emergency Department RN will be documented in the Electronic Health Record. RN will use the physician on duty at time of patient presentation to place the orders and will do so under the standardized procedure order source option.

STAFF AUTHORIZED TO PERFORM THE FUNCTION: Registered Nurse

REQUIREMENTS FOR: Registered Nurse

A. **Education:** Valid California Registered Nurse License

B. **Training:** Meets initial and annual competencies for standardized procedure

C. **Experience:** Actively employed as an Emergency Department Registered Nurse, having passed the 90 day probationary period.

DEVELOPMENT & APPROVAL OF THE STANDARDIZED PROCEDURE:

A. **Method:** Approval of Emergency Department Committee, Emergency Department Director, and Emergency Department Medical Director.

REFERENCES:

- Walls, R. et al. (Eds.). (2018). Rosen's Emergency Medicine: Concepts and Clinical Practice: Volume 1&2, (9th ed.). Philadelphia: Elsevier.

SUBJECT:	SECTION:
VANCOMYCIN PROTOCOL PER CLINICAL PHARMACIST	***Drug Protocols***

PURPOSE:

To provide a guide for safe and effective dosing of vancomycin.

POLICY:

The pharmacist will monitor vancomycin and assess for appropriate empiric vancomycin dosing; assess and adjust vancomycin doses to maintain trough goals and minimize vancomycin toxicity; assess laboratory trends; and maximize the use of each hospital stay to achieve the therapeutic goals.

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

PROTOCOL AND PROCEDURE:

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

A. Vancomycin Drug Overview

1. Vancomycin is a glycopeptide antibiotic that exhibits (slow) bactericidal activity on most Gram positive (+) bacteria.

2. Vancomycin exhibits "concentration-independent" or "time-dependent" bactericidal activity. Therefore, increasing antibiotic concentration beyond the therapeutic threshold will not result to faster killing or elimination of bacteria.

3. Vancomycin is approximately 55% protein bound; a half-life of 4 to 6 hours with normal renal function but the half-life can be up to 7.5 days with renal impairment; the manufacturer states that vancomycin is not effectively removed by dialysis.

B. Indications and Trough Goals (or desired trough goal as requested by physician order)

Indication	**Recommended Trough Concentration (mcg/mL)**
Skin and Soft Tissue Infections	10 – 15
Bacteremia	15 – 20
Endocarditis	15 – 20
Hospital-Acquired Pneumonia (Staph. aureus)	15 – 20
Meningitis	15 – 20
Osteomyelitis	15 – 20

Note: FDA unlabeled uses include treatment of beta-lactam resistant gram-positive infections; bacterial endopthalmitis; treatment of infections caused by gram-positive organisms in patients who have serious allergies to beta-lactam agents; surgical prophylaxis.

C. Monitoring: Initial Patient Assessment

1. When an order for vancomycin is requested for a patient, the pharmacist will assess the following baseline parameters prior to initiation of vancomycin:

   a. Past medical history and allergy history;

   b. Indication for vancomycin and trough goal;

   c. Renal function (e.g. serum creatinine, calculated CrCl);

   d. Appropriate objective measures (e.g. UA, CBC, culture and sensitivities);

   e. Refer to SVMC Antibiotic Susceptibility Report.

2. Drug-drug interactions will be assessed.

D. Dosing

Note: Vancomycin should be administered intravenously at a rate no faster than 10mg/min. This has been shown to significantly reduce infusion related reactions.~~over an infusion period of at least 1 hour to minimize infusion related adverse effects. For higher dosages (e.g. 2g), the infusion should be extended to 1.5 to 2 hours.~~

Key: t_{inf} is the infusion time (hours)
tau is the dosing interval (hours)
Δt = tau - t_{inf} (hr)

1. *Calculation of Vancomycin Dose and Frequency*

   a. Estimate the Ideal Body Weight (IBW) in kilogram:

   IBW_{MALE} (kg) = 50 kg + 2.3 kg [height (inches) - 60 inches]

   IBW_{FEMALE} (kg) = 45.5 + 2.3 kg [height (inches) - 60 inches]

   b. If the patient is obese (greater than 120% of IBW), adjust body weight as determined by the following formula and will be used in place of IBW when calculating creatinine clearance.

   Adjusted Body Weight (kg) = IBW + 0.4(Actual Body Weight – IBW)

c. Estimate the creatinine clearance using the Cockcroft and Gault Formula in patients not receiving dialysis.

d. Pharmacist performing calculation may use appropriate online tools such as Global RPH or ClinCalc at their discretion.

$$\text{Creatinine Clearance (mL/min)} = \frac{(140 - \text{age}) \text{ IBW (kg)}}{\text{SCr (mg/dL)} \times 72} \quad [\times 0.85 \text{ for females}]$$

e. Calculate elimination rate constant (ke-hr) using the Matzke formula:

$$k_e{}^{-hr} = 0.00083 \times (\text{CrCl in mL/min}) + 0.0044$$

f. Calculate the half-life (t1/2):

$$t_{1/2}\,(hr) = \frac{\ln 2}{k_e}$$

g. The dosing interval of vancomycin should be based on the practical elimination of drug based on the individual's half-life (t1/2). A general guideline of appropriate dosing intervals is provided below:

CrCl (mL/min)	**Interval (hours)**
≥ 120	Every 8 – 12
100	Every 12
80	Every 12
60	Every 18
40	Every 24
30	Every 36
20	Every 48
≤ 10	Determined by random levels

h. Estimate volume of distribution.

$$\text{Vd (L)} = (0.7 \text{ L/kg}) \times (\text{actual body weight})$$

i. Calculate predicted peak and trough concentrations from the regimen:

$$\text{Predicted Peak: } C_{max}\,(mg/L) = \frac{\text{Dose}/t_{inf}}{k_e \times Vd} \times \frac{1 - e^{-ke \times tinf}}{1 - e^{-ke \times tau}}$$

$$\text{Predicted Trough: } \quad C_{min}\,(mg/L) = C_{max} \times e^{-ke \times \Delta t}$$

2. *Dose Adjustment*

   a. The dosing interval and/or dose will be adjusted as needed based on the kinetics of the drug in the individual calculated using the vancomycin levels.

   b. In light of declining or increasing renal function, vancomycin dosing interval and/or dose will be adjusted in order to maintain therapeutic levels.

E. Monitoring: Laboratory trends for Vancomycin

1. When a patient has an active order for vancomycin the pharmacist will monitor for trough goals based on the current IDSA Guidelines or per physician recommendations. Monitoring process will be done on a daily basis, and for the duration of therapy and/or the duration of hospital stay.

2. The trough level should be drawn 30 minutes prior to the next scheduled dose of vancomycin when deemed by pharmacist to be at steady-state concentrations. Based on clinical judgment of the pharmacist, random vancomycin levels may be drawn before and after steady-state concentration is reached (e.g. patients with severe renal insufficiency).

3. The RN may order troughs, or random vancomycin levels at the request of the pharmacist or physician (a common example of this practice may occur for obtaining accurate post hemodialysis troughs).

4. The following monitoring parameters will be assessed by the clinical pharmacist:

   a. Renal function: BUN, SCr, CrCl, urine I & O, etc.

   b. Laboratory data: Culture and sensitivities, CBC, trough levels, etc.

   c. Physical findings: Vital signs, weight, temperature, etc.

   d. Other pertinent tests or data that the clinical pharmacist deems necessary to maintain and/or achieve therapeutic goals and ensure patient safety.

4. The clinical pharmacist will document all pharmacokinetic monitoring and adjustments on their daily review sheet.

REFERENCES:

- Antimicrobial Stewardship Initiatives Optimize Vancomycin Dosing and Reduce Nephrotoxicity. Retrieved from https://www.aha.org/case-studies/2015-06-16-antimicrobial-stewardship-initiatives-optimize-vancomycin-dosing-and-reduce. Accessed January, 3rd 2023.
- Bartlett JG, Auwaerter PG, Pham PA. (2015) John Hopkins ABX Guide: Diagnosis and treatment of infectious diseases. The John Hopkins University School of Medicine; pg. 613-615.
- Cockcroft DW and Gault MH.(1976) Prediction of Creatinine Clearance from Serum Creatinine. Nephron; 16(1):31-41.
- Gilbert DN, Moellering RC, Eliopoulos GM, et al (2012). The Sanford Guide to Antimicrobial Therapy: The Forty-Second Edition. Antimicrobial, Inc.; pg. 75-76.
- Gold Standard, Inc. Vancomycin Monograph. Clinical Pharmacology. Retrieved November 1, 2017 from www.cinicalpharmacology.com.
- Lexi-Comp, Inc. Vancomycin Monograph. Lexi-Comp OnlineTM. Retrieved November 1, 2017 from www.online.lexi.com.
- Rybak M, Lomaestro B, Rotschafer JC, et al. (2009) Therapeutic monitoring of vancomycin in adult patients: A consensus review of the American Society of Health-System Pharmacist, the Infectious Diseases Society of America, and the Society of Infectious Diseases Pharmacist. Am J Health-Syst Pharm; 66: 82-98.

SUBJECT: **VASCULAR ACCESS DEVICE--BLOOD DRAW**	SECTION: *Nursing Procedures (NR)* **Page 1 of 3**

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

PURPOSE:

Obtain blood for laboratory analysis without performing a venipuncture.

POLICY:

Prevention of blood clotting within the catheter is extremely important during this procedure. Catheter occlusion can be prevented by maintaining positive pressure within the catheter at all times and by vigorously flushing after aspirating blood.

SPECIAL CONSIDERATIONS FOR BLOOD BANK SPECIMENS

All blood specimens drawn from a vascular access device for the purpose of blood bank testing will be obtained and labeled by a registered nurse (RN) or physician in the presence of a second licensed person or certified/licensed lab person, with each person 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.

AFFECTED AREAS/ PERSONNEL: *RN, LVN, CERTIFIED/LICENSED LAB PERSONNEL*

EQUIPMENT NEEDED:

1. One pair sterile gloves
2. Three betadine/ chlorhexidine swab sticks
3. Alcohol wipes
4. "Gripper" non-coring needle with attached extension tubing
5. Two 11cc syringes filled with normal saline
6. Assorted lab collection tubes
7. One 12cc empty syringe
8. One 19 gauge sterile needle
9. One Band-Aid
10. One clamping type needleless system adapter
11. One needleless helplock cap

PROCEDURE:

NON-ACCESSED PORT

1. Check physician orders.

2. Identify patient using the two-patient identifier system.

3. Observe and palpate vascular access device site for post septum. Look for possible complications such as: edema, erosion of tissue over port, signs of infection and dislodgment of port within subcutaneous pocket.

4. Explain procedure to patient. Have patient report any change in sensation during infusion.

5. Prepare the injection site:

   a. Done sterile gloves.

   b. Cleanse area thoroughly with alcohol wipes. Let dry.

12. Paint area with betadine or chlorhexidine swab sticks starting over the port and moving outward in a spiral motion to cover an area 5 inches in diameter. Repeat in same manner with remaining two swab sticks and let dry.

6. Prepare non-coring needle by flushing with normal saline and clamp extension tubing. Leave normal saline syringe firmly attached during insertion procedure.

7. Clamp tubing to prevent air embolism.

8. Use the first and second fingers of one hand and place on either side of port to stabilize it during puncture. Insert the non-coring needle perpendicular to the septum and push it firmly through the skin and port septum until it makes contact with the bottom of the port chamber. It should make a "clicking" sound as the metal needle contacts the metal base of the port. Once the septum is punctured, do not tilt or rock the needle as this may cause fluid leakage or damage to the septum.

9. Open clamp and pull slightly on syringe plunger. If blood return is present, flush catheter with entire 12cc of normal saline.

10. Immediately withdraw 6cc of blood/saline into same syringe and clamp tubing. Remove syringe and discard.

11. Attach 12cc empty sterile syringe, open clamp and quickly withdraw at least 6cc of blood for lab specimen. Clamp tubing. Remove syringe and hand off to lab technician. The blood specimen will then be labeled in the presence of the patient.

If lab tech is unavailable, complete #10, then attach 19-gauge needle to syringe and fill lab collection tubes.

12. Attach 12cc syringe of normal saline and quickly flush tubing. Clamp tubing.

13. Withdraw needle while firmly stabilizing port with two fingers of other hand.

14. Cleanse site with alcohol preps and apply Band-Aid.

ACCESSED PORT WITH CONTINUOUS INFUSION

1. Check physician orders.

2. Identify patient using the two-patient identifier system.

3. Stop infusion and clamp Porta-Cath extension tubing. Disconnect IV tubing and replace needle with new clamping-type needleless system adapter.

4. Maintaining aseptic technique to prevent catheter line infection, attach 12cc pre-filled normal saline syringe to Porta-Cath extension tubing. Open clamp and flush system.

5. Immediately withdraw 6cc of blood/saline into same syringe and clamp tubing. Remove syringe and discard.

6. Attach 12cc empty sterile syringe, open clamp and quickly withdraw at least 6cc blood for lab specimen. Clamp tubing. Remove syringe and hand off t lab technician.

7. If lab technician is unavailable, complete #5, then attach 19-gauge needle to syringe and fill lab collection tubes.

8. Attach 12cc syringe of normal saline and quickly flush tubing. Re-clamp.

9. Remove syringe and attach new sterile needleless connector. Re-attach IV tubing and check IV flow rate.

NOTE: Needless connectors need to be changed every time a blood specimen is taken.

REFERENCE:

- Moureau, N. (2019) The peer reviewed journal of nursing excellence. *Drawing blood through a central venous catheter.* Retrieved from https://journals.lww.com/nursing/Fulltext/2004/02000/Drawing_blood_through_a_central_venous_catheter.27.aspx.

SUBJECT:	SECTION:
VASCULAR ACCESS DEVICE --BOLUS INJECTIONS	*Nursing Procedures (NR)* **Page 1 of 2**

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

PURPOSE:

Short-term venous access for administration of vesicant/irritating chemotherapy drugs, usually on an outpatient basis, but can be used as in inpatient. Also to ensure patency of catheter during periods of non-use by flushing with heparized saline every four weeks.

POLICY:

As most chemotherapy causes peripheral venous sclerosis, peripheral IV access is limited and questionable for vesicant administration. Patency of the vascular access device must be maintained and complications from long-term vascular access device use should be prevented.

AFFECTED AREAS/ PERSONNEL: *NURSING*

EQUIPMENT NEEDED:

1. One pair sterile gloves
2. Three Betadine or chlorhexidine swabs
3. "Gripper" non-coring needle with attached extension tubing
4. Two 12cc syringes filled with normal saline
5. One 6cc syringe filled with Heparin 100u/cc
6. One Band-Aid
7. 100-500cc bag of normal saline for vesicant drugs
8. One IV administration set
9. Syringes of medication supplied by Pharmacy (if ordered)
10. Alcohol wipes

PROCEDURE:

1. Observe and palpate vascular access device site for post septum. Observe site for possible complications such as: edema, erosion of tissue over port, signs of infection and dislodgment of port within subcutaneous pocket.
2. Explain procedure to patient. Have patient report any change in sensation during infusion. Stop infusion if any changes are noted, and request X-ray confirmation of port functional capability. Patient may experience slight discomfort when port is accessed.

3. Prepare the injection site:

   a. Don sterile gloves.

   b. Cleanse area thoroughly with alcohol wipes. Let dry.

   c. Paint area with Betadine/chlorhexidine swabs starting over the port and moving outward in a spiral motion to cover an area five inches in diameter. Repeat in the same manner with remaining two swabs and let dry.

4. Prepare non-coring needle by flushing with normal saline and clamp extension tubing. Leave normal saline syringe firmly attached during procedure.

5. Clamp tubing to prevent air embolism.

6. Use the first and second fingers of one hand and place on either side of port to stabilize it during puncture. Insert the non-coring needle perpendicular to the septum and push it firmly through the skin and port septum until it makes contact with bottom part of the port chamber. It should make a "clicking" sound as the metal needle contacts the metal base of the port.

7. Open clamp and pull slightly on attached syringe plunger. If blood return is present, flush catheter with entire 12cc of normal saline. To flush port only to maintain patency, proceed directly to Number 11. For intra-peritoneal port, proceed directly to Number 12.

8. Clamp extension tubing and attach IV line of normal saline using sterile technique

9. Open all clamps to start normal saline flowing. Using chemotherapy gloves, administer the drugs slowly, stopping every 2-3ml to check for blood return. Flush with at least 20cc of normal saline between each drug to prevent incompatibility.

10. Clamp extension tubing and disconnect IV tubing.

11. Attach physician ordered heparin . Open clamp, flush extension tubing slowly. Re-clamp tubing while maintaining positive pressure on syringe plunger as the last ml of heparin is injected.

12. Withdraw needle while firmly stabilizing port with two fingers of other hand.

13. Remove Betadine/ chlorhexidine solution from patient's skin with alcohol wipes. Apply Band-Aid.

REFERENCE:

- The Joint Commission (2022). Hospital accreditation standards. Joint Commission Resources. Oak Brook, IL.

- Nettina, S. (2019) Lippincott Manuel of Nursing Practice 11th ed: Amber, PA: Williams & Wilkins

SIERRA VIEW MEDICAL CENTER

COMMUNITY PHYSICIAN
DIRECT ADMIT TO SVMC CHECKLIST

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
_____	_____
_____	_____
_____	_____
_____	_____

SIERRA VIEW MEDICAL CENTER **REPATRIATION BACK TO SVMC CHECKLIST**

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)

SIERRA VIEW MEDICAL CENTER **REPATRIATION BACK TO SVMC CHECKLIST**

_____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
_____	_____
_____	_____
_____	_____
_____	_____

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

PATIENT'S LABEL

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 _____

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

PATIENT'S LABEL

_____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

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MINUTES OF A REGULAR MEETING OF THE BOARD OF DIRECTORS OF SIERRA VIEW LOCAL HEALTH CARE DISTRICT

The regular meeting of the Board of Directors of Sierra View Local Health Care District was held **March 28, 2023 at 5:00 P.M.** in the Sierra View Medical Center Board Room, 465 West Putnam Avenue, Porterville, California

Call to Order: Chairman REDDY called the meeting to order at 5:03 p.m.

Directors Present: REDDY, MARTINEZ, PANDYA, KASHYAP

Directors Absent: LOMELI

Others Present: Blazar, Dan, Patient Experience Officer, Canales, Gomez, Cindy, Director of Compliance, Dickson, Doug, Chief Financial Officer, Espinoza, Alexis, Porterville Recorder, Fenesis, John, Moss Adams, Gomes, Justen, Moss Adams, Hefner, Donna, President/Chief Executive Officer, Hirte, Todd, Contracts Administration, Hirte, Todd, Financial Strategy and Contracts Administrator, Hudson, Jeffery, VP Patient Care Services, CNO and DIO, Pryor-DeShazo, Kimberley, Director of Marketing and Public Relations, Reed-Krase, Alex, Legal Counsel, Sandhu, Harpreet, Chief of Staff, Sousa, Kelvin, Community Member, Watts, Whitney, Executive Assistant and Clerk to Board of Directors, Wheaton, Ron, VP Professional Services and Physician Recruitment, Wilbur, Gary, Admin Director of General Services

I. Approval of Agenda:

Chairman REDDY motioned to approve the Agenda. The motion was moved by Director PANDYA, seconded by Director MARTINEZ, and carried to approve the agenda. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Absent
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Absent

II. Closed Session: Board adjourned Open Session and went into Closed Session at 5:03 p.m. to discuss the following items:

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

Director KASHYAP presented at 5:07 p.m.

B. Pursuant to Evidence Code Section 1156 and 1157.7:

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

2. Quality Division Update

C. Pursuant to Gov. Code Section 54956.9, Exposure to Litigation to subdivision (d) (2): Conference with Legal Counsel. BETA Claim No. 23-000400

D. 4962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (1 Item). Estimated Date of Disclosure – July 2024

Closed Session Items E - G were deferred to the conclusion of Open Session as there was not time for discussion prior to Open Session.

III. Open Session: Chairman REDDY adjourned Closed Session at 5:28 p.m., reconvening in Open Session at 5:30 p.m.

Pursuant to Gov. Code Section 54957.1; Action(s) taken as a result of discussion(s) in Closed Session.

A. Chief of Staff Report provided by Chief of Staff Sandhu. Information only; no action taken.

B. Pursuant to Evidence Code Section 1156 and 1157.7:

1. Evaluation – the Quality of Care/Peer Review

Following review and discussion, it was moved by Director PANDYA, seconded by Director MARTINEZ, and carried to approve the Quality of Care/Peer Review as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Absent
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

2. Quality Division Report

Following review and discussion, it was moved by Director PANDYA, seconded by Director MARTINEZ, and carried to approve the Quality Division Report as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Absent
MARTINEZ	Yes

PANDYA	Yes
KASHYAP	Yes

C. Conference with Legal Counsel

Following review and discussion, it was moved by Director PANDYA, seconded by Director MARTINEZ, and carried to deny BETA Claim No. 23-000400 as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Absent
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

IV. Public Comments

None.

V. Consent Agenda

The Medical Staff Policies/Procedures/Protocols/Plans and Hospital Policies/Procedures/Protocols/Plans were presented for approval (Consent Agenda attached to the file copy of these Minutes). It was moved by Director MARTINEZ, seconded by Director KASHYAP, and carried to approve the Consent Agenda as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Absent
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

VI. Approval of Minutes:

Following review and discussion, it was moved by Director LOMELI and seconded by Director KASHYAP to approve the February 28, 2023 Minutes of the Regular Meeting of the Board of Directors as presented. The motioned carried and the vote of the Board is as follows:

REDDY	Yes
LOMELI	Absent
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

VII. Business Action Items

A. Single Audit Review

Presented by John Fenesis and Justen Gomes of Moss Adams

Following review and discussion, it was moved by Director PANDYA, seconded by Director MARTINEZ and carried to approve Single Audit Review as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Absent
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

B. February 2023 Financials

Doug Dickson, CFO presented the Financials for February 2023. A copy of this presentation is attached to the file copy of these minutes.

Total Operating Revenue was $12,211,059. Supplemental Funds were $1,111,961. Total Operating Expenses were $13,512,865. Loss from operations were $1,301,806.

Following review and discussion, it was moved by Director PANDYA, seconded by Director MARTINEZ and carried to approve the February 2023 Financials as presented. The vote of the Board is as follows:

REDDY	Yes
LOMELI	Absent
MARTINEZ	Yes
PANDYA	Yes
KASHYAP	Yes

C. Board Education

Board Education was presented by Emily Brinkman, Hooper, Lundy & Bookman, P.C.

Ms. Brinkman educated the Directors regarding the role of the Board, The Board as the Governing Body, Bylaws, California State requirements, Conflict of Interest, Code of Conduct.

Information only; no action taken.

VIII. CEO Report

Donna Hefner, President/CEO provided a report of activities and happenings around Sierra View:

In the District:

- Golf Tournament April 27, 2023 location change to Tulare Golf Course
- Annual Service Awards
- Volunteer League Update
- McKnight's Pinnacle Unsung Hero Awardee

IX. Closed Session: Board adjourned Open Session at 6:42 p.m. and went into Closed Session at 6:42 p.m. to discuss the following items:

E. Pursuant to Gov. Code Section 54956.9, Exposure to Potential Litigation (d) (2): Conference with Legal Counsel; Government Code Sections 54957 (b) 1 and 54957(b) (2) and Pursuant to Gov. Code Section 54962; Health and Safety Code Section 32106(b): Discussion Regarding Trade Secrets, Pertaining to Service (1 Item). Estimated Date of Disclosure – December 2023

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

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

X. Open Session: Board adjourned Closed Session at 7:17 p.m. and went into Open Session at 7:17 p.m. to discuss the following items:

E. Trade Secret. Information only; no action taken.

F. Trade Secret. Information only; no action taken.

G. Conference with Legal Counsel. Information only; no action taken.

XII. Announcements:

A. Regular Board of Directors Meeting – April 25, 2023 at 5:00 p.m.

The meeting was adjourned 7:18 p.m.

Respectfully submitted,

Areli Martinez
Secretary
SVLHCD Board of Directors
AM: ww

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FINANCIAL PACKAGE
March 2023

SIERRA VIEW MEDICAL CENTER

BOARD PACKAGE

Sierra View Medical Center
Financial Statistics Summary Report
March 2023

Statistic	Mar-23 Actual	Mar-23 Budget	Mar-23 Over/ (Under)	Mar-23 % Var.	YTD Actual	YTD Budget	YTD Over/ (Under)	YTD % Var.	Fiscal 22 YTD	Increase/ (Decrease) Mar-22	% Change
Utilization											
SNF Patient Days											
Total	124	75	49	65.3%	1,149	675	474	70.2%	682	467	68.5%
Medi-Cal	93	79	14	18.0%	837	594	243	41.0%	609	228	37.4%
Sub-Acute Patient Days											
Total	875	903	(28)	-3.1%	7,689	8,127	(438)	-5.4%	8,170	(481)	-5.9%
Medi-Cal	559	613	(54)	-8.7%	5,188	5,351	(163)	-3.1%	5,372	(184)	-3.4%
Acute Patient Days	1,888	1,923	(35)	-1.8%	16,612	17,305	(693)	-4.0%	20,311	(3,699)	-18.2%
Acute Discharges	462	469	(7)	-1.5%	4,197	4,221	(24)	-0.6%	4,309	(112)	-2.6%
Medicare	174	194	(20)	-10.2%	1,599	1,601	(2)	-0.2%	1,634	(35)	-2.1%
Medi-Cal	221	215	6	2.7%	2,048	2,036	12	0.6%	2,077	(29)	-1.4%
Contract	66	59	7	11.7%	528	560	(32)	-5.6%	570	(42)	-7.4%
Other	1	1	0	3.2%	22	28	(6)	-20.6%	28	(6)	-21.4%
Average Length of Stay	4.09	4.10	(0.01)	-0.3%	3.96	4.10	(0.14)	-3.5%	4.71	(0.76)	-16.0%
Newborn Patient Days											
Medi-Cal	162	179	(17)	-9.3%	1,607	1,599	8	0.5%	1,542	65	4.2%
Other	29	34	(5)	-15.9%	292	318	(26)	-8.2%	363	(71)	-19.6%
Total	191	213	(22)	-10.3%	1,899	1,917	(18)	-0.9%	1,905	(6)	-0.3%
Total Deliveries	111	111	-	0.0%	1,047	1,007	40	4.0%	999	48	4.8%
Medi-Cal %	85.45%	82.98%	2.48%	3.0%	83.14%	82.98%	0.16%	0.2%	81.80%	1.34%	1.6%
Case Mix Index											
Medicare	1.5026	1.6783	(0.1757)	-10.5%	1.6309	1.6783	(0.0474)	-2.8%	1.6968	(0.0659)	-3.9%
Medi-Cal	1.1587	1.2438	(0.0851)	-6.8%	1.1913	1.2438	(0.0525)	-4.2%	1.2652	(0.0739)	-5.8%
Overall	1.2896	1.4431	(0.1535)	-10.6%	1.3658	1.4431	(0.0773)	-5.4%	1.4711	(0.1053)	-7.2%
Ancillary Services											
Inpatient											
Surgery Minutes	8,773	8,728	45	0.5%	79,655	78,552	1,103	1.4%	78,002	1,653	2.1%
Surgery Cases	100	100	-	0.0%	949	900	49	5.4%	894	55	6.2%
Imaging Procedures	1,572	1,231	341	27.7%	13,733	11,079	2,654	24.0%	13,929	(196)	-1.4%
Outpatient											
Surgery Minutes	14,208	13,010	1,198	9.2%	110,762	117,090	(6,328)	-5.4%	96,935	13,827	14.3%
Surgery Cases	205	198	7	3.5%	1,663	1,782	(119)	-6.7%	1,468	195	13.3%
Endoscopy Procedures	227	185	42	22.7%	1,634	1,665	(31)	-1.9%	1,475	159	10.8%
Imaging Procedures	4,273	3,880	393	10.1%	35,292	34,920	372	1.1%	32,620	2,672	8.2%
MRI Procedures	289	290	(1)	-0.3%	2,582	2,610	(28)	-1.1%	2,569	13	0.5%
CT Procedures	1,240	1,009	231	22.9%	10,580	9,081	1,499	16.5%	9,064	1,516	16.7%
Ultrasound Procedures	1,195	904	291	32.2%	9,177	8,136	1,041	12.8%	8,324	853	10.2%
Lab Tests	35,902	30,494	5,408	17.7%	305,205	274,446	30,759	11.2%	348,158	(42,953)	-12.3%
Dialysis	16	5	11	220.0%	39	45	(6)	-13.3%	45	(6)	-13.3%

Sierra View Medical Center
Financial Statistics Summary Report
March 2023

	Mar-23				YTD					Increase/	
Statistic	Actual	Budget	Over/ (Under)	% Var.	Actual	Budget	Over/ (Under)	% Var.	Fiscal 22 YTD	(Decrease) Mar-22	% Change
Cancer Treatment Center											
Chemo Treatments	1,537	1,794	(257)	-14.3%	15,063	16,146	(1,083)	-6.7%	16,346	(1,283)	-7.8%
Radiation Treatments	2,557	1,817	740	40.7%	15,169	16,353	(1,184)	-7.2%	14,267	902	6.3%
Cardiac Cath Lab											
Cath Lab IP Procedures	9	9	-	0.0%	87	81	6	7.4%	85	2	2.4%
Cath Lab OP Procedures	30	24	6	25.0%	253	216	37	17.1%	213	40	18.8%
Total Cardiac Cath Lab	39	33	6	18.2%	340	297	43	14.5%	298	42	14.1%
Outpatient Visits											
Emergency	3,216	3,249	(33)	-1.0%	30,079	29,241	838	2.9%	27,152	2,927	10.8%
Total Outpatient	14,111	13,731	380	2.8%	116,934	123,579	(6,645)	-5.4%	110,886	6,048	5.5%
Staffing											
Paid FTE's	915.18	935.67	(20.49)	-2.2%	900.72	935.67	(34.95)	-3.7%	914.86	(14.14)	-1.5%
Productive FTE's	775.59	804.83	(29.24)	-3.6%	768.96	804.83	(35.87)	-4.5%	773.94	(4.98)	-0.6%
Paid FTE's/AOB	5.30	5.51	(0.21)	-3.9%	5.27	5.41	(0.14)	-2.6%	5.15	0.13	2.5%
Revenue/Costs (w/o Case Mix)											
Revenue/Adj.Patient Day	11,233	10,468	765	7.3%	10,901	10,417	484	4.6%	10,225.17	676	6.6%
Cost/Adj.Patient Day	2,718	2,608	110	4.2%	2,722	2,592	130	5.0%	2,588.01	134	5.2%
					-						
					-						
Revenue/Adj. Discharge	57,233	53,412	3,821	7.2%	53,802	53,154	648	1.2%	60,124	(6,322)	-10.5%
Cost/Adj. Discharge	13,848	13,309	539	4.0%	13,433	13,224	209	1.6%	15,217	(1,784)	-11.7%
Adj. Discharge	1,051	1,032	20	1.9%	9,483	9,280	204	2.2%	8,285	1,198	14.5%
Net Op. Gain/(Loss) %	-6.62%	-6.98%	0.36%	-5.2%	-13.80%	-6.98%	-6.82%	97.7%	-7.25%	-6.55%	90.2%
Net Op. Gain/(Loss) $	(903,572)	(895,977)	(7,595)	0.8%	(15,449,710)	(7,754,728)	(7,694,982)	99.2%	(8,527,859)	(6,921,851)	81.2%
Gross Days in Accts Rec.	87.10	85.78	1.32	1.5%	87.10	85.78	1.32	1.5%	88.26	(1.16)	-1.3%
Net Days in Accts. Rec.	73.87	66.37	7.50	11.3%	73.87	66.37	7.50	11.3%	66.54	7.33	11.0%

COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

	MAR 2023	FEB 2023
ASSETS		
CURRENT ASSETS:		
CASH & CASH EQUIVALENTS	$ 5,513,515	$ 6,035,573
SHORT-TERM INVESTMENTS	3,553,732	3,294,310
ASSETS LIMITED AS TO USE	370,722	367,941
PATIENT ACCOUNTS RECEIVABLE	167,055,464	166,326,921
LESS UNCOLLECTIBLES	(24,388,053)	(24,053,274)
CONTRACTUAL ALLOWANCES	(112,523,346)	(112,240,973)
OTHER RECEIVABLES	18,140,087	19,778,042
INVENTORIES	4,062,241	4,110,562
PREPAID EXPENSES AND DEPOSITS	2,555,151	2,211,389
LEASE RECEIVABLE - CURRENT	353,008	356,698
TOTAL CURRENT ASSETS	64,692,521	66,187,189
ASSETS LIMITED AS TO USE, LESS CURRENT REQUIREMENTS	33,321,474	32,744,844
LONG-TERM INVESTMENTS	129,279,965	128,002,329
PROPERTY, PLANT AND EQUIPMENT, NET	88,786,772	89,323,949
INTANGIBLE RIGHT OF USE ASSETS	619,741	633,544
LEASE RECEIVABLE - LT	1,398,336	1,425,942
OTHER INVESTMENTS	250,000	250,000
PREPAID LOSS ON BONDS	1,825,226	1,846,206
TOTAL ASSETS	$ 320,174,035	$ 320,414,003

COMBINED BALANCE SHEET FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

	MAR 2023	FEB 2023
LIABILITIES AND FUND BALANCE		
CURRENT LIABILITIES:		
BOND INTEREST PAYABLE	$ 434,975	$ 289,983
CURRENT MATURITIES OF BONDS PAYABLE	3,880,000	3,880,000
CURRENT MATURITIES OF LONG TERM DEBT	1,188,800	1,188,800
ACCOUNTS PAYABLE AND ACCRUED EXPENSES	6,795,113	7,187,609
ACCRUED PAYROLL AND RELATED COSTS	7,626,136	8,169,122
ESTIMATED THIRD-PARTY PAYOR SETTLEMENTS	3,592,767	3,650,959
LEASE LIABILITY - CURRENT	124,753	124,753
TOTAL CURRENT LIABILITIES	23,642,544	24,491,226
SELF-INSURANCE RESERVES	1,853,000	1,853,000
CAPITAL LEASE LIAB LT	2,201,353	2,283,952
BONDS PAYABLE, LESS CURR REQT	41,565,000	41,565,000
BOND PREMIUM LIABILITY - LT	3,599,619	3,664,525
LEASE LIABILITY - LT	503,096	515,660
OTHER NON CURRENT LIABILITIES	375,854	375,854
DEFERRED INFLOW - LEASES	1,691,169	1,724,233
TOTAL LIABILITIES	75,431,634	76,473,448
UNRESTRICTED FUND	258,952,972	258,952,972
PROFIT OR (LOSS)	(14,210,571)	(15,012,417)
TOTAL LIABILITIES AND FUND BALANCE	$ 320,174,035	$ 320,414,003

COMBINED INCOME STATEMENT FOR SIERRA VIEW LOCAL HLTHCR DISTR
SIERRA VIEW LOCAL HEALTH CARE DISTRICT

MAR 2023 ACTUAL	MAR 2023 BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE		Y-T-D ACTUAL	Y-T-D BUDGET	DOLLAR VARIANCE	PERCENT VARIANCE
				***** OPERATING REVENUE *****				
5,396,207	5,482,863	86,656	(2)%	INPATIENT - NURSING	46,587,528	49,026,369	2,438,841	(5)%
21,074,284	19,567,406	(1,506,878)	8%	INPATIENT - ANCILLARY	179,542,574	175,335,860	(4,206,714)	2%
26,470,490	25,050,269	(1,420,221)	6%	TOTAL INPATIENT REVENUE	226,130,102	224,362,229	(1,767,873)	1%
33,701,689	30,050,450	(3,651,239)	12%	OUTPATIENT - ANCILLARY	284,101,090	268,880,510	(15,220,580)	6%
60,172,179	55,100,719	(5,071,460)	9%	TOTAL PATIENT REVENUE	510,231,192	493,242,739	(16,988,453)	3%
				DEDUCTIONS FROM REVENUE				
(17,557,441)	(17,761,628)	(204,187)	(1)%	MEDICARE	(154,406,830)	(158,989,823)	(4,582,993)	(3)%
(21,967,904)	(17,597,797)	4,370,107	25%	MEDI-CAL	(184,338,893)	(157,478,980)	26,859,913	17%
(7,550,860)	(6,898,909)	651,951	10%	OTHER/CHARITY	(59,866,122)	(61,755,713)	(1,889,591)	(3)%
12,462	(10,755)	(23,217)	(216)%	DISCOUNTS & ALLOWANCES	(118,730)	(96,277)	22,453	23%
(174,781)	(494,656)	(319,876)	(65)%	BAD DEBTS	(3,963,555)	(4,427,992)	(464,437)	(11)%
(47,238,523)	(42,763,745)	4,474,778	11%	TOTAL DEDUCTIONS	(402,694,129)	(382,748,785)	19,945,344	5%
12,933,656	12,336,974	(596,682)	5%	NET SERVICE REVENUE	107,537,062	110,493,954	2,956,892	(3)%
721,353	496,385	(224,968)	45%	OTHER OPERATING REVENUE	4,404,711	4,467,461	62,750	(1)%
13,655,009	12,833,359	(821,650)	6%	TOTAL OPERATING REVENUE	111,941,773	114,961,415	3,019,642	(3)%
				***** OPERATING EXPENSE *****				
5,492,712	5,212,662	280,050	5%	SALARIES	47,481,570	46,220,606	1,260,964	3%
815,390	660,534	154,856	23%	S&W PTO	6,002,433	5,832,087	170,346	3%
1,577,825	1,441,819	136,006	9%	EMPLOYEE BENEFITS	12,267,381	12,836,206	(568,826)	(4)%
1,989,141	1,838,136	151,005	8%	PROFESSIONAL FEES	19,020,533	16,620,813	2,399,720	14%
812,763	746,677	66,086	9%	PURCHASED SERVICES	7,676,616	6,733,358	943,258	14%
1,986,336	2,008,846	(22,510)	(1)%	SUPPLIES & EXPENSES	18,701,357	18,071,973	629,384	4%
220,391	230,964	(10,573)	(5)%	MAINTENANCE & REPAIRS	1,991,776	1,975,119	16,657	1%
229,855	212,617	17,238	8%	UTILITIES	2,199,914	1,913,553	286,361	15%
44,239	45,029	(790)	(2)%	RENT/LEASE	360,233	405,262	(45,029)	(11)%
145,607	100,975	44,632	44%	INSURANCE	1,042,193	908,775	133,418	15%
810,944	864,381	(53,437)	(6)%	DEPRECIATION/AMORTIZATION	7,516,375	7,848,915	(332,540)	(4)%
433,379	366,696	66,683	18%	OTHER EXPENSE	3,131,105	3,349,476	(218,371)	(7)%
0	0	0	0%	IMPAIRED COSTS	0	0	0	0%
14,558,581	13,729,336	829,245	6%	TOTAL OPERATING EXPENSE	127,391,484	122,716,143	4,675,341	4%
(903,572)	(895,977)	7,595	1%	NET GAIN/(LOSS) FROM OPERATIONS	(15,449,710)	(7,754,728)	7,694,982	99%
112,969	112,423	(546)	1%	DISTRICT TAXES	1,016,721	1,015,086	(1,635)	0%
313,027	169,167	(143,860)	85%	INVESTMENTS INCOME	2,639,273	1,525,772	(1,113,501)	73%
48,219	37,741	(10,478)	28%	OTHER NON OPERATING INCOME	551,093	339,671	(211,422)	62%
(86,584)	(84,840)	1,744	2%	INTEREST EXPENSE	(776,899)	(763,559)	13,340	2%
(21,012)	(50,588)	(29,576)	(59)%	NON-OPERATING EXPENSE	(351,194)	(455,297)	(104,103)	(23)%
366,619	183,903	(182,716)	99%	TOTAL NON-OPERATING INCOME	3,078,994	1,661,673	(1,417,321)	85%
(536,954)	(712,074)	(175,120)	(25)%	GAIN/(LOSS) BEFORE NET INCR/(DECR) FV INVSMT	(12,370,716)	(6,093,055)	6,277,661	103%
1,338,800	0	(1,338,800)		NET INCR/(DECR) IN THE FAIR VALUE OF INVSTMT	(1,839,855)	0	1,839,855	
801,846	(712,074)	(1,513,920)	(213)%	NET GAIN/(LOSS)	(14,210,571)	(6,093,055)	8,117,516	133%

SIERRA VIEW MEDICAL CENTER
Statement of Cash Flows
03/31/23

	CURRENT MONTH	YEAR TO DATE
Cash flows from operating activities:		
Operating Income/(Loss)	(903,572)	(15,449,710)
Adjustments to reconcile operating income/(loss) to net cash from operating activities		
Depreciation and amortization	810,944	7,516,375
Provision for bad debts	334,779	1,360,701
Change in assets and liabilities:		
Patient accounts receivable, net	(446,170)	(2,138,455)
Other receivables	1,637,955	(9,533,296)
Inventories	48,321	(116,746)
Prepaid expenses and deposits	(343,762)	(276,898)
Advance refunding of bonds payable, net	20,980	188,817
Accounts payable and accrued expenses	(392,495)	(1,423,881)
Deferred inflows - leases	(33,064)	33,730
Accrued payroll and related costs	(542,986)	(296,642)
Estimated third-party payor settlements	(58,192)	(562,800)
Self-insurance reserves	-	-
Total adjustments	1,036,310	(5,249,095)
Net cash provided by (used in) operating activities	132,738	(20,698,805)
Cash flows from noncapital financing activities:		
District tax revenues	112,969	1,016,721
Noncapital grants and contributions, net of other expenses	24,072	177,087
Net cash provided by (used in) noncapital financing activities	137,041	1,193,808
Cash flows from capital and related financing activities:		
Purchase of capital assets	(259,964)	(5,084,385)
Proceeds from lease receivable, net	31,296	(44,568)
Principal payments on debt borrowings	-	(3,715,000)
Interest payments	(3,364)	(1,855,741)
Net change in notes payable and lease liability	(95,163)	(383,569)
Net changes in assets limited as to use	(579,411)	2,126,208
Net cash provided by (used in) capital and related financing activities	(906,606)	(8,957,055)
Cash flows from investing activities:		
Net (purchase) or sale of investments	61,164	6,616,887
Investment income	313,027	2,639,273
Net cash provided by (used in) investing activities	374,191	9,256,160
Net increase (decrease) in cash and cash equivalents:	(262,636)	(19,205,892)
Cash and cash equivalents at beginning of month/year	9,329,883	28,273,139
Cash and cash equivalents at end of month	9,067,247	9,067,247

SIERRA VIEW MEDICAL CENTER

MONTHLY CASH RECEIPTS
March 2023

	PATIENT ACCOUNTS RECEIVABLE	OTHER ACTIVITY	TOTAL DEPOSITED
Apr-22	10,302,842	5,121,377	15,424,219
May-22	10,717,469	760,349	11,477,818
Jun-22	11,174,875	4,902,151	16,077,026
Jul-22	10,591,327	206,562	10,797,889
Aug-22	11,384,869	198,928	11,583,797
Sep-22	11,025,336	384,733	11,410,069
Oct-22	10,879,234	1,521,302	12,400,536
Nov-22	10,716,042	298,921	11,014,963
Dec-22	9,551,250	2,895,404	12,446,654
Jan-23	11,383,815	396,451	11,780,266
Feb-23	10,444,477	1,486,294	11,930,771
Mar-23	**11,036,309**	**4,353,856**	**15,390,165**

NOTE:

Cash receipts in "Other Activity" include the following:

- Other Operating Revenues - cash receipts for Cafe and Coffee Corner sales, rebates, refunds, and receipts from miscellaneous funding sources

- Non-Operating Revenues - rental income, property tax revenues

- Medi-Cal OP Supplemental and DSH funds received
- Medi-Cal and Medi-Care Tentative Cost Settlements received for prior year
- Grants, IGT, & HQAF
- Medicare interim payments received

March 2023 Summary of Other Activity:

581,257	M-Cal HQAF7 Direct Grant CY22
2,562,466	Anthem BC QIP IGT 01/21 - 12/21
824,615	M-Cal IP DSH FY19 Audit Redistribution Pymt
385,518	Miscellaneous
4,353,856	03/23 Total Other Activity